FACILITATION OF THE PLANNING OF AN ADOLESCENT TREATMENT CENTRE: A SOCIAL WORK CONTRIBUTION

A practicum report submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Social Work.

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BY

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A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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A very special thank you to Marian McEwan for her commitment, skill and patience in typing this report. Thank you also to the back-up typists Marjorey Dwornick and April Quigley.

This work is dedicated to my father, Walter N. Boyd, a practising social worker for the past thirty-five years.

His work in the social services field is a testimonial to his respect for, and belief in, the dignity and value of the individual, and to his profound commitment to ameliorating the impact of the "dis" in "ability".

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CHAPTER I - INTRODUCTION

> "Treasury board at its meeting of December 9th, 1980, approved that the Manitoba Health Services Commission construct a 25-bed psychiatric unit for adolescents in the City of Winnipeg. The stipulation was that the property exist in the core area of Winnipeg near the Health Sciences Centre. The Manitoba Health Services Commission was also instructed to enter into architectural design contract and to proceed to construction of this unit.
>
> This 25-bed unit will deliver multidisciplinary psychiatric services to selected adolescents and their families with severe psychiatric disturbance. The name suggested for this psychiatric facility is The Manitoba Adolescent Treatment Centre. It is proposed that a non-profit corporation with a Board of Directors appointed by the Minister of Health be constituted under the Corporations Act. The corporation would be responsible for the operation of the Manitoba Adolescent Treatment Centre but the ownership of the building would be vested in the Manitoba Health Services Commission." (Cabinet Paper, "Psychiatric Facility for Adolescents")

In 1981, the provincial Minister of Health, Honourable Bud Sherman assigned a community child/adolescent psychiatrist and a representative of the Manitoba Health Services Commission Urban Facilities Division, to plan a provincial psychiatric hospital for the long-term treatment of adolescents. Following planning sessions between these two principals, an architectural firm was awarded the contract, and in the late fall of that year the Planning Committee was constituted.

Working with this Committee to plan an adolescent psychiatric facility, which had been talked about, and, recommended by task force reports for decades, presented an unique setting for my social work practicum.* A meeting was held with my advisor, the psychiatrist who was the Chairperson of the Committee, and myself, to negotiate my role with the Committee. It was agreed that I would

* Prior to returning to complete my M.S.W., I had been working for several years in rural Manitoba for Community Psychiatric Services for Children, of which the psychiatrist was the Director. This was a positive contributing factor in the psychiatrist's decision to explore the possibility of my completing my practicum as a member of the Planning Committee.

fulfill the role of "facilitator-coordinator" and "planner". The psychiatrist explained to the Planning Committee that an M.S.W. student had requested to complete her practicum as a member of the Planning Committee. There was agreement by the Committee on my involvement in this identified role of facilitator-coordinator and planner.

The duration of my involvement with the Planning Committee was from November 1981 to the Spring of 1984.

My goals for this practicum were to improve my social work skills in planning and group facilitation. The practicum setting was an ideal one in which to realize both of these goals. The Planning Committee was comprised of senior professionals who had years of experience in their particular field and in working on various planning committees. This, then, presented me with the opportunity of focusing my interventions on enabling experienced professionals to work effectively and efficiently on achieving an end product that was consistent with its original mandate and goals.

Sarason describes the challenge.

> "Creating a physical environment is under the best of circumstances a formidable task. Unlike the administrative chart, a brand new structure cannot be changed, and this knowledge is a stimulus both to anxiety and creativity - under the best of circumstances." (Sarason 163)

The warning phrase "cannot be changed" appeared to me to be the key to successful task achievement by the Planning Committee. In my role, I would have to concentrate on supporting consensus testing and resolving conflicts to facilitate the planning and decision making process.

Specifically, my functions were outlined as follows:

Support Consensus Testing	Encourage group to explore areas of agreement, suggest alternatives, propose compromise solutions.
Facilitate Decision Making Process	Encourage participation by all members.
	Explore whether Committee is nearing a decision, caution against premature decision-making and/or delayed or deferred decision-making.
	Encourage Committee to reach decisions that are consistent with previous decisions and consistent with treatment philosophy and the terms of reference of the group.
	Initiate or propose ideas, actions or procedures relevant to the tasks of the group.
Facilitate Conflict Resolution	Explore disagreements, relieve tension and bring to a resolution.

One of the methods of facilitating accurate, realistic and consistent planning and decision making would be through my role as the liaison and resource consultant and as the recorder of the committee's decisions and plans.

Specifically, these functions were described as follows:

Document Process at Each Meeting	Accurately record minutes and ensure their distribution.
Arrange for Consultants/Resource Material	Make arrangements for resource consultants (education, occupational therapy, etc.) to attend meetings when their specific expertise is required.

The function of assisting with "group maintenance functions" was described as follows:

Assist in Group Maintenance Functions	Increase the personal satisfaction of each member as it relates to his functioning in the group.
	Enhance group morale through support of a common purpose, shared goals.

In addition, it was agreed that I would work closely with the psychiatrist, Chairperson of the Committee, to facilitate his role as the government appointed "User Group". This enabled me to include a social work perspective in the development of the Functional Plan and subsequent design of the treatment environment, and in discussions of the proposed role of this facility within the provincial mental health service delivery system.

The principal members of this Planning Committee were as follows: the Chairperson, who was a community child/adolescent psychiatrist, a representative of the Urban Facility Planning Division of the Manitoba Health Services Commission, the architectural firm, represented by the senior architect and the draftsperson, and myself.

All members were appointed to the Planning Committee. With the exception of the architect, the members' appointments were identified as part of their job description within the provincial Department of Health for the duration of the task. Each member of the Committee was given the authority to make final decisions within the purview of their roles and constituencies. This fact, and the fact that I had worked previously with the pschiatrist had implications for my choice of intervention strategies. This will be discussed in later chapters.

The Planning Committee did not exclude me from any sessions on the basis that certain information was highly confidential. However, they did not give permission for audio-taping meetings, and occasionally, during the meetings, requested that certain comments not be entered into the formal written record. To protect confidentiality, members of the Planning Committee will be referred to by their profession/agency, throughout this report. Details of some illustrative examples may also be limited to the formal written record when confidentiality has been requested, or, in my opinion, is required.

The following chapter will explore the historical and political context under which the Planning Committee worked. The chapter on Methodology will provide more detail on my role with the Planning Committee. Following this explanation

of my various functions, I will review the process with which decision were made and the role of the social worker in facilitating this process. An evaluation by Planning Committee members of my role with the Committee and a self-evaluation will follow.

CHAPTER II - HISTORICAL POLITICAL CONTEXT

A. THE MANDATE TO BUILD

From Pinel's removal of the chains and shackles of inmates in Paris asylums in 1792, and his introduction of moral treatment, to the present belief that mental health services should be concentrated in the community, there has been an evolution in the understanding of mentally ill people, and a growing repertoire of "best" intervention systems to treat them. Each generation places emphasis on certain aspects of diagnosing and treating the mentally ill.

The challenge for the Planning Committee became the designing of a permanent structure that reflected the beliefs and constraints of the present, and anticipated the beliefs and prospects of the future.

> "The ultimate test of the success of a designed setting is its ability to satisfy and support explicit and implicit human needs and values; that is, to provide a physical and social milieu within which individuals' and groups'lifestyle aspirations are reinforced and values are recognized." (Friedmann et al. 9)

The identification of a need for distinctive treatment programs for psychiatrically disturbed adolescents is a relatively new phenomenon. In the past, if adolescents were clearly mentally ill they were committed to an adult psychiatric hospital; if they did something clearly anti-social, they were committed to a juvenile correctional facility; if they had "behaviour problems", they were placed in child welfare institutions or group homes. Many adolescents presented with more than one need or problem and clearly "did not fit". These adolescents appear to have been "diagnosed" according to their level of negative visibility in the community, and, according to the availability of space in each program.

When the directive to build a long-term adolescent psychiatric facility was announced, many vested interest groups in the province believed it would answer their needs. The Juvenile Corrections professionals hoped that the new facility would take all of the juvenile offenders whose crimes were somewhat bizarre, or, had elements of extreme violence against society. Child welfare professionals hoped that the facility would admit those adolescents whose behaviour was such that they could not be maintained in open settings. Media reports emphasized that adolescents sent out-of-province, for psychiatric treatment at enormous expense to the taxpayer, would be repatriated to this proposed psychiatric facility.

The hospital psychiatric assessment units with a combined total of eighteen (18) beds for children and adolescents for Manitoba and Northwest Ontario, believed that the new facility would be the answer for those adolescents whom they had assessed as needing longer term inpatient or day patient treatment. The rural component of Community Psychiatric Services for Children hoped that the facility would provide a therapeutic milieu for those adolescents requiring intensive psychiatric treatment, beyond the ability of the community of origin to provide, and, that it would provide immediate access for adolescents, throughout the province, who were in acute crisis.

Discussions with staff in similar adolescent treatment facilities across Canada, and the literature, strongly support the fact that you cannot successfully mix adolescents whose primary problem is that of disordered thinking, caused by mental illness, with those adolescents whose problems are not the result of mental illness, but who have been identified by the community as displaying behaviour that is considered unacceptable according to society's mores. The

critical factor in identifying the mandated population is the primary diagnosis or problem. Secondary to the primary diagnosis of mental illness, adolescents with criminal charges, behavioural problems, family problems, and academic problems, would be included in the target population.

The directive from the Provincial Department of Health was to build an adolescent psychiatric hospital. The description of what an adolescent psychiatric hospital is in the 1980's was less clear. The institutions that were visited in Canada, including Thistletown in Ontario, Woods Christian Homes in Calgary, and British Columbia Youth Development Centre, recommended a melding of intensive residential care with psychiatric input. The amount of each ingredient to be combined into this mixture was an unknown factor. The Planning Committee's goal was to achieve a strategic balance of the best components of a psychiatric hospital, and of a residential, home-like milieu. The implications for the system of creating this new setting were discussed from the first meeting to the last, because of the vested interest groups and the degree of political pressure brought to bear on the process.

Depending on the philosophy and goals of the User Group, the final result could have differed remarkably from what this particular planning group put together. There was no existing model to follow. Facilities in Western Canada and local psychiatric units were consulted as to problems they encountered with their respective settings, and I reviewed the available literature. These sources, combined with the philosophy, knowledge and experience of the User Group, provided the basis for the functional plan and for the decision-making process of the Planning Committee.

The Planning Committee met from the fall of 1981 to the spring of 1984. I will not be reviewing the development of this group, nor its content and process issues in a chronological manner. Rather, I propose to discuss several major themes to illustrate the workings of the group in its task of creating an adolescent treatment facility. References to the literature will be incorporated into the discussion.

The Committee was given limited direction and, therefore, set its own design goals. These goals and the philosophy vested in them were the focus of discussions at the group meetings. Constraints were many - some common to any team working on a task, others specific to the political, socio-economic environment in which this task was to be realized.

Data will be drawn from several sources, as follows: the written record of detailed minutes which I kept as part of my role with the group, and observation notes I compiled on both the process and content of each meeting, and from individual conversations I had with Committee members and their support staff, and in particular with the Chairperson of the Planning Committee.

In my review of the literature, I found material which could be considered supportive, but not directly related to the planning process and specific problems of designing a psychiatric facility, or other similar facility. There was some limited material on the building boom of the asylums, or mental hospitals, in the early 1950's.

Humphrey Osmond's well-known statement, quoted in "Function as the Basis of Psychiatric Ward Design", Mental Hospital, Vol. 8, April 1957,

> "Structure will determine function, unless function determines structure."

is a classic commentary on the importance of the process of making decisions according to identified need.

Recently, two human service writers have examined the process of designing facilities. Seymour Sarason, in "The Creation of Settings and Future Societies", published in 1972, expressed his concern over this dearth of written material, as follows:

> "One of the thorny obstacles to understanding and formulating the creation of settings is the lack of well-described instances... I would suggest that the complex task is made a near impossible one by the lack of an organized set of conceptions which would help select and order data according to the basic problems confronting the creation of any setting." (Sarason 21)

A decade later, Mayer Spivak, whose collected writings on the process of interdisciplinary planning in facility development, were compiled into a book in 1984, "Institutional Settings, An Environmental Design Approach", described the result of this lack of data.

> "Throughout the whole dreary history of institutional architecture, we have repeated our mistakes and our successes, undifferenciated, from building to building, from state to state, from decade to decade." (Spivak 65)

It is not that the designing and construction of settings is a new and unusual occurrence. Rather, it is that sociologists, psychologists and architects have concentrated on evaluating specific aspects of the finished product, rather than on the process of designing this product.

The environmental design literature provided examples of the environmental effects of residential settings on children and adolescents. Literature reviewed on mental illness and mental health, on the history of the evolution from the asylum to community-based treatment, provided contextual background. The literature on groups was reviewed with an emphasis on the planning and decision making process of task groups.

As stated earlier, with the exception of those few writers who have considered the process of facility design, the literature drawn from these sources was helpful in a supportive, rather than a direct sense. The literature and its contribution to my agreed upon role with the Planning Committee, will be discussed in further detail as we proceed through the next chapters.

B. HISTORICAL OVERVIEW OF THE CARE AND TREATMENT OF THE MENTALLY ILL IN CANADA

Before considering the events specific to the Manitoba scene, which contributed to the context within which the planning and designing of the Manitoba adolescent psychiatric hospital occurred, I will briefly review the history of the care and treatment of the mentally ill, with emphasis on Canada.

> "The term emotionally disturbed child is a recent import in psychological and psychiatric literature." (Despert 37)

In her book "The Emotionally Disturbed Child", L. Despert attempted to trace the history of the classification and treatment of children who did not qualify as "normal". In her opinion, the term "emotionally disturbed" does not reflect the emergence of a new phenomenon, but is the successor to earlier terms such as "incorrigible", "wicked", and "possessed". She states the term "emotionally disturbed" was first applied specifically to children by Sullivan in 1932. (Despert 37)

Children were treated as "miniature adults" up until the late 1800's, the poor, working and subject to the same harsh laws as adults from ages 6 or 7, and the rich, preparing for their life as the "chosen class". Leo Kanner, the author of the first American textbook in child psychiatry writes,

> "The concept of child psychiatry as a distinct specialty did not arise - and could not have arisen - before the twentieth century." (Glasscote 11)

Prior to the seventeenth century, mentally ill persons, variously referred to as "possessed", "witches", etc. were considered to be the responsibility of the

family unit. Often, families were unable or unwilling to provide for these people, and "community care" of the mentally ill more often than not resulted in ridicule, neglect and abuse. Religious institutions provided some supplemental care. In 1656, Louis XIV of France established several "general hospitals" to care for the destitute, aged, lunatics, idiots, and others considered as "useless to society". Following their example, New France (Québec) built, under François Charon, the Hôpital Général Villa Marie in 1694. This hospital and the Hôpital Général de Québec were the first institutions in Canada who admitted and cared for persons who were considered insensé.

In the nineteenth century, crusaders such as Pinel in France, Turke in England, and Dorothea Dix in North America, reacting to the deplorable conditions to which mentally ill people were sent, to be held in many cases until their death, introduced the era of "moral treatment" with its belief that mental illness is curable. The environment was considered to be the key to the cure. This translated into isolating the person from the harmful effects of the world in a place of "asylum", in order to heal the broken spirit, and the provision of a balance of work, culture and recreation, under the constant support and encouragement of staff, to restore the person's ability to cope with an eventual return to the outside world.

The prevailing mood was optimism, cure rates of 100% were claimed, and large sums of private and public money heralded the era of the mental hospital movement, the building of the asylum. (Leighton 20)

Within fifty years, optimism was replaced with the realization that some people were not cured, that hospitals were becoming overcrowded and under-financed, and that conditions were fast approaching those against which Pinel and others had fought.

The discovery of biological determinism and belief in survival of the fittest, swung the pendulum to the theory that the mentally ill are incurable, and require only safe custody, at a minimal cost. This change in society's beliefs did not close the floodgate of people being sent to asylums, but did change the role of the asylum to a place of secure custody. With referrals continuing, and chronic patients occupying beds, reduced funding and untrained staff, "moral treatment" or the "therapeutic environment" was replaced by less expensive, custodial care. In Canada, and in the United States, massive immigration further strained the resources of existing institutions to provide even a minimal standard of custodial care, and more and bigger institutions were constructed.

In the early 1900's the asylum, then, was society's basic response to the problem of mental illness. Social Darwinism with its emphasis on the natural selection process and survival of the fittest, justified labelling and isolating the mentally ill from "normal society". Their heredity was obviously defective, and normal people and future generations had to be protected from them.

Then came the Mental Hygiene Movement, the influence of Freud in emphasizing the effects of environment on personality development, and the development of neurology and psychobiology under Adolf Meyer, who included psychological, biological, familial and social factors as causative. Meyer moved psychiatry into a more scientific approach and developed it as a sub-specialty of medicine.

The Mental Hygiene Movement supported by Meyer and promoted by Clifford Beers, a former mental patient, was seen as a means of bringing together professional and lay people to support research and to prevent mental illness. In Canada, Dr. C.M. Hincks introduced intelligence testing, and with the help of Clifford

Beers, established the first Mental Hygiene Clinic at the Toronto Juvenile Court. (C.M.H.A., "More For The Mind" 4, 5)

Freud's analysis and writings on the effects of early childhood on adult personality sparked interest in the study of the child. The Mental Hygiene Movement's emphasis on prevention fostered the Child Guidance Clinic Movement, with services provided to children as a preventative measure to mental illness later in life.

Kanner outlines the following events as being the main building blocks in the development of child psychiatry as a separate discipline. (Glasscote et al. 12)

(1) The Introduction of Psychometry - Goddard introduced the Binet-Simon Test of Intelligence in the United States in 1910, Terman adapted it in 1916 as the Stanford Revision of the Binet-Simon Test.

(2) Advent of Dynamic Psychiatry - Freud, and Meyer in the United States, and their retrospective search for meaning of childhood events led to an interest in childhood.

(3) Establishment of Juvenile Courts - psychiatric and psychological consultation on juvenile offenders was provided to judges.

(4) Mental Hygiene Movement - 1909, Clifford Beers, "National Committee for Mental Hygiene" with emphasis on prevention and research.

(5) Probation for Young Offenders - the role of the Probation Officer was defined as a "protector" and a "guide".

(6) Foster Home Placement Agencies - provided since the 1850's for homeless immigrants; from 1915 for disturbed children who needed to be removed from unsuitable homes.

(7) Special Education Services (1910-1920) - United States passed legislation to promote education of the mentally retarded or otherwise handicapped pupils.

(8) Child Guidance Clinics (1909-1911) - promoted the ideal of treating children in the home environment.

(9) Play Therapy - Melanie Klein, Anna Freud - first involvement of the child per se in treatment.

Quentin Rae-Grant and Patricia Moffat in their 1971 report "Children in Canada, Residential Care" record that the first hospital school for retarded children opened in 1876 in Orillia, Ontario. This hospital became the prototype for several dozen institutions across Canada. Until recently, there was generally no distinction made between those children seen as psychiatrically disturbed or mentally retarded. The recognition and specialized treatment of children and adolescents with psychiatric disturbance is of recent origin with the first children's in-patient psychiatric unit in North America opening in New York's Bellevue Hospital. (Rae-Grant and Moffat 7)

In 1918, Hincks and Beers organized Canada's National Committee for Mental Hygiene. World War I demonstrated that everyone is vulnerable to stress when many people became shell-shock casualties. At the close of the war, Hincks

originated chapters of Canada's National Committee for Mental Hygiene across Canada, and advocated small regional hospitals, associated with universities, to alleviate the deplorable conditions of the mental asylums.

> "The economic depression of the 1930's provided an impetus for the change in social philosophy, stimulating a new ideology of social welfarism that promoted federal intervention and the formulation of social planning and public policy at the national level." (Segal and Aviram 16)

In Canada, the Rowell-Sirois Commission of 1939 stated there was a continuing need for additional mental health accommodation. This Commission was the beginning of organized efforts by the Federal Government to assess mental health services across Canada, and to promote the planning and equitable provision of mental health services to people in all parts of the country.

The treatment of World War II's mental health casualties resulted in a dramatic increase in mental health professionals and services, and concomitantly more acceptance by society of persons with emotional disabilities. This acceptance, the continuing deterioration of the asylums and the impossible projected costs needed to bring these structures up to standard, and the introduction of psychotropic medication to control symptoms, provided the impetus for a community-based care system.

In 1943, the Parliamentary Special Committee on Social Security presented a brief from the Provincial Mental Health Directors on the importance of considering psychiatric wards as part of the general hospital. In contradiction to this recommendation of treating the mentally ill as they would be in a general hospital, the Canadian Hospital Insurance and Diagnostic Services Act specific-

ally excluded benefits to mental hospital patients. (C.M.H.A., "More For the Mind")

The federal government responded to the Provincial Mental Health Directors' Brief by providing Mental Health Grants in the 1950's to the provinces to survey the existing situation and to plan for improvements.

One of the first recommendations to be realized by the federal government was financial assistance to construct 20,651 beds between 1948 and 1961. (Royal Commission on Health Services, "Psychiatric Care In Canada" 42) It became obvious, by 1955, to the National Scientific Planning Council of the Canadian Mental Health Association (formerly National Committee for Mental Hygiene) that the other provincial recommendations were not being considered. The Council therefore appointed a Standing Committee on Psychiatric Services which was to review the current situation and to develop a methodology of setting standards for evaluation of service provision.

Their main recommendations can be summarized as follows:

(1) Integration of psychiatric services with the rest of medicine.

(2) Regionalization of treatment services.

(3) Decentralization of management and administration of psychiatric services.

(4) Close cooperation of treatment personnel and coordinators of psychiatric services.

(5) Increasing and improved training and career programs.

(6) Coordination of local psychiatric services in hospitals or centres to ensure maximum effectiveness.

(7) Periodic evaluation of quality of patient care by an independent agency. (Royal Commission on Health Services, "Psychiatric Care In Canada" 7)

In 1960, Mr. MacNaughton introduced a private member's bill to the federal house which suggested that the Federal and Provincial governments and professional groups cooperate in "making a national survey of the extent of mental illness, its causes, problems and methods of treatment." (C.M.H.A., "More For the Mind" 18)

After much debate, the resolution was accepted in principle by the federal Minister of Health and Welfare, Honourable J. Waldo Monteith and the government appointed a Royal Commission under Justice Emmet M. Hall, in June 1961, to study health services in Canada. (C.M.H.A., "More For The Mind" 18)

This Commission resulted in several reports including eleven (11) briefs from C.M.H.A. - one from each province, and one from the national office which are contained in the document "More for the Mind' 1963 and the "Royal Commission on Health Services - Psychiatric Care in Canada, Extent and Results", 1966.

The former report recommended a mental health system based on medical integration, regionalization, decentralization, continuity of care and coordination. There were specific recommendations made for children's services. The Committee

stated first that these five (5) key factors of a mental health system should be applied to children. It recommended a range of services including inpatient, partial hospitalization, and outpatient services to the family, and a variety of specialized living arrangements. It emphasized special provisions in the classroom for educating children and adolescents, early assessment by the psychiatric team and coordinated integrated services, and separation of patients according to disability and treatment need. The following quote from the Dominion Bureau of Statistics in 1965 indicates the results of their attempts at compiling information on children involved in treatment programs.

> "The number of first admissions to these institutions is a function of reporting of facilities provided and has little or no relation to incedence or prevalence." (Rae Grant and Moffat 18)

The Royal Commission stated "the quality of psychiatric care is related to the degree to which it is available, acceptable, comprehensive, continuous and has treatment based on diagnosis rather than symptoms. In terms of these five criteria the general quality of psychiatric care is not high in Canada." (Royal Commission on Health Services, "Psychiatric Care In Canada" 18)

Similar studies were being conducted in the United States by the Joint Committee on Mental Illness and Health from 1955 to 1960. The final report entitled "Action for Mental Health" (1961) was studied by the United States Cabinet. President John F. Kennedy then called for

> "the creation of comprehensive community mental health centres that would make it possible for most of the mentally ill to be successfully and quickly treated in their own communities and to return to a useful place in society." (Segal and Aviram 29)

The passing in 1963 of the "Community Mental Health Centres Act" provided the funds for construction. These centres were to include

> "at least five essential services: inpatient, outpatient, partial (day and night) hospitalization, 24-hour emergency services, and community services, consultation and education. Other allowable services were diagnosis, rehabilitation, pre-care and after-care, training, and research and evaluation." (Segal and Aviram 29)

This Joint Commission on Mental Illness and Health did not review or make recommendations on services for children and adolescents. Therefore, in 1975, the United States Congress appointed a second "Joint Commission to Review the Mental Health Needs of Children and Adolescents." Results showed that, although children and adolescents were to have been provided with services by the Community Mental Health Centres, services were adequate in very few centres. As a result, the Federal legislation was amended in 1970 and separate and specific monies were allocated for developing child and adolescent services. (Glasscote et al. 3, 4)

In 1978, the President's Commission on Mental Health considered

> "the upgrading and expansion of services for children with psychiatric disorders an urgent priority" (President's Commission on Mental Health 617)

and funding was recommended for a comprehensive range of mental health services.

Residential services, were to be provided in separate settings from adults, and were to include a range of services, and increased linkages with public and private agencies.

> "In contrast to the trend toward de-institutionalization of adults, there remains a scarcity of residential resources for children and adolescents." (President's Commission on Mental Health 628)

C. HISTORICAL OVERVIEW OF MENTAL HEALTH SERVICES TO CHILDREN IN MANITOBA

The planning of a long-term treatment facility for psychiatrically disturbed children/adolescents in Manitoba has been discussed by various task forces and agencies since the 1930's. With each new proposal, the goals of the facility, as well as the functional plan, were adapted to reflect currently accepted treatment methodology. For example, early proposals for a 160 bed psychiatric hospital would be considered totally unacceptable today. The following section traces the history of significant, task force and agency reports and recommendations on mental health service delivery in Manitoba. This history of aborted attempts to provide treatment to psychiatrically disturbed children/adolescents in Manitoba, provided historical context within which the Planning Committee tried, once again, to successfully plan and build a long-term psychiatric hospital.

In 1955 the Community Welfare Planning Council recommended the construction of a 160-bed child and adolescent hospital in Winnipeg. The Council appointed a "Psychiatric Services Standing Committee", under Dr.George Sisler whose report in 1956 included the following recommendations on children and adolescents.

(1) "Combining of the Child Guidance Clinic and Children's Hospital Outpatient Department into a new clinic in the medical centre to serve all the psychiatric needs of children year round. This would include "facilities for intensive long-term treatment."

(2) "Board of Directors responsible for this clinic to include representatives of government, city, school and hospital boards, and, of voluntary organizations."

(3) Establishment of an Outpatient Department in St. Boniface Hospital Children's Department." (Sisler 7, 8)

By 1958 there had been no progress on the above, and a member of the Child Welfare Planning Council, Nan Murphy was appointed to chair a standing committee to advise on the development of psychiatric services for children and adolescents in Manitoba. The Committee recommended in 1960 to the Hospital Survey Board the opening of a 15-bed assessment unit for children and a 160-bed psychiatric hospital for children. A construction grant was approved for the latter in 1963. The Welfare Council, through psychiatric services, approached Children's Home in November 1960 regarding the provision of administrative services in affiliation with Children's Hospital for the 15-bed unit. This was approved by the Minister of Health as the top priority in developing mental health services.

The standing committee was terminated in 1964 with the following achievements: construction of a special education building, opened in 1961 to house the Ellen Douglas School and the Child Guidance Clinic, and the opening of a pre-school Child Development Clinic, at Children's Hospital, in April of 1964. No progress had been made in the psychiatric assessment unit nor on the psychiatric hospital.

According to the 1966 survey for the Royal Commission, Manitoba was providing in-patient and out-patient services at the Selkirk Mental Hospital, opened in 1886, the Brandon Mental Hospital, opened in 1891, the Psychopathic Hospital opened in 1919 (Winnipeg Psychiatric Institute), the Manitoba School for Mental Defectives, and at the psychiatric units of St. Boniface Hospital, Health Sciences Centre, Misericordia General Hospital, and Deer Lodge Hospital. Specifically for children, an in-patient and out-patient service operated

through Children's Hospital, The Winnipeg Child Guidance Clinic, and The Brandon Child Guidance Clinic. (Royal Commission on Health Services, "Trends In Psychiatric Care" 92)

Children's psychiatric needs identified through this 1966 survey were as follows:

(1) 15-bed unit for acutely disturbed children at Children's Hospital.

(2) Undetermined number of beds for the Manitoba School, for emotionally disturbed children who are grossly handicapped.

(3) 20-bed unit for children in a medical centre in Winnipeg for inpatient treatment from one to two years.

(4) Facilities for the inpatient treatment of disturbed adolescents. (Royal Commission on Health Services, "Trends In Psychiatric Care" 99)

Dr. Jim Asselstine, then the Director of the Winnipeg Child Guidance Clinic, and his staff, began work on developing the previously discussed psychiatric facility. In September 1966, a functional plan for 448 patients, of which 48 would be in-patients, 100 would be partial hospitalization, and 300 would be active out-patient cases, was negotiated with various interested parties. However by 1970, the only change in service delivery was the inpatient child psychiatric unit at Children's Hospital which had gradually evolved to a capacity of 15 beds, designated for assessment and short-term treatment. Outpatient services continued to be provided through Children's Hospital.

In 1968, the Social Services Audit made the following recommendations in the areas of mental health.

> "Diagnostic services should be available to improve the use of institutional and clinical care placements. This should include residential observation units, clinical diagnostic services and treatment facilities. All services for the older adolescent should be included." (Social Service Audit 28)

In 1972, the report "Five-Year Plan for Mental Health in Manitoba" outlined the following basic principles which were to be followed in planning and delivering mental health services in Manitoba.

(1) Where possible the patient should be treated in his community.

(2) Community-based resources should be utilized as far as possible.

(3) The emphasis should be on the severely disturbed.

(4) An attempt should be made to more equitably distribute services, through increased decentralization and increased emphasis on prevention.

(5) Services should maximize dignity, and provide restoration of function with the least disruption to the patient's lifestyle.

Dr. Graham Clarkson, tabled his 1973 report on The Mental Health and Retardation Services in Manitoba "stating that a modern mental health program should be based on three (3) basic components, those of normalization, care in the community, and regionalization of services and facilities." (Clarkson 8)

His first recommendation was that mental health and mental retardation services should be considered separate and distinct programs.

Recommendation, Section 1.2 No. 1

> "The Mental Retardation program should be separated out from the Mental Health program, and placed under separate direction." (Clarkson 1)

He recommended that mental health services should be accessible to people in their own communities.

Recommendation, Section 1.3 No. 5

> "The development of a regionally-based, community-oriented mental health program should emphasize care in the community as opposed to hospitalization." (Clarkson 2)

In 1973, the position of "Coordinator of Community Psychiatric Services for Children" was established by the government and in 1974 Community Psychiatric Services for Children began providing mental health services to children/adolescents and their families in rural and northern Manitoba.

Children's services had been described in the Clarkson Report as "fragmented and ill-coordinated." (Clarkson 52) According to Clarkson, this lack of coordination has often resulted in the child/adolescent receiving services based on first contact, not on identified need, or in the child/adolescent being referred to agency after agency in an attempt to find the right services. Clarkson identified the Child Guidance Clinic and the Children's Hospital as the two major children's mental health service providers and noted their separation promotes problems. His recommendation on integration of these services is as follows:

Recommendation, Section 1.3 No. 8

> "A central and major child and adolescent service should be established by the integration of the psychiatric component of the Winnipeg Child Guidance Clinic and the Children's Hospital psychiatric ward." (Clarkson 3)

In February of 1973 an Advisory Board Council of the Child Guidance Clinic approached the Health Sciences Centre for action on the long-term treatment facility. In April, the Ad Hoc Committee (Drs. George Sisler and Harold Penner, members) recommended that the in-patient short-term unit should be expanded from 15 to 30 beds, that 50 beds should be identified for extended treatment, and that 100 spaces should be identified for day treatment. In 1974, it was recommended that this plan begin with a pilot project of 15 beds for long-term in-patient treatment of severly disturbed children. This report was presented to the Advisory Board of the Child Guidance Clinic and to the Child Care Committee of the Health Sciences Centre, who approved and forwarded it to the Planning Committee of the Health sciences Centre for consideration and to the Department of Psychiatry, and then to the Minister of Health, the Honourable Saul Miller.

In 1975, the Manitoba Psychiatric Association completed a study on the needs of children and adolescents and recommended the construction of a 50-bed facility (possible site - Old Grace Hospital). Concern was expressed at the placement of children and adolescents in out-of-province psychiatric treatment facilities. In 1976, this totalled 70-80 adolescents at an approximate cost of one million dollars.

In 1975, the Ryant report on the Review of Child Welfare Policies reviewed proposals for closed treatment of emotionally disturbed children and adolescents. The Clarkson report and the alternate proposal for a 50-bed hospital at

the Old Grace Hospital were discussed. The latter was not supported because of its contradiction with the recommendation of the Clarkson report, and the Five-Year Plan, both of which emphasized decentralization, individualization, and community-based services. The Ryant report emphasized improved linkages with other service providers and better use of existing resources. (Ryant 188 189)

On September 30th, 1975, there was a Cabinet Submission to Health, Education and Social Policy Committee of Cabinet, entitled the "Extended Treatment Facility for Emotionally Disturbed Children and Adolescents." This submission for a 10-bed pilot project under the auspices of the Health Sciences Centre agreed to follow the principles outlined in the Five-Year Plan. Funds were approved in the 1975-76 Government Estimates for $176,000.00.

In 1976, the Psychiatric Task Force (Mr. David Pascoe and Dr. John Toews) which was studying the redevelopment of psychiatric services at the Health Sciences Centre listed the following needs for psychiatrically disturbed children and adolescents: for children - a 15-bed long-term unit, 15-bed short-term unit, day treatment for 20, and outpatient department; for adolescents - a 15-bed acute unit, 20 day treatment spaces, and an outpatient department. The first priority, a detailed plan for psychiatric services for children was to be completed by April 1977. (Psychiatric Task Force Minutes)

The "Planning Committee for the Children's Long-term Unit" met from 1976 to 1978 under the Chairship of Dr. Harold Penner, then Director of Community Psychiatric Services for Children. The architectual firm had completed the drawings when there was a change of government (NDP to Conservative), and the review of capital expenditures froze the planning just prior to construction. Planning continued regarding other phases of the Health Sciences Centre psychiatry

redevelopment.

The 1978 report of the "Task Force on Government Organization and Economy" recommended increased psychiatric services for children.

> "Children, whether delinquent, disturbed or deprived often require special services. Psychiatric services are most needed at this time and are not available in sufficient quantity." (Spivak 104)

The "Response of the Social Planning Committee" to the Spivak report highlighted three (3) issues as follows:

> "(1) There is a critical shortage of acute treatment beds for adolescents.
>
> (2) There are a number of treatment facilities but no coordination of placements to make effective use of these resources.
>
> (3) Comprehensive planning to establish child and adolescent mental health services is required." (Social Planning Council, "Challenge and Opportunity" 13, 66, 104)

In 1980, the newly appointed Director of Community Psychiatric Services for Children, Dr. K. Sigmundson was approached by the Minister of Health, to prepare a feasibility plan for a 25-bed "long-term unit" for psychiatrically disturbed adolescents. Although negotiations for redevelopment of Psychiatry within the Health Sciences Centre were continuing, and provision for child and adolescent services was a part of this planning, it was proposed and agreed that this 25-bed unit would be a freestanding unit under the aegis of a community board of directors.

In 1983, Mr. David Pascoe chaired a Ministerial Task Force on "Community Mental Health Services in Manitoba." Several sub-committees were appointed and Dr. Sigmundson and I sat on the "Child/Adolescent Mental Health Services Committee."

The report of this Committee was submitted in May of 1983. Among the recommendations were several references supporting the need for a long-term treatment facility.

1.4 - Mental Health Service Delivery System

"(1) The Mental Health Service Delivery System should ensure accessible, comprehensive and coordinated services to all persons in Manitoba.

(2) There should be a spectrum of services available and the level of intervention should be the least restrictive alternative, considering the needs of the individual."

1.6 - Assessment

"(1) The funding of assessment and treatment services for children/adolescents should be considered a high priority. The practice of the Manitoba Health Services Commission of determining funding according to inpatient beds should be re-evaluated, in recognition of the potential role of day hospital and outpatient programs in the assessment process."

1.7 - Treatment

"(4) The number of crisis beds in Manitoba should be increased. These beds should be of two (2) types, as follows: emergency beds, and back-up crisis beds to residential treatment centres.

(5) Treatment resources in Manitoba should be coordinated, and specialized services developed where indicated, to allow repatriation of those adolescents presently placed out-of-province."

(Child/Adolescent Mental Health Services in Manitoba 4, 7, 8)

The practice of sending adolescents out-of-province for treatment had continued at an estimated cost of one million dollars in the year 1982. In the eyes of the community, providing treatment resources to adolescents within their own community was one of the publicly known and accepted reasons for building a long-term treatment facility. (Winnipeg Free Press 30/12/82)

"Sending children out of the province is poor mental health practice ...but it's also poor economic practice."
(Winnipeg Free Press 30/12/82)

1.7 Treatment

"The proposed Manitoba Adolescent Treatment Centre (name for long-term treatment facility) should provide placements for those out-of-province adolescents who meet Manitoba Adolescent Treatment Centre's criteria, and a provision of crisis and respite beds as back-up to the residential treatment centres should be provided.

(7) ...There should be a spectrum of treatment resources from high--level intensity services to community support systems, and a degree of flexibility between levels, allowing movement back and forth as required." (Child/Adolescent Mental Health Services in Manitoba 9)

D. EXTERNAL STRESSORS

During the time that this sub-committee report of the Pascoe Report, was researched and written, the Planning Committee had been proceeding according to the 1981 cabinet mandate to plan and build an adolescent psychiatric hospital. There were two major political events which occurred during this time frame. (Nov. 1981 - Dec. 1982) which threatened, once again, to abort the process. Time pressures were also significant because of the government's desire to go to construction while the economy was depressed.

> "An important aspect of the task is the amount of stress under which the task must be performed. For optimal performance the amount of stress should neither be so great as to result in collapse of the system or cause the group members to give up the task if they are frustrated in reaching the goal, nor so small that the group members are not motivated to perform." (Hare, "Handbook of Small Group Research" 265)

According to Paul Hare, in the "Handbook of Small Group Research" the most common stress experienced by a task group is the time limit and this group was no exception. There were two major external events that hampered the ability of the Committee to meet its time commitments and that affected the cohesiveness of the group. The first, occurring early in the planning process, was the Provincial election of November 17th, 1981. The second event was the problem of the zoning variance for the facility.

Election speculation was that there would be a change in government from Conservative to NDP. This traditionally means putting all projects on hold until they can be reviewed by the incoming Minister and his staff. Planning of the facility was in its infancy and could easily be halted. It had happened in the

previous election when the Conservatives had defeated the N.D.P.

The election results of November 17th, 1981, confirmed a win by the N.D.P. and the Planning Committee met to discuss the question of to what extent the incoming government was committed to the initiatives of the outgoing government. The architect was particularly concerned because the firm had clearly been appointed by the Conservation government, based on a recommendation by the then Conservative Minister of Community Services.

The NDP appointed the Honourable L. Desjardins as Minister of Health, the same position he had held previously in the NDP Cabinet. The Committee was informed that he considered the building of the treatment centre to be a continuation of his directive from his last term in office. A senior government spokesperson confirmed the Minister's commitment to the Functional Plan, and stated that the mandate and the appointed members of the Committee were acceptable to the Minister and to his department.

During the pre-election period, there had been a slowdown in the planning process, pending the outcome. In terms of group process, the external stressor, the realistic possibility of having the project cancelled entirely, resulted in the Committee members pulling together on an emotional support level and in a renewed commitment to the mandate, "if only they don't take it away from us". This had resulted in an increased degree of trust among the members of the Committee, who began to identify themselves as a group.

The announcement that the project was to continue was seen as a personal victory for the Committee, that the members had "suffered and triumphed" together. The advantage of this external stressor occurring early in the life of the Commit-

tee, was the resulting positive effect on commitment to the process and to the group goal.

This feeling of identity as a group was tested shortly afterwards with the departure of the senior Manitoba Health Services Commission staff representative, and the appointment of one of his field staff as a replacement. There was a sense of loss among the group members, at both the task level and the affective level. The Chairperson in particular, discussed the loss of the senior Manitoba Health Services Commission's staff's expertise in building facilities, his knowledge of the target population, and his skills in working with planning groups. The senior Manitoba Health Services Commission representative expressed to the Committee that he had completed his task of initiating the project through the laying down of the government's ground rules for design, participating in the discussion of, and sanctioning of, the design criteria, initiating the communication and decision-making pattern for the group, and through my role as coordinator-facilitator, ensuring that he could monitor the progress of the group, through the written record.

> "As individuals leave the group, as new members enter or a crisis develops, the equilibrium may be disturbed and the power struggle renewed and sometimes intensified." (Bradford 89)

This was the first time that the Manitoba Health Services Commission would be involved as a member of a Planning Committee throughout the process of building a new facility. Traditionally, the need for a hospital or personal care home would be identified by members from the community who would then incorporate a board, raise funds, and approach the Manitoba Health Services Commission for sanction and the balance of the construction and operating funds. In this situation, the Manitoba Health Services Commission was actively involved in the

planning and construction process, and new roles and working parameters had to be developed. It was regarding problems with this kind of issue, that the senior Manitoba Health Services Commission representative was most frequently consulted after his departure from the group. The field staff person he assigned to the Committee saw his role as the "watchdog" of the public purse, the traditional role he would have played in previous situations. In this planning process, that was only a part of his role. In addition to monitoring costs he had to ensure that the building was a sound investment in this turn-key operation. He and the Committee were aware that other professionals were watching and evaluating the unfolding of this process, in terms of it being the proposed, standard operational procedure for future projects.

The combination of the provincial election and resulting fear of the project being cancelled, and then, renewed hope when it was not cancelled, the loss of a trusted member of the group, and the arrival of a new member were examples of events which disturbed the equilibrium of the Planning Committee.

The second external event that adversely affected the ability of the group to meet its time schedule was the zoning variance.

The Process Notes of August 5th, 1982, record a meeting with a representative from the Attorney General's Department to discuss the zoning variance process.

> "The correspondence showed the Order-in-Council agreeing to the sale of land for the Adolescent Psychiatric Facility, the cost of same and of the operating budget. There were two letters from the the City of Winnipeg - one indicating no problem as variance is just a curb cut; another from a City Planner stating they would never allow the building to proceed due to an agreement with the Health Sciences Centre." (Boyd, "Process Notes" 43)

Part of the confusion was again the result of the unique role of the Manitoba Health Services Commission. Traditionally, the community board would have made application for zoning, but in this situation, the Manitoba Health Services Commission had this responsibility. The senior Manitoba Health Services Commission representative became actively involved at this point in attempting to direct this process.

There was also a question as to who held title to the land, Winnipeg School Division #1, or the Health Sciences Centre, and as to the process of transferring the title to the Manitoba Health Services Commission. It was late summer and there was pressure to get into the ground before winter freeze-up. There was also increasing pressure from external vested interest groups for control of the planned facility, and a concern that delays would further exacerbate this problem.

The Planning Committee was notified that the City Centre Fort Rouge Community Committee would hear submissions and vote on Conditional Use Order DCU 84/82 on September 28, 1982. The Committee had been assured that the councillors would support the variance proposal and that this meeting was simply a formality. However, after the architect and psychiatrist had described the proposed facility and its use, the City Planner, backed by some local residents recommended against support of the variance because of an agreement that the Health Sciences Centre would not build outside of the zone bounded on the west by the east side of Tecumseh Street.

The land site for the treatment facility identified and approved by a joint Provincial and City Committee was on the west side of Tecumseh. However, the proposed treatment facility was not part of the Health Sciences Centre, nor this

agreement. Despite this fact, the vote was unanimous against the issue of the variance, because of location. Several Councillors approached the group after the meeting and the Chairperson "apologized to us, saying the Councillors had no choice but to listen to the City Planner." (Boyd, "Process Notes" 64)

The group, again comprised of the original members, i.e. Senior Manitoba Health Services Commission representative present, cost consultant not present, was shocked and angry. There had been promises that the zoning variance was merely routine. The City and Province had chosen the land site and the City, by way of the City Centre-Fort Rouge Committee was now saying that they didn't agree with the land site. The planning for the construction of the unit was near completion, and we were ready to proceed with construction tenders.

The process became political for the next period of time with the Manitoba Health Services Commission representative, Chairperson and I attending citizen's meetings, looking for other possible land sites, answering questions from the media, and with much political dealing taking place at the Provincial and Municipal levels, with the Premier and the Mayor each playing their parts.

The analogy discussed by members throughout these months was that of the sense of being on a roller coaster, fuelled by rumours, and occasional accurate glimpses of future direction. There was only one Planning Committee Meeting called during this time, but there were frequent contacts between the members. The cost consultant was on the periphery of this process, saying that this was not part of his job and that he preferred to wait for the outcome of the appeal process.

Finally, after three months on December 13th, 1982, the Executive Policy Committee agreed to hear the appeal. At this meeting, the Senior Manitoba Health Services Commission representative stated that many alternate sites had been considered and rejected, and reiterated that the treatment centre was to be run by a community board and had no connection with the Health Sciences Centre. The Resident's Advisory Group, some residents of the area, and the City Planner voiced their objections. However, the Executive Policy Committee did not agree that a "gentleman's agreement" with the Health Sciences Centre had any say over the location of this new and independent facility. The vote was a complete reversal of the previous meeting. The Executive Policy Committee voted unanimously in favour of the zoning variance.

Time lost due to problems with zoning was more extensive than time lost due to the results of the Provincial election. Both represented major external threats to the process, and to the completion of the project. Mutual support among members was high, but remained specific to the assigned task. There was much discussion of strategy, alleviation of blame, and encouragement in the meetings and by phone. However, Committee members did not socialize outside of the context of the task, nor, more than a few times, even combine work with lunch. During these times of external stressors the senior Manitoba Health Services Commission representative had a higher degree of involvement with the Committee, and the cost consultant remained on the periphery. He stated his decision not to be involved during times of stress from outside forces, was because the senior Manitoba Health Services Commission representative was involved. However, in my opinion, this adversely affected his status on the Planning Committee as "one of the group". This, in turn, affected the on-going decision making process because of a perceived difference in the degree of his commitment to the group goal.

Following the successful appeal in December, 1982, the Planning Committee intensified its meeting schedule in an attempt to make up for time lost in the zoning variance process.

On June 20, 1983, the Honourable L.L. Desjardins officiated at the official sod-turning ceremony for the long-term treatment facility, the Manitoba Adolescent Treatment Centre. In his address, he commented on the 60 years of planning that had proceeded this "milestone."

> "The development of this much needed facility is a milestone in the field of child and adolescent psychiatry in Manitoba. The residential and educational programs at the Manitoba Adolescent Treatment Centre will focus upon comprehensive treatment including medical services, education and community integration." (Manitoba Information Services News Release 20/06/83)

CHAPTER III - METHODOLOGY

> "The aim of social work is to facilitate the social functioning of the individual, the group, or the community. Social group work is thus one part of the social work whole with a distinct way of helping individuals in groups based upon and growing out of the knowledge, understanding, and skill that is generic to all social work practice." (Trecker 30)
>
> The function of the social group worker is a helping or enabling function." (Konopka 165)

The opportunity of completing my practicum as a member of the Planning Committee for the proposed adolescent psychiatric hospital was an unique and challenging experience. As stated earlier, my role with the Planning Committee was in the capacity of planner and facilitator-coordinator.

As in any intervention with members of a group, there are individual dynamics and group dynamics which must be identified and assessed. The main players in this particular group were the psychiatrist, architect, and representative(s) from the Manitoba Health Services Commission. No one had previous direct experience in the planning and designing of an adolescent psychiatric facility. This project was to be the pioneer in this area of facility development. Each member brought the viewpoint of his/her professional training and experience to the group discussions. The architect had experience in designing schools and correctional institutions. The senior Manitoba Health Services Commission representative had experience in facility planning and his appointed staff person had experience in coordinating the development of, and assessing the costs required for, personal care homes and for hospitals. The psychiatrist, had experience in the planning of the provincial children's mental health system, in acute care child/adolescent psychiatric units, and experience in

training and supervising non-medical professionals to deliver community psychiatric services to children and their families in rural/northern Manitoba, and through the Child Guidance Clinic, had experience with psychiatric consultation with multi-disciplinary teams. I had experience in the delivery of community psychiatric services to children/adolescents and their families in rural Manitoba, in an acute care child/adolescent psychiatric unit, and experience in the planning of systems for children's mental health service delivery.

> "Design is not simply a response to the demands of the user. The design process involves the participation of three parties - the designer, the user and the client who commission the work. Each group may be expected to have its own set of needs which have to be brought into line in design situations. It is perfectly possible for the needs of either designers or clients to deflect the chosen design away from the one that would be best suited to user requirements." (Gold 233)

The stated goal of the cost consultant from the Manitoba Health Services Commission was to bring the project in under budget. The architect's identified goal was to design a practical and aesthetically pleasing facility based on the functional needs of the User Group. The psychiatrist's expressed goal was to develop a facility which would operate effectively, in order to bring about therapeutic treatment of adolescents, recognizing that in addition to the effects of human interaction on change, the physical environment also affects change. My goal was to facilitate the group process to enable consistent and appropriate decisions to be made for the new treatment centre. The format of my involvement included interventions at the planning meetings, interventions with individual members of the group, and pre- and post-meeting planning sessions with the Chairperson.

Each member of the Committee had to balance the need to meet their individual goals against the group goals. The professionals who were a part of this

decision-making process came from a specific professional training and attitudinal base which was reflected in the way they thought and the information and issues they presented and defended. Social work, with its knowledge base in systems theory, was well-suited to the role of enabling resolution of disparate information. My role in this regard became particularly significant when the senior Manitoba Health Services Commission representative turned the project over to his field staff. He had been involved with the planning process from its inception and had fulfilled a coordinating, integrating role within the Committee. His departure after the second official planning meeting, and replacement by someone with a cost-accounting background, left a gap in team functions that my assigned role of facilitator-coordinator came to fill. One can speculate that if he had continued as an active participant on the Committee, my role and his role may have evolved in a different manner.

Introduction to the Planning Committee and the initial stages of my involvement were confused by the presence of consultant staff of Community Psychiatric Services for Children. As a result, the Committee had difficulty understanding my proposed role. The only member of the Committee I had worked with previously was the Chairperson. Much of this early period was spent working with the Chairperson to complete the functional plan and to identify clear principles which could later be translated into design goals. The confusion as to my role was evident in the comments recorded in the evaluation questionnaire when the members stated that initially they thought I was "just taking minutes". Each member went on to say they gradually came to understand, and to rely on my role in the planning and facilitating/coordinating functions. My role had been explained to the Committee by the Chairperson prior to my arrival and further at my first meeting. Based on my initial assessment of the individual expertise of the members and their experience in group decision making, I decided not to address

my proposed role directly, but rather to let it evolve to meet the needs of the Committee members at different stages of the planning process.

One of the first specific requests came from the architect who stated that the mixed messages from various consulting professionals were making it difficult for him to clearly understand the functional plan.

In previous planning committees for child/adolescent psychiatric facilities in Manitoba, the user group had been comprised of the key players in each of the principal disciplines - psychiatry, psychology, social work, occupational therapy, education, nursing, and administration. Each provided expertise on specific components of the total design. The architect would then attempt to sort through this often confusing and contradictory information, and to integrate it into a working design concept. The Chairperson and I had both been involved in one or more of these committees.

The problem of a large user group is that it results in a heirarchical, professional totem pole style of decision-making. Space and function decisions are often made based on getting everything you can for your jurisdiction/model of treatment, thereby reinforcing the importance of your profession in other people's eyes. Because the user group cannot agree, compromises are eventually made and these often prove unworkable at the operational level. The ultimate decisions are to some extent governed by the architect's willingness to listen to one or the other of the arguments, and then to create into the design features that that particular group feels are most important. The result is often a "camel is a horse designed by a committee".

Power and control issues occupy much of the working dynamics of the group. Professional loyalties result in much discussion of the conflicting merits of different treatment modalities, and the relative size of offices and desks, according to the position on the totem pole.

The Chairperson had been appointed as the official "user group". As such he had to ensure that critical functional needs and information from each profession were available to the architect. As stated earlier, the initial planning meetings followed this traditional practice of having representatives from psychiatry, psychology, nursing, social work, education, and occupational therapy attend. There was a need for the input of these professionals, but the existing method was not satisfactory.

The Chairperson and I discussed the architect's request to handle this differently, and we agreed that the consistency of the design was of paramount importance.

It was agreed that I would perform a liaison function between the Planning Committee and these resource professionals, ensuring that both groups had sufficient information to make educated recommendations/decisions about design problems. When necessary, the two groups met together to solve specific or detailed issues that required face-to-face interaction and communication. A record, including formal minutes of the meetings, and process and content notes, was kept of these interactions. The Planning Chart proved to be indispensible in coordinating these dual track meetings and ensuring that decisions were made in proper sequence and within time limits.

This resulted in a reduction of the number of people attending the Planning

Committee meetings to the core group, which consisted of the Chairperson, the architect and draftsman, cost consultant, and clearly identified me as a member of the core group.

> "To select the appropriate size group for a given problem, Thelen (1949) has suggested the 'principle of the least group size'. The group should be just large enough to include individuals with all the relevant skills for problem solution." (Hare, "Handbook of Small Group Research" 388)

In my opinion, this liaison function was effective in facilitating the decision-making process. It allowed time for each sub-group to thoroughly explore options for identified problems without feeling pressured that they were encroaching on the time of other professionals. It allowed for several issues to be discussed concurrently by different sub-committees. At planning meetings, I would briefly summarize the progress of the sub-committee on their specific problem areas, and target dates would be set for discussing specific issues and/or their final recommendations with the Planning Committee. As a result, meetings at which the sub-groups and Planning Committee met together were more focused and task oriented.

At approximately the same time, the Chairperson and I formalized the plan to meet before and after each planning meeting, to integrate philosophy with the needs of the target population, and in such a way that the presentation to the architects was clear and consistent.

One of the first goals identified in discussion between the Chairperson and me was the necessity for the architect and cost-consultant to have a clear understanding of the target population and the philosophy of treatment.

Community Psychiatric Services for Children has operated in rural/northern Manitoba for the past 12 years, with the last six years being under the direction of the psychiatrist assigned to this project. Non-medical professionals complete an intensive 6-month internship in child/adolescent community psychiatry, and are then deployed to each region of the province. The role of these professionals is to provide direct intervention to the most severely psychiatrically disturbed children/adolescents and their families in the community, and to provide consultation to agencies, and public and professional education to the community on mental health issues.

Over the years, it had become increasingly apparent that there were two critical missing links in this system. The first was the need for a facility which could provide easily accessible, acute, highly intensive and sophisticated interventions, for children/adolescents, identified and triaged by these community-based workers.

The second identified gap in service provision was the lack of psychiatric hospital beds for that small percentage of the population who required longer term intensive treatment outside of the home/community environment.

Community Psychiatric Services for Children has a strong bias towards provision of services within the geographic area of origin. The provision of services according to this model had been meeting its mandated goals with the exception of equitable access to a higher order of intensity of service provision. Therefore, with the community program securely in place, planning could now focus on the meeting of these identified gaps in service provision.

The bias towards community-based treatment was evident in discussions between the Chairperson and myself, and later with the Planning Committee, as emphasis continued to be placed on a community focus and holistic model of treatment for adolescents in the new facility. The target population was identified as those adolescents age 12 to 21 with severe psychiatric disorders, based on the belief that mixing psychotic adolescents with those with behaviour disorders adversely effects the treatment of each. Severe psychiatric disturbance was defined within this context as follows: adolescents showing symptoms of thought disorder, psychosis, extreme depression with active suicidal attempts, extreme mood swings, severe personality disorders, and organic or neurological dysfunction.

If there was a primary diagnosis of mental illness, the adolescent was eligible for admission regardless of other problems, resulting from the illness, or secondary to it, including behavioural problems, juvenile delinquency charges, drug and alcohol abuse, school and family problems, etc.

This was a difficult concept to explain to the Planning Committee. Part of the role that the facilitator-coordinator shared with the Chairperson, was an educative role. In the early meetings, much of the focus was on educating professionals whose areas of expertise were in building design and cost consulting, on the differences between mental illness and behaviour problems, and between constructing a psychiatric hospital for adolescents and a residential treatment centre. Based on this understanding, the architect could then find potential solutions in a design sense, and the cost consultant could assess the appropriate level of funding.

The basis of many discussions between the Chairperson and me, centered on how one designs a facility which combines the integral parts of a psychiatric hospital

without designing an institutional setting, or, conversely, a group home setting.

The Chairperson was committed to the philosophy of mental health service delivery in the community of origin. At nodal points in the life of the identified mentally ill person, the degree of intensity of required treatment might necessitate a temporary transfer to a psychiatric hospital. This hospital setting would have to meet all the necessary requirements under the Manitoba Hospital Act, but would not have to be designed as a regimented and sterile institution. In discussions with the Chairperson, it became clear that his vision of a hospital that operated with all the rigors and safeguards required for accreditation, but that appeared to those individuals who were temporarily transferred to it, to be a place of safety, treatment, and support to the individual's return to his/her community. The hospital setting was not to function as a community unto itself, but to provide a base for the patient's progress in achieving a satisfactory level of functioning.

For example, it was agreed that a school program was required, but that this program should be run by the Winnipeg School Division #1, not by staff of the treatment centre. In designing the gym - cafeteria - auditorium, decisions were made not to purchase equipment such as weights and exercise machines. Rather, it was expected that the adolescents would use community club and other health club facilities. Further, adolescents admitted to the centre were to be supported to continue in any community activities and with community agencies that were involved prior to admission to the centre.

The other role for the proposed psychiatric hospital was that of a centre for adolescents who were experiencing some mental health problems and who might benefit from an evening group or social activities. This emphasis on community, however, did not negate the belief that the centre must have all the necessary aspects of a psychiatric hospital - medical admissions and discharges, interventions based on diagnosis, highly trained staff, availability of medications, and on-going research into etiology, etc...

One of the more interesting manifestations of this came in design decisions regarding the Nursing Station. Hospitals have Nursing Stations; group homes do not. The Nursing Station serves the traditional function of communications centre for hospital staff and for patients. So traditional, that in the architect's first schematic drawings each unit had its own Nursing Station. The Chairperson recommended a change to a single Nursing Station located outside the living area of each unit, but with visual access to them. To parents and guardians, this would be the symbolic representation of the official hospital function of admitting and discharging their adolescents. To adolescents, it would be the communication centre for information regarding the overall operation of the centre, in contrast to information provided by their individual living units.

Each design decision then, had to achieve this balance between the appropriate components of a psychiatric hospital and the appropriate components of a residential group home setting. This concept will be discussed further throughout this paper.

Access to the Chairperson was initially facilitated by my previous contact with him in his capacity as Director of Community Psychiatric Services for Children. However this involvement had been limited and in a different context. I felt the previous connection resulted in the Chairperson "giving me a chance", but nothing more than that. This feeling was validated in the Evaluation Questionnaire when he stated that he saw my involvement initially as that of a student requiring a practicum placement, and if what I did proved useful, fine, but he was not counting on it, one way or the other.

Initially, I began by offering to complete more concrete assignments, such as compiling the history of task force reports on the proposed treatment facility, and searching out resource people and materials. In later meetings, I began providing my post meeting assessment of the Planning Committee meeting, gradually increasing the specificity of my feedback as to how I saw his role interacting with the other members of the Planning Committee. My role in the pre-planning meeting sessions with the Chairperson followed a similar process. After the initial few months, in which I learned what the Chairperson's goals with the Committee were, and how his personal style of working interacted with the other Committee members, the pre and post-planning sessions were completely open discussions which dealt with all issues effecting the planning of the treatment centre.

This strengthing relationship naturally effected the members of the Planning Committee and the group process. The Committee members were aware of my increasing involvement with the planning and began phoning me directly on some

issues or, on other issues, phoned me if the Chairperson was not available. At the same time, they saw my role as becoming more independent of the Chairperson in the Planning Meetings per se. By this time, I felt I had established a credible track record, and could openly support, or disagree, with the Chairperson in front of the group, without adversely effecting my working relationship with the Chairperson or the other Committee members. This eventually resulted in some Committee members attempting to lobby the Chairperson through me. At times, this was valid; at other times it was more a function of the strong vested interest of the member, rather than interest in the group goal. These were attempts to get "the Chairperson on their side", to brief the Chairperson and then attempt to demonstrate a united front in support of their need.

Sub-committee meetings were initiated by the Chairperson or myself if it appeared that the discussion or decision making process could more easily be resolved by dealing with the contentious issue outside of the formal planning meeting. This approach was used most frequently with the cost consultant whose consistent, initial response was a defensive and suspicious, confrontational mode. Later, in discussion with the Chairperson and I, he would appear more relaxed in considering the issue. This was reflected in the minutes as the Planning Committee agreeing that the Chairperson, the member and I would set up a meeting to discuss the issue further. It would also be recorded on the Planning Chart to ensure that the contentious issue returned to the Planning Committee for final discussion and decision.

When the Chairperson was out of town, and could not be reached by phone, there was direct testing of my role and my power. The first incident of this type occurred approximately four months into my involvement with the Committee.

I received a phone call from the architect who stated that he wanted an immediate meeting with the educational consultants regarding space requirements, and that he was upset over a telephone call from the cost consultant telling him to reduce a cost estimate immediately. This was at a time when the cost consultant was establishing his role and power on the Committee, and when the architect, having formed a working alliance with the previous representative from the M.H.S.C., was being given contradictory messages by this new representative as to how he should proceed.

In assessing the situation, I decided I had several options, as demonstrated by my Process Notes, dated March 24, 1982.

(1) "I could refuse to do anything until Chairperson's return."

assessment: "Not appropriate because:

(a) architect concerned about pressure from cost consultant and,

(b) consultants are available to make decisions re: educational area."

(2) "I could phone the former representative from the M.H.S.C., the supervisor of the present cost consultant, (knowing that he had said, in confidence, to ignore this cost cut), to ask for his recommendation as to how to proceed."

assessment: "Not appropriate at this stage, further exploration required first."

(3) "I could meet with the architect, thereby reducing his concern and the pressure on him, and suggest that we wait for the Chairperson's return."

assessment: "I decided to proceed with the last option, and attempted to reduce the architect's concern and anxiety as we continued talking on the phone. When this appeared to be only mildly effective, I agreed to meet with the architect at his office to discuss this situation in more detail, and to set up the meeting with the educational consultants." (Boyd, "Process Notes" 29, 30)

My Process Notes of March 29, 1982 showed that the educational consultants attended and that this issue was dealt with first. I then asked the consultants to leave and began to discuss with the architect his concerns about cuts to the budget.

> "The architect reviewed all his concerns about the cost consultant wanting costs reduced, yet refusing to authorize working drawings at the same time as he asked for more details. The architect expressed concern that the User Group should be involved in these decisions and that the 'cost consultant's role seems to be to split the group'. Early into the discussion, the architect expressed concern that I was recording his 'complaints' and that this wasn't really a meeting. I reassured him that I wasn't going to send 'minutes' from this discussion, and stopped recording except for the main points." (Boyd, "Process Notes" 29, 30)

My role, in this situation, was to listen, to interpret, and to reassure the architect that waiting for the Chairperson to return was appropriate, and that continuing with his working drawings was appropriate. At this time, I believe

my intervention was successful in defusing a crisis situation. It combined the function of facilitating conflict resolution and the function of "assisting in group maintenance functions by increasing the personal satisfaction of each member as it relates to his functioning in the group, and enhancing group morale through support of a common purpose, shared goals."

Later, as this issue progressed, there was a "showdown" on the part of the cost consultant. Shortly after the Chairperson's return, the cost consultant called a meeting for April 16, 1982, at his office, to review the budget. The cost consultant was clearly upset with the architect and he listed many complaints. Sitting at the end of the table, he began by asking the Chairperson why he sat at the opposite end of the table from him. The Chairperson replied with the explanation that people tend to take the same seats in subsequent meetings.

> "Groups which meet over a series of sessions frequently develop a pattern seating arrangement." (Hartford 173)

The Manitoba Health Services Commission architect was present for this discussion and decided to try switching chairs. After five minutes, she returned to her original chair saying that she had felt uncomfortable. The cost consultant then made several disparaging comments to me, saying, "I see Mrs. Minutes is here again.", etc.

The topic for this meeting was budget, and the Chairperson reiterated his position that

> "(a) deletions would be made on items that could be added at a later date and
>
> (b) that if the project came in under budget these items could be added."

> "The Chairperson therefore suggested that we agree on a top price and that within this total, items could be deleted or added depending on tenders. The cost consultant stated his concern with this arrangement was that the user lobbied at the eleventh hour for items considered to be 'indispensable'." (Boyd, "Planning Committee Minutes" 16/04/82)

In the Process Notes (April 16, 1982) I note a comment that the Chairperson made frequently throughout these negotiations with the cost consultant, "You have to trust me. We're both working for the same things." (Boyd, "Process Notes" 32)

> "Trust is the pacemaker variable in group growth. Feedback is dependent upon trust. Goal formation is dependent upon feedback and trust. Interdependence is dependent upon goal formation, feedback and trust formation." (Bradford 107)

The cost consultant stated that all the problems were the fault of the architect who had refused to give him the details he needed. The Chairperson reminded the cost consultant that the architect could not provide these details without the cost consultant's authorization for working drawings.

Shortly after this discussion, the architect arrived. If we had planned for him to come a half-hour late, it could not have been better orchestrated. The Chairperson asked the cost consultant for permission to review the preceeding discussion. He gave permission, the Chairperson reviewed it, and the architect confirmed that he had been waiting for authorization to proceed with working drawings. This permission was immediately granted by the cost consultant, and the group then began reviewing the architect's plan of identifying items that could be deleted to reduce costs. The atmosphere was conciliatory with consensus reached on major outstanding issues.

> "As a person becomes more and more defensive, he becomes less and less able to perceive accurately the notices, the values, and the emotions of the sender. The converse, moreover, also is true. As defenses are

> reduced, the receivers become better able to concentrate upon the structure, the content, and the cognitive meanings of the message." (Cathcart and Samovar 301)

The acknowledgement of the cost consultant's position, and of his anger related to his late arrival on the Planning Committee, was dealt with openly by the Chairperson and me. This proved effective in helping the cost consultant to identify with the Committee and especially with the Chairperson, and it allowed him to take a more thought out, considered, middle ground on certain issues, rather than his heretofore automatic confrontation of any issue involving increased expenditures. It also confirmed for the Chairperson and me the source of his anger, and his feeling of being watched by his supervisor, watched by the Planning Committee, by the M.H.S.C., and by the hospital community, to prove that he had dealt fairly and capably with supervising the planning and construction of the first M.H.S.C. owned building, by fulfilling his role of tightly controlling costs.

In our discussion of the Functional Plan, the Chairperson acknowledged that other psychiatrists and other mental health professionals may have focused on other aspects of the treatment milieu. One of the most significant parts of my role regarding decisions made by the Chairperson in our discussions, and decisions made by the Planning Committee, was the analysis and confirmation that decisions being made were "consistent with previous decisions, and consistent with the treatment philosophy and the terms of reference of the group."

At times, this resulted in "cautioning against premature decision-making." An example of this was the decision regarding the residential kitchens, when the recommendation by the expert consultants quickly lulled the group into abandoning a previous decision to teach residents to cook meals in the residential kitchens. My analysis of the situation was that the weight of the recommenda-

tions from the expert consultants, the fact that the psychiatric nursing consultant was well-known to the Chairperson and present at this meeting, and the knowledge that the other consultant was on staff of the Manitoba Health Services Commission, resulted in the architect assuming that the recommendation was not only being made by the external consultants, but also by the Chairperson and cost-consultant. The Chairperson then responded positively to this assumption of the architect, the decision to change was made, and the group began discussing problems specific to this decision, such as keeping food hot.

My intervention was planned to achieve two goals - to defer the decision-making process and to alert the Chairperson to further consider the clinical implications of this change in direction. I reminded the group of previous discussions of treatment philosophy which emphasized adolescents learning life skills, and stated that today's discussion and decisions appeared contradictory to previous decisions.

The architect's reply was that the consultant and psychiatrist were in agreement. I then suggested that perhaps building in the flexibility in the Industrial Kitchen (located in school area) to accommodate two meals a day did not necessarily mean we had to reduce the proposed functions of the residential kitchen, and recommended that the Chairperson and I discuss this further, and solicit some additional opinions. I had made a sufficient intervention by this point for the Chairperson to realize my concern from a clinical point of view, and he supported the recommendation to build in flexibility for the Industrial Kitchen and not to change the focus of the residential units at this time.

What I found most striking about this example was how quickly and easily the group forgot the basic principles of using the residential kitchen to teach

activities of daily living and to provide a family-like atmosphere for meals. Although the group had previously agreed in principle with the design criteria, this example demonstrated it was more a theoretical concept, than a conscious operating principle. This incident occurred early in the lifespan of the group, and my intervention at this time helped to more clearly define my role within the group.

> "Generally a problem-solving group has some method of recording its actions through minutes or records." (Hartford 238)

Another of my functions was the recording of the discussions and decisions made by the group. There were several parts to this function. I attended all the meetings of the Planning Committee, and sub-committees, and took detailed notes. I then divided the information into three parts as follows: the formal minutes of the Planning Committee, comments on the content, and comments on the process. The formal minutes were detailed minutes and were distributed to the Committee.

Included with the minutes of each meeting was the Planning Chart I prepared. This provided the structure for monitoring progress and for identifying accountability for assigned tasks. At some point during the years, each member interrupted himself to say, "Don't write that down." These statements naturally didn't appear in the formal minutes, but did provide for speculation in the process notes. Statements, suggestions and decisions in the formal minutes were attached to names, thereby enhancing accountability on the part of each member, and enhancing discussions at a later date as to who had said what. The process notes and content notes commented on the planning meetings, individual meetings between the Chairperson and me, and other meetings and events significant to the goals of the Planning Committee. For example, I recorded discussions with significant external players at the time of the provincial election of November,

1981. These notes were helpful to me in assessing the dynamics of the Planning Committee. I also referred to them during planning and evaluation meetings with the Chairperson, to remind him of the dynamics that had been operating at the time of a certain decision, and how these forces were again affecting the process, decision making, etc.

> "Dimock discusses this function of "group recorder". A group recorder is one of the most effective aids in helping a group keeps its discussion on the track and to know where it is in its sequence of problem-solving steps. The person in the group who acts as recorder keeps track of ideas and suggestions, of decisions reached, and the position of the group in respect to its agreed upon procedures or steps in problem-solving." (Dimock 29)

I found the written record to be invaluable to my role. All other functions were based on the accurate and thorough completion of the recording of the minutes per se, and the process and content notes. These allowed me to effectively plan my interventions with the Chairperson and other Committee members, and with the Committee as a whole. This function, together with the small size of the Committee, were main contributors to the consistency of the decision making process and the effective realization of the task.

> "The most productive groups are those which can carry out effectively the major steps in the process of solving task and social-emotional problems for the group and for the individual members." (Hare, "Handbook of Small Group Research" 390)

This was the basic challenge to the role of facilitator-coordinator. Decisions had to be made by a virtually, mutually exclusive group which had little basis of shared experience.

As a social worker, I brought specific expertise and knowledge which was a part of my training and my perspective, to the goal of bringing together profes-

sionals from disparate backgrounds in an atmosphere and structure that encouraged maximum participation and productivity. At times, I made direct recommendations on both content and process issues. More often, I influenced the process by lobbying the Chairperson. This required an understanding of the shifting dynamics and the balance of power.

At some stage, after all options had been considered, a decision had to be made. Reaching a consensus which did not compromise the legitimate requirements of the user group, in this situation represented by the psychiatrist, was my goal.

CHAPTER IV - PHASES OF THE DESIGN PROCESS

(2) to achieve a high degree of spatial flexibility; and

(3) to provide a setting for the coordinating of individualized treatment plans including, as required, assessment, treatment and rehabilitation programs which would emphasize community involvement.

These three design goals were not mutually exclusive. They had to be integrated and tested for consistency at the level of each decision and subsequent decisions. For example, designing each residential unit with a kitchen reduced the institutionalized standard of meals being delivered from a central kitchen; designing the kitchen area for flexible use, and considering the learning of meal preparation a part of the treatment program, integrated the three (3) design criteria.

> "The type of problem a group deals with partially determines its goals, style of operation, and form of solution. The dimensions in which a group can work are laid out by the type of problem" (Phillips 19)

These design criteria emanated from discussions with the Chairperson of the Committee, at the time of writing the Functional Plan, and from on-going pre-and post-meeting sessions between the Chairperson and me. The ability to delineate these goals and the specifics attached to them, in a way that the architects could translate into line-by-line drawings, and then bricks and mortar, was the objective of each planning meeting. As a result, there was much discussion in the early meetings on the philosophy of community-based psychiatric treatment, and on identification of the target population.

The group goal was to design a facility to meet the needs of adolescents who are psychiatrically disturbed.

John Lang in "A Model of the Designing Process" states that the process of designing follows a number of inter-related phases.

> "There is considerable interaction between phases, each of which, in fact, consists of analytical, design, and choice activities; and each is, in itself, a decision-making process." (Lang et al.44)

The functions of each member on the Planning Committee differed according to the phase of the design process.

The first phase is the "intelligence or analytical phase" with an emphasis on identifying and assessing the needs and possible solutions, and on identifying the available resources and possible constraints. As discussed earlier, the group goal was the mandate provided by the Manitoba Department of Health. The elucidation of the mandate and the process chosen to reach it, were determined by the Planning Committee. It is during this phase that the conflict resulting from the differing values and individual goals of each member were most evident. The process of translating functional needs into design goals was effected by external constraints on the group as a whole, and on the role of each member.

> "The decision to create a new and independent setting, usually reflects two considerations: the opinion that the existing settings are inadequate for one or another reason, and, independent of this, the awareness that the conflicts that emerged in the process of arriving at a decision were of such strength and quality as to make a new independent setting the desirable possibility." (Sarason 31)

The decision to build, then, was a political one, based on the social and economic pressures of vested interest groups in Manitoba. That the process had been on-and-off for the preceding 60 years clearly illustrated the role of politics in the process.

The architect was affected by the external constraints of the predetermined land site, building and safety codes, and cost constraints.The cost consultant was constrained by available monies for this project. These constraints were all the more interesting because it was the first time the Manitoba Health Services Commission was building for "themselves", and because the uniqueness of the project had resulted in no preconceived budget.

This method of facility planning and construction was a new venture for the Department of Health. Preliminary discussions among senior members of the Department of Health had determined that the facility would be designed for twenty-five (25) residential spaces, with day treatment, education and rehabilitation space for an additional twenty-five (25) adolescents. Square footage was negotiated from 12,000 square feet to 25,000 square feet to accommodate the day treatment component. The Manitoba Health Services Commission was for the first time, to have a role as an active participant in the planning process. Traditionally, the community identifies a health need, forms a committee or board, raises some money, and then approaches the Manitoba Health Services Commission for assistance with funding. The Manitoba Health Services Commission has the "watchdog" role of seeing that the public's money is effectively spent. In this situation, the planning called for a turn-key operation, i.e.,

Manitoba Health Services Commission would determine and fund the capital costs, and, on completion, turn the programming over to an independent board, while maintaining ownership of the building. The traditional single role of holding down the spending costs did not apply. Further, because of the unique nature of the facility, there was no pre-determined budget - total capital costs were to be "less than a general hospital, but more than a personal care home." This dual role for the Manitoba Health Services Commission representative resulted in predictable conflicts which have been discussed.

The psychiatrist was constrained by pressure from professionals with vested interests who attempted to have the final design and proposed usage meet the needs of their client population.

Sixty years of history cannot be ignored. Sarason emphasizes the importance of the "before the beginning phase" in understanding how a new setting, which is often seen as competing for scarce resources, is portrayed as the answer to all problems for all people.

> "Before-the-beginning period contains organizational dynamics which tend to work against rather than for the new setting in the sense that its heritage is marked by conflict, real or potential." (Sarason 30)

Some of the constraints in the decision-making process were external. For example, the choice of a land site was made by a tripartite government committee. The size of the site immediately closed off the option of deinstitutionalizing the setting by detaching the living units from the main building, and from each other.

The alternate decision was to attempt to define the areas of the building according to proposed function. From this decision, came the concept of three (3) zones - residential, administrative/therapeutic and school. This decision set the stage for developing each of these areas as distinctive, and yet a part of the comprehensive treatment milieu.

John Lang states that this first stage of the design process, the "intelligence or analytical phase", is made more complex by the constraints on the internal decision-making process.

> "A normative model of the intelligence process can by summarized as one of establishing goals and directions from needs and desires; of defining these goals in terms of available resources; of identifying activity patterns and the psychological requirements for attaining a satisfying end product; and of establishing the required architectural elements to cater to these needs." (Lang et al.47)

Members of the Committee proposed various options to solve problems in translating functional needs into design.

For example, a defined functional need was to provide illumination, a sense of open atmosphere and visual access to adolescents. There is no single, correct solution to these three inter-related needs. Sarason defines this as the concept of the universe of alternatives:

> "The kind of problems which confront the creation of settings do not logically lead to one, and only one, solution. In the process of creating a setting, awareness and acceptance of the concept of the universe of alternatives, as well as sustaining such acceptance, are extraordinarily difficult." (Sarason 18)

There were several suggestions made on solving the identified need for illumination, a sense of open atmosphere, and visual access. One recommendation made by the architect, and agreed to by the Committee, was the use of the pod system in the residential zone. Each self-contained pod, or unit, was to include bedrooms, kitchen, living room, bathrooms, laundry area and storage area. The design goal was to create a group living component of a psychiatric hospital which met the criteria of safety, security and indestructability, and the criteria of a relaxed home-like atmosphere which encouraged individual pursuits, at a cost acceptable to the Manitoba Health Services Commission.

> "An optimum hospital environment is one which is formed as closely as possible upon models of ordinary everyday common environments which might be experienced by a typical member of the typical patient population to be served." (Spivak 26)

The residential pods were to be designed for adolescents with a primary diagnosis of severe psychiatric disorder, who may have secondary symptoms of aggressive, acting-out behaviour or of withdrawn, regressed behaviour. The goal of treatment was to reduce acute symptomatology, to educate the adolescent on his/her diagnosed mental illness and treatment regime, and to prepare the adolescent for life in the community through the teaching of life skills and community participation.

Specific to the defined functional need of providing illumination, the pod system would eliminate the institutional feeling of long hallways, would allow natural light into each bedroom and from there into the central living area, and would facilitate unobtrusive visual access of adolescents in all parts of the units. It was agreed that the disadvantage of this system would be insufficient light in the living area. Other proposed solutions included the following:

designing a skylight over the kitchen-dining area, changing the basic design to include windows in the living area, increasing the use of glass, installing a combination of incandescent and fluorescent lights, and/or using table and floor lamps to give local illumination.

A second consideration in design planning which affects decision-making is described by Bennet, C. in Spaces for People,

> "Design is a difficult process, for one reason, because good design attempts to satisfy several goals simultaneously." (11)

Therefore, not only is there a universe of alternative answers, but each answer, or design decision, achieves more than one design goal, and at the same time mitigates for and against future decisions.

A third consideration is that changing a decision is not self-limited, but out of necessity, must result in modifications to previous decisions. The decision to design the residential area as a pod system automatically included and excluded certain other decisions. If, for example, at a future point in the design discussion, illumination provided by windows in the living area had been agreed upon, the group would have had to review all decisions related to the fundamental decision of the pod design.

A fourth inter-related element is that decisions which translate into drawings on paper, do not remain as ideas, but become the working mortar of a permanent structure that cannot be erased like pencil from paper, a permanent structure that cannot be altered to incorporate forgotten concepts or better ways of doing things.

Further, this brand new structure is expected to continue fulfilling its mandate far into the future. This fifth, inter-related element, is designing within the social-historical context of the past, for the future. This element resulted in much discussion and emphasis on the design goal of flexibility.

> "Designed environments are not passive, neutral physical entities; rather, these environments are a complicated system that take on new meanings as society changes, as political currents shift, as the economy improves or worsens, as philosophies, styles and mores evolve." (Friedmann et al. 14)

In this context, the architect and the user group expressed concern over the decision of the funder not to allow for a crawl space. The additional half-million dollar cost for this space would have ensured ready access to plumbing and electrical systems. Access to electrical systems was considered critical for future expansion in the area of computerization. Attempting to predict what advances would be made in the next 20 to 30 years was not the ideal way to proceed. Nevertheless, prior to my involvement with the committee, the decision had been made to authorize construction of slab on slab and when the issue was raised at critical points throughout the planning process, this decision was considered a government directive and not open for discussion or negotiation.

In the second phase of the design process, the "design phase or synthesis stage", the architect combines all the design decisions into schematics of increasing complexity and detail. Within the constraints of time, alternative solutions are explored on paper.

> "Architectural design, like music to a film, is complimentary to human activity; it does not shape it. Its (architectural) prime social function is to facilitate people's doing what they wish, or are obliged to do. The architect achieves this by designing a physical structure that is able to meet known and predictable activities as conveniently and economically as possible." (Gutman 183)

Lang's third phase of the design process is identified as the "evaluation and choice phase", the evaluation of possible solutions and the selection of one basic design. At this stage, previous decisions made in the intelligence phase, were reviewed as they appeared transformed into the schematics. The written record was an invaluable tool, as decisions were assessed for consistency with each other, and with the design goals.

> "Thus, institutional design requires us to produce: (1) permanent behaviour-maintaining structures, (2) structures that will exercise latent healthy behaviour that may be learned for permanent use (rehabilitation), and (3) structures that will allow freedom of operation and an expansion in scope of healthy aspects of the individual (self-realization). This triple function of the institutional environment leads us back to the principle of congruity; not only do different people need different environmental solutions, but even the same individual's differing competencies may require prosthetic, therapeutic and self-realizing aids." (Lang et al.62)

The last phase of the design process is the implementation phase, the phase of finalizing the working drawings which comprised the working drawings for tender. The Chairperson and I agreed that reviewing these drawings, although not traditionally part of the role of the user group, was important in avoiding change orders. Several examples of the design not fully meeting the needs of the user group were noted. For example, the working specifications for glass showed glass extending over part of a wall in the audio-visual suite, rather than achieving maximum visual access translated into an entire wall of glass, as had been discussed.

The senior architect attended this meeting "and commented on the thoroughness of the review of the design, that this is never done." (Boyd, "Process Notes" 93)

The Chairperson and I discussed this after the meeting, and he stated that he is

> "concerned that the translation of function to design be as accurate as possible, that he feels a heavy responsibility that the unit will function as planned." (Boyd, Process Notes" 93)

This was consistent with two individual goals stated by the Chairperson early in the Planning Meetings; the goal of accurately estimating costs and the goal of avoiding change orders. Throughout the planning process, the Chairperson continued to say that we must strive to make decisions in such a way that it will not be necessary to change our minds after the fact, thereby requiring costly change orders. This goal of consistency in the decision-making process, was facilitated by my role with the Committee, in terms of my interventions in the meetings and the availability of the group record.

Change orders on government construction projects of this type usually approximate 35% of the total cost. The goal, promoted by the Chairperson, was that the user would prefer to use better quality materials, knowing that extra expenditures at the point of purchase would be much less than the standard contingency budget for change orders.

I think the general feeling of the Planning Committee on this issue was that the Chairperson was well-meaning, but naive to think that he could dramatically

decrease the number of change orders. The Committee was told by the cost consultant that these are considered a "standard" cost on government projects. The Chairperson insisted, that with my involvement as the facilitator-coordinator and the availability of the detailed records of design decisions, change orders would be decreased. The contingency budget for change orders was set by the cost consultant at $100,000.00. Change orders ultimately totalled $3500.00, with the largest amount going towards changes in the mechanical-electrical sub-contract.

The other significant process goal of the Chairperson was to state, and to maintain throughout, that the user group would not ask for anything simply because there is traditionally a percentage cut-back on government projects. The cost consultant was told that the user would ask for, and justify appropriately, only what was needed.

An example of this was the decision regarding the audio-visual suite. It had been proposed that the facility would have a major teaching role in community child/adolescent psychiatry, with students and professionals in the allied disciplines. As such, a well-functioning audio-visual suite, with one way mirrors was critical.

The committee agreed to tour psychiatric and youth facilities on the viability of their set-up. Invariably, they were all experiencing serious problems which resulted in very limited usage. The two most frequent complaints were those of poor and limited visual access, and poor soundproofing and audio quality. In discussion with the architect, the user requested an Observation Room which

viewed two small therapy rooms and one large therapy room. The traditional "window" effect in the therapy room was to be replaced by a wall of glass. The effect for people in the room would be similar to mirror tiles. The cost consultant felt that the cost was prohibitive, and quoted the costs in other hospital facilities for the traditional mirror set-up. The user's argument was that this should be done properly from the outset; i.e. spend the money that is necessary to design a system that works.

The user also insisted that money be spent on soundproofing, another constant problem in most facilities. As a result, the specifications called for double drywall ceilings, insulation in the walls, carpet, and solid doors with weather-stripping.

Each design proposal, then, had to be identified and analyzed, reviewed in its schematic form, evaluated, and a choice made against the criteria of flexibility, security, indestructability, homelike, residential atmosphere, and cost considerations.

CHAPTER V - FACILITATION OF GOAL ATTAINMENT IN THE FACE OF PRESSURE FOR CHANGE

Plan #1: Residential unit to be designed and built as a high intensity area with provisions for optimal security.

Plan #2: Residential unit to be designed and built to allow for flexibility in servicing the needs of varying target populations.

Plan #3: Black and white surveillance audio system to be in all units."

I. THE RESIDENTIAL ZONE

The decision was made to designate the residential zone as a high intensity treatment area with provision for optimal security, designed and built to allow for flexibility in operating, with "emphasis on staff responsibility for supervision as opposed to architectual design controls." (Boyd, "Planning Minutes", 14/01/82)

A) Single Occupancy Bedrooms

As discussed previously, the preference would have been for the 25 beds to be divided into three detached living units. However, there was not sufficient room on the land site. Within this constraint, attempts were made to simulate the preferred detached setting. Each pod or unit was designed with an open living area consisting of kitchen, dining area, and living area. Individual bedrooms (8, 8, and 9 per unit), three bathrooms, laundry room, and storage space were built on the perimeter of each self-contained unit. In this way, adolescents could remain in the safety of their bedrooms and observe the activities of the unit from a distance. This also eliminated the institutionalized feeling of a long corridor with rows of doors. Staff working in the central living area of each unit also would have visual and auditory access to adolescents without having to physically intrude on their space.

> "Not only must individuals and groups have freedom of choice with respect to their privacy, but the physical setting must afford them the opportunity to exercise this freedom. In effect, space must be designed and administered with this objective in mind." (Lang et al. 199)

Issues of privacy, territoriality, control and independence are significant to the developmental stage of adolescence. The literature was supportive of providing individual bedrooms, and the group was in agreement with this recommendation from the literature.

A study published in 1970 by Proshansky, Ittelson and Rivlin, on the activity levels in one, two and three person bedrooms, and larger bedrooms, within psychiatric wards, demonstrated that patients with private rooms withdrew least frequently from treatment activities.

> "It would appear then that the small rooms provide the patient with a considerable freedom of choice in what he does in his room, whereas the large, multi-occupancy room limits freedom of choice and almost forces him into isolated passive behaviour." (Lang et al. 179)

Their results were supported in a 1978 study by Golan.

> "Golan, (1978), found that within two psychiatric hospitals, those children in single-occupancy bedrooms had significantly more experiences of privacy as chosen aloneness and had higher levels of self-esteem than children in multiple-occupancy bedrooms, even though the staff rated them as equally ill, equally likely to socially participate, etc. It provided opportunities for chosen aloneness which gave children more of a sense of objectivity and an ability to see themselves and the institutional environment more clearly." (Altman and Wohwill 218)

Once there was agreement that designing each unit with individual bedrooms met the criteria for flexibility, security, and home-like atmosphere, attention was focused on the bedroom itself. Probably one of the most contentious and potentially dangerous of the decisions made by the Planning Committee was to install solid wood doors.

The Planning Committee had visited the B.C.Youth Development Centre and Woods Christian Homes in Calgary, and the Winnipeg psychiatric units at Grace Hospital, Seven Oaks Hospital, St. Boniface Hospital, Health Sciences Centre, and the Manitoba Youth Centre. These settings had employed various methods to resolve the dual problem of privacy and surveillance for security reasons. Units such as the Grace Hospital closed off the bedrooms with curtains and the Manitoba Youth Centre used the traditional peephole in the door.

The basic issue, discussed in the planning meetings, was that of privacy for the adolescent (solid door) versus supervision by staff for security reasons (visual access). The psychiatrist recommended that the commitment to individualized treatment planning, and the acceptance of the adolescent's need for privacy, take precedence.

> "Therefore, to waive the protection of the door is to foresake that sense of individuality which it guarantees. Doors provide boundaries between ourselves (ie. our property, behaviour, and appearance) and others." (Gutman 160)

The psychiatrist stated, that, when there was an indication that suicidal observation was required, the door could be left open, or the staff person could sit with the adolescent in his/her bedroom. He stated that staff will be

expected to identify an adolescent who is a potential suicide risk and to intervene appropriately. Risk is generally the highest on, and shortly after, admission. All treatment interventions are to be individualized according to the needs of the adolescent. Therefore, the psychiatrist's assumption was that adolescents would respond appropriately to their environment, unless there was a reason otherwise. To generalize, or to over-emphasize the risk of suicide as applying to all mentally-ill adolescents would be contradictory to tailoring treatment interventions to individual needs.

> "The first principle is that design should seek to maximize the congruity between the individual and the environment, rather than seek an "ideal solution" that would fit all people of a given class." (Lang et al. 60)

Recommendations of this kind were met by the architect with concern and with him asking for a 100% assurance that no adolescent would commit suicide in his/her bedroom.

In the discussions the Chairperson and I had, with the professional resource groups, Nursing in particular, there had been little agreement on this issue. Recommendations often appeared to relate most to personality styles - from those who were very cautious, the statement that it was ludicrous to allow disturbed adolescents to have a door without a means of continuous visual surveillance of them ; and from others, the impression that is was "worth the risk".

My role throughout this issue was to work with the Chairperson in helping the Committee members to understand the rationale behind the recommendation for individual bedrooms with solid wood doors. Discussions on suicide potential

were a constant theme in early meetings of the Planning Committee. This issue could be described as the first significant test of the psychiatrist's knowledge and experience. From the architect's point of view, the issue could be clearly identified as fear - fear that an adolescent would commit suicide and that he "as the designer, then, would feel morally responsible for the death and politically in trouble with an outraged community." (Boyd, "Process Notes", 12) The Planning Committee was in the early stages of development as a group, and consistent with this, the developmental task was that of trust.

My working relationship with the Chairperson was also in the early stages of establishing trust. Individual bedrooms with solid doors were certainly consistent with the Planning Committee's design criteria. However, questions such as: are we making this decision merely for the sake of being consistent with our earlier decisions? or, is this decision really the best possible option?, were on my mind, and on discussion with the Chairperson, on his mind also. One of the specific tasks I undertook for the group was a review of the literature, which proved to be supportive of the Planning Committee's decision. However, the issue was more related to developing trust and credibility within the Planning Committee than to the content of the literature. There was much challenging of the Chairperson to prove that he was right. It was too early in my involvement with the Committee for me to have credibility in my own right. Therefore, I supported and clarified, when necessary, the explanations of the Chairperson.

In pre- and post-planning sessions with the Chairperson, we reviewed many "what-if" scenarios. After much discussion, the best possible option remained

the same. Solid doors were more consistent with the philosophy of a community-based psychiatric treatment centre, and more consistent with the Committee's stated design goals. There was not an attempt to discredit the architect's fears, which the Chairperson agreed were realistic. However, there was a recommendation that recognizing that there is a suicide risk may indicate the Committee needs to look for creative solutions, rather than changing its fundamental commitment to the design goals.

In my opinion, this issue was successfully resolved at the task level and emotional level for the Planning Committee members. Based on the discussions in the meetings, the architect decided that he would risk trusting the psychiatrist and he agreed to follow the recommendations of the user group.

> "In general, conceptions of the qualities of the physical environment that will provide the proper therapeutic milieu for the disturbed child are of a speculative nature, most often based on the experiences of persons dealing with these children." (Lang et al.196)

Following the decision on installing solid wood doors, attention was turned to the interior of the bedrooms, where the goal was now to make the room as suicide-proof as possible. In contrast to the supervised living area which had a suspended T-ceiling, a potential danger for a hanging death, the ceiling in the bedrooms was designed with double drywall impenetrable without an electric drill. Doors were designed to open out. Hospital beds were seen as too institutionalizing, so a built-in wooden unit with a platform and bookcase was installed and anchored to the cement floor on one corner to prevent barricading of the door. Closets, and a desk unit under the window were also built-in. The desk chair was sleigh-based to prevent the legs from being used as a weapon.

Curtain rods were designed to collapse under weight. The rod in the closet was installed lower to the floor, and plastic hangers were to be used instead of metal. Walls were brick-faced concrete block which were aesthetically pleasing, and more difficult to deface than masonry painted walls.

The floor was concrete and covered with the new Heuga carpet tiles. This was to give the visual effect of wall-to-wall carpeting with the convenience of being able to replace single tiles if there was damage. A tack board was placed along the complete length of one wall to provide a place for personal momentos, and to further discourage writing on the walls.

With these modifications, and the addition of bedroom curtains, and duvets, rather than hospital-style bedding, the bedroom met the criteria for residential, home-like atmosphere, flexibility, and security. Two bedrooms in one unit were designed with wider doors to allow for access by adolescents with a physical disability.

Each unit also had two bedrooms designated as high intensity. These rooms differed only in the addition of an audio pick-up monitor installed in the ceiling. This device could be used to auditorily monitor adolescents who were in crisis. The functional plan proposed that two units would accommodate adolescents requiring longer term intervention and planning, and one unit would function as an acute/respite unit. The latter unit would accommodate new admissions in acute crisis, many of whom would be potentially suicidal/homocidal. This additional security precaution of an audio monitor was predicted to be a necessity for the acute unit to function appropriately.

However, keeping in mind the principle of flexibility regarding future populations, it was decided to equip two bedrooms in each longer term unit in the same fashion.

B. Unit Bathrooms

Bathrooms are also an area of potentially high risk for suicide. In keeping with the concept of home-like atmosphere, each unit was designed with three bathrooms, two with showers, and one with a bathtub. According to the proposed program plan, two to three adolescents would be assigned to each bathroom and could then leave their towels, toothbrushes, etc. Residential fixtures were used, rather than indestructable, correctional or institutional issue. Showers were installed with shower heads that collapsed under weight, and with three-quarter height doors. This eliminated the need for curtain rods, a potential danger. As this was identified as a high risk area, double drywall was to be used in the ceilings.

C. The Therapeutic Milieu

> "One of the functions of a therapeutic milieu is to use the resources of the non-hospital world in the process of rehabilitating the patients." (Greenblatt et al. 142)

As has been discussed earlier, there was continuing discussion on how to design a psychiatric hospital that was a part of the community and not a self-contained institution. With the Planning Committee, I recommended that we consider decisions within the concept of a psychiatric centre, which secondarily had beds. This was most difficult for the Manitoba Health Services Commission representative to fully understand, because of its traditional funding structure

of a per diem rate for occupied beds. However, I attempted to remind the Committee as each design decision was discussed, that we should first consider the design from a community bias point of view, and then, determine the possibility of developing supportive operational systems.

For example, this meant advocating for kitchen facilities in each unit and a budget for adolescents and staff to use to shop in the community for their food. It meant equipping the residential kitchens with dishes and equipment that could be bought on a low-income or welfare budget, which was closer to the future reality of most young adults moving out on their own. It meant that hospital laundry services were out, and that adolescents would be expected to care for their own linen, clothes, and property.

I also strongly advocated in planning sessions with the Chairperson, for a focus on the learning of life skills and job skills. The latter resulted in agreement that all staff of the centre would be involved with adolescents, and as such, had to be hired with that in mind. Rather than hiring maintenance staff, the money allocated to this function would be utilized in formally hiring adolescents on a part-time basis for these jobs, under the supervision of a child care worker who functioned as a work experience trainer and supervisor. At the Committee level, this meant the kind of materials to be used on the interior of the building, and the landscaping of the exterior, had to be considered in the context of adolescents maintaining the structure.

The premise was that the more residential the atmosphere and furniture was, and the more involved the adolescents were in the care of the unit, the less damage

to persons and property could be expected. Using obviously indestructable materials to prevent vandalism was an invitation for many adolescents to prove their power and prowess.

> "Much experience and observation supports the view that people respond to the expectations made of them. They will respect quality settings and attempt to destroy "vandalproof" environments." (Willis 490)

D) The Quiet Room

Each of the residential units had a room, approximately the same size as the bedrooms, designed as a time-out or quiet room. This was to be designed as an empty room with the highest level of security and indestructability, to be used for time frames of 20 - 30 minutes, whe adolescents were out of control and could not be contained in the milieu, or, in their bedrooms. It was anticipated that the greatest need for this space would be in the acute/respite unit for adolescents who were admitted in acute distress. The possibility of the target population in the two longer term units changing at some future date, resulted in the decision to include a quiet room in each residential unit. However, it was also decided that the quiet rooms in these longer term units would be built with a false ceiling, and would initially be designated as an office/interviewing room to be used by staff, agency personnel, parents, etc. In the opinion of the psychiatrist, the use of the quiet room for adolescents who are well-known to staff should be a rare occurrence, or questions have to be asked about the intervention approaches of staff. The inconvenience of having to use the quiet room on the third unit, for these adolescents was seen as a deterrent to indiscriminate use of the room by staff, and an incentive to staff to find innovative intervention schemes. On those rare occasions when the Quiet Room was a necessity, the close proximity of the third unit would not make this an

inaccessible resource.

E) Unobtrusive Security Measures

Within the design criteria of emphasizing home-like atmosphere, provisions had to be made, for unobtrusive observation of those adolescents who were in the acute phase of their illness and identified as high risk, and for identifying high security areas.

> "It is primarily a matter of balancing: (A) the risks of suicide, escape, and assaultiveness, with (B) respect for the patient, trust in him, and an opportunity to share some of the responsibilities for himself and his environment." (Boyd, "Planning Committee Minutes" 19/03/82)

Wherever possible, the interior layout of the building was designed to allow visual and auditory observation. For example, the central nursing station was designed to allow staff to clearly see both outside entrances to the residential component, into all the living areas of the residential units, and into the music lounge. Through the use of glass doors and windows, an open atmosphere was to be achieved without jeopardizing the separate identity of each residential unit.

Video cameras were to be located in the hallways leading to the school area and administration area, and in the ceiling of the Quiet Room. Black and white TV monitors were installed in the nursing station. This ensured that an adolescent in the quiet room could be viewed at all times to ensure his/her safety, and, that adolescents who were confused and regressed, could be monitored walking along from home to school, a measure of increased independence from having to be accompanied by a staff person.

In order to ensure visual privacy in bedrooms, and yet have the ability to monitor extremely disturbed psychotic or suicidal patients, the decision was made to put in audio microphones in the ceilings of two bedrooms in each unit. In addition, a decision was made to install audio monitors in the living area of each residential unit, thereby allowing night staff to work at the nursing station comfortably assured that a disturbance would be immediately be detected.

The Planning Minutes of the March 19, 1982 meeting discuss this system.

> "The purpose of this system is to ensure a high level of security on a 24-hour basis. This system is designed to allow the reduction in the number of staff for the night shift without compromising security. The central controls are in the nursing station."

An adequate level of staffing would allow for a measure of safety, but no absolute assurance that if an adolescent was totally out of control that he/she couldn't destroy the interior of the building. There was recognition of the fact, that if an adolescent wants out, or wants to destroy property, there are not fences high enough, nor materials strong enough, without designing a maximum security prison, to withstand him/her.

Therefore, philosophically, the Committee accepted the risk that we were designing a community facility and that we would provide a measure of security and safety, but in no way would we design a "jail". As will become evident from the following examples this acceptance of risk, at a philosophical level, seemed to be less definite, when specific issues of importance to one, or the other members of the Committee, were being discussed.

Discussions regarding the use of glass were an example of constraints on the decision-making process, resulting from differences in each person's vision of the problem and proposed solution.

F) The Use of Glass

Use of glass could be considered a major suicide risk, or an important element in creating natural light and an ambience of openness and security. It could be considered non-cost-effective because of the potential for continual breakage, or cost-effective because of increased visual surveillance resulting in a lower staff ratio.

The architect came to this project after completing plans for an adult correctional institution, and concerns for client security were paramount in his mind. Several times, he expressed fear over the media blaming the architectural firm for the scandal of a suicide by an adolescent.

The decision to make extensive use of glass was made by the original members of the Planning Committee, prior to the cost consultant's involvement with the group. However, he had attended subsequent meetings when the decision to use glass had been discussed. He raised this issue as part of a discussion on indestructability, saying he did not agree with the previous decision to use glass, and that he wanted the discussion re-opened. He informed the group that in discussions with the former Chief Provincial Psychiatrist, he had understood that every possible measure, at whatever cost, had to be taken to prevent suicides and destruction of property.

As an example, the cost consultant "introduced to the discussion problems the Manitoba Youth Centre had had with damages, such as carpets being ripped, counters broken, walls marked and punched in, etc." (Boyd, "Planning Committee Minutes" 15/03/82)

I interpreted this as a challenge to the psychiatrist's knowledge of the needs and behaviour of the target population. As was discussed in "Methodology", the cost consultant was concerned about decisions made prior to his involvement. The decision to make extensive use of glass was interpreted by him as a potential threat to his goal of designing a hospital under budget, and a hospital with low costs for maintenance and replacement.

In the earlier discussion, the architects had felt caught between their fear of a suicide, and the design advantages of glass as an element in softening the ambience and providing natural light to interior spaces. However, based on the previous discussion and decisions, they were now convinced that, despite their feelings of apprehension that glass could be used as a weapon in a suicide attempt, or in an attack against a peer or staff, the correct decision had been to make extensive use of glass.

In my role of facilitating decision-making, I reviewed the previous minutes for the Committee, and indicated that the decision to use glass had been made after thorough discussion and consideration of options and was consistent with the design criteria.

The psychiatrist then reviewed for the cost consultant the thinking behind his

previous recommendation, and stated that he continued to believe that this was the appropriate clinical response to the potential problem of glass breakage. He reminded the Committee that we were designing a community centre, not a "jail", and that glass is a normalizing element. Adolescents have breakable windows in their bedrooms at home. Glass allows for transfer of natural light and opens up spaces to provide an ambience that is appealing and not threatening. It allows for staff to have visual access to adolescents without being physically present in their space at all times. It allows for psychiatrically disturbed adolescents to monitor the reality of the time of day, the year, and location.

Discussion then moved to the use of Lexan, with the cost consultant's initial position being that at least we could use unbreakable glass. Again, this was seen as contradictory to the philosophy, in that "unbreakable" glass challenges the angry adolescent to achieve status with peers by breaking it. The psychiatrist also considered the cost to be a significant, unnecessary expense, at four times the cost of regular glass.

In terms of group dynamics, this was an issue of the cost consultant challenging the credibility of the Chairperson.

> "Such instances of clinical and design personnel being on dramatically different wave lengths might be minimized through careful attention in advance to the clinical problems that determine the functions to which the design is directed." (Gutheil and Daly 268)

Previous discussions with the architect regarding target population and proposed functional plan resulted in the architect now being on the same "wave length".

However, the cost consultant had been absent, or only peripherally involved in these previous discussions and had similiar doubts, regarding the credibility of the psychiatrist as the architect had expressed previously.

The cost consultant, having heard directly from the psychiatrist the rationale for the decision to make extensive use of glass, was prepared to support the original decision. Consensus was reached on the installing of regular glass and on monitoring of the cost of maintenance. If replacements became frequent, it was agreed the decision to convert to Lexan would be made on a location by location basis.

II. THE RESIDENTIAL AND INDUSTRIAL KITCHEN

The discussions regarding kitchen facilities exemplify the different interpretation of the design criteria of spatial flexibility, home-like, residential atmosphere and providing a setting to learn life and job skills.

The Functional Plan called for an industrial-size kitchen to be located in the academic-vocational zone of the building and for a kitchen unit in each residence. The industrial-size kitchen was to function as a vocational training centre in Human Ecology, and to serve hot meals, cafeteria style, to the students of the school and staff of the school and the treatment centre. Each living unit was to have its own kitchen with the capacity to prepare all meals for the residents and staff of each unit. The residential kitchens were to be the setting for the teaching of life skills, i.e., teaching adolescents to budget, shop for, and to prepare and serve meals.

The architectural interpretation, or schematic design, of the Functional Plan was reviewed by the Manitoba Health Services Commission's expert consultant on kitchen facilities who found the design and the functional plan to be unrealistic. Much of this consultant's previous experience was in the planning of nursing homes, with some in the planning of food preparation centres for larger, acute care hospitals. She strongly recommended that the industrial kitchen prepare lunch and supper, transporting the meals to the residential unit on a hot cart. She conceded that having the residents prepare a simple breakfast of cereal and toast was feasible. She also recommended that we re-design the residential kitchens so that they were not a part of the living area, and recommended removal of direct access between the Human Ecology classroom and the industrial kitchen.

The Chairperson reported the above recommendations to the Planning Committee Meeting of February 3, 1982, as the M.H.S.C. kitchen consultant was unable to attend the meeting. Also attending this planning meeting was the resource person from the psychiatric nursing area. He supported the consultant's recommendation stating categorically that nurses would refuse to cook two meals a day, and that Union rules would not allow this in any case.

An argument was legitimately raised that kitchens are dangerous places. There are knives and other sharp instruments which could be used to attack others or self, and there is the possibility of someone getting hurt. Some would argue that a good therapeutic program in a psychiatric hospital would protect its

residents from these obvious dangers. Added to this security risk is the issue that many of the adolescents don't know, nor want to learn, how to prepare meals and that staff's time commitments preclude cooking and meal clean-up.

These pieces of information had an interesting effect on the group process. There was initially an unquestioning acceptance of the information, with discussion focusing on the practical aspects of how to keep the food warm on the carts and shift changes for the cook. The implication was that the Chairperson was just not being practical in recommending residential kitchens, i.e. it was an interesting concept but when it comes down to good design, you should follow a proven design specification record.

Due to the lack of time between his meeting with the consultant and the Planning Committee meeting, the Chairperson and I had not discussed the consultant's recommendation and had not planned strategy on how to present the recommendations to the Planning Committee. If we had, my intervention would likely have been of a supportive, rather than a directive, intervention. This meeting occurred early in my involvement with the group and was the first occasion on which I intervened directly to stop what I considered to be premature decision-making and decision-making that was not consistent with treatment philosophy.

Referring to the records of past meetings, (January 14 and 22, 1982; February 3, 1982), I indicated my concern that the Committee was changing too quickly from its original goal of designing and equipping residential kitchens to teach activities of daily living, without considering the ramifications of this decision.

The Minutes of January 14th, 1982 describe the kitchens as follows:

> "1. Full Service Kitchen - Part of Vocational/Rehabilitation Program;
> 2. Unit Kitchen - Residents to learn how to shop for unit, prepare and cook own food." (Boyd, "Planning Committee Minutes" 14/01/82)

The Minutes of January 22nd, 1982, continue on the same premise in describing the equipment needed for the Industrial Kitchen, and its adjoining academic area, the Human Ecology classroom.

> "The Kitchen will:
>
> (1) serve as a training area for students to learn necessary job skills to eventually apply for a job in the community; and
> (2) students will be assessed individually to determine extent of involvement in this kitchen." (Boyd, "Planning Committee Minutes" 22/01/82)

My primary goal, in intervening directly in the decision-making process, was to alert the Committee to my concern that the decision to accept the M.H.S.C.'s and psychiatric nurse consultants' recommendations was not consistent with the previous decision of the Committee, nor was it consistent with the design criteria. I hoped to convince the Committee that further exploration was required before finalizing this design decision. Based on my assessment of the Committee at that point, I did not think I would succeed in convincing them to

return to the original decision. Therefore, my emphasis was on encouraging them to explore further, explain our unique needs to the consultant again, and to consider other solutions that would meet the needs of the functional plan and the recommendation of the consultant.

In my opinion, I was successful in reaching my goals. The discussion concluded with the following plan.

> "Plan #1: The Committee decided that the flexibility of being able to serve supper (i.e. perhaps one unit each day) from this kitchen would be an asset.
>
> Plan #2: A decision to transfer all evening meals from the residential units to the main kitchen was not made.
>
> Plan #3: The details of evening use of the kitchen will require further discussion. It was noted that the kitchen is to be considered a therapeutic work area for training adolescents, and that decisions would be based on this concept.
>
> Plan #4: The Committee decided that the kitchen would be designed with the capacity to serve two meals a day.
>
> Plan #5: The Manitoba Health Services Commission consultant requested a letter from the Chairperson outlining the parameters of the kitchen and its usage. She will then meet further with the architects." (Boyd, "Planning Committee Minutes" 03/02/82)

Following the meeting, the Chairperson and I met and reviewed the process. Based on the expert advice of the Manitoba Health Services Commission consultant and the psychiatric nurse, a decision had almost been reached to change one of the basic goals of rehabilitation. Perhaps because a similar concept had not been tried before, there was more of a tendency to follow the advice of the experts. It was unfortunate that the timing of the two meetings was such that the Chairperson and I had not been able to plan strategy. As a result, my intervention in the meeting had to be more tenacious. In discussing the plan as

quoted above, the Chairperson and I agreed that the letter to the Manitoba Health Services Commission consultant would provide an opportunity to again outline the philosophy and goals of the residential kitchen and of the industrial kitchen.

By May 31st, 1982, following several meetings with the consultant, and a thorough review of the consultant's recommended changes for the residential kitchens, the architect stated that he believed the original architectural design to be more in keeping with the functional requirements of the user group.

The Minutes of May 31st, 1982 read as follows:

> "Unit Kitchens - architects recommend set-up as originally planned, in contrast to suggestion of M.H.S.C. consultant." (Boyd, "Planning Committee Minutes" 31/05/82)

The consultant and the Manitoba Health Services Commission architect attended the September 20, 1982, planning meeting. There were conflicting views on the location of the door between Human Ecology and the industrial kitchen. The consultant also had continuing concerns about the unit kitchens as noted in the following quotation from the minutes of September 20th, 1982.

> "(1) Too much distance between sink and stove;
> (2) Corridor space is dangerous;
> (3) U-shaped design hampers easy access to the kitchen counters for cooking, return of dishes, etc." (Boyd, Planning Committee Minutes 27/09/82)

It was agreed that a sub-committee would continue exploring these issues and would inform the Planning Committee of the results.

The Planning Committee met on September 27th, 1982, and discussed the final recommendations of the kitchen consultant and made the following decisions.

> "The original design (of the architect) better meets the needs of the residents as envisioned in the Functional Plan. The kitchen is designed to approximate as closely as possible a kitchen in a private home or apartment, thereby enabling the residents to learn skills in this kitchen appropriate to their return to the community. The main kitchen is designed to provide vocational training specific to employment in a commercial kitchen setting." (Boyd, "Planning Committee Minutes" 27/09/82)

There was concern on the part of the Manitoba Health Services Commission that the recommendations of their consultant were not being followed, but the consistency of the original design with the needs of the user eventually resulted in their consensus with the plan. The industrial kitchen was designed with the capacity to prepare an evening meal. This required no changes to the original plan because consideration had already been given to design and equipment which would allow for evening activities such as school dances, concerts for parents, etc. The residential kitchen also remained as originally designed. The U-shape allowed for staff and residents to work together in meal preparation, and for others to watch from the stools which sat up to the eating counter. The design resolved the issue of safety, because it was open to the living area, thereby allowing unobtrusive visual surveillance by staff. The concern over sharp knives was resolved by providing one locked drawer; a far less restrictive solution than locking up the entire kitchen.

> "It (physical setting) will reflect the attitude of the institution toward the patient, will make possible certain attitudes and approaches, and will ensure that others will be omitted." (Greenblatt et al. 141)

This decision to maintain the integrity of the residential kitchen was a critical factor in meeting the design criteria of home-like atmosphere and spatial flexibility. Its design would encourage interaction between staff and adolescents, and provide a normalized atmosphere for adolescents to talk about areas of concern and to learn skills, and would encourage adolescents and their families to feel at home, to make a cup of coffee, have a glass of milk, etc.

Thinking back on these discussions, it seems hard to believe how close the proposed treatment centre came to institutionalizing the setting by having meals provided through a traditional, central hospital kitchen. Although this recommendation contradicted all the design criteria, the advice of the expert consultants appeared to overwhelm the Committee members, who accepted the advice with few questions. I feel my intervention was particularly significant in not only deferring the decision-making to allow the group to assess its decision within the context of the design criteria, but also in clearly establishing this process as the acceptable one to follow in future meetings. I think the members of the Planning Committee were also surprised, in retrospect, at how easily they had changed direction and lost sight of the original principles and specific design goals.

III. FURNISHINGS, FIXTURES AND EQUIPMENT

Furnishings, fixtures and equipment, F.F. & E., was tendered according to the same principles of security, indestructability, flexibility, and to achieve a home-like atmosphere in the residential areas, and was tendered according to function, in the academic zone, and the administrative-therapeutic zone.

Furniture for the school was similar to that for junior/senior high schools with the exception of ordering solid oak tables, and solid wood trim on all counters. This was based on the knowledge that school furniture is often the target for minor vandalism - carving of initials, breaking off corners of counters, etc. The initial extra cost of purchasing oak tables and wood counter edges was considered a preventative cost for maintenance, i.e., if an adolescent carved up a table, he/she could sand it down in the Industrial Arts room. An added bonus was that the weight of the solid wood made using the furniture as throwable weapons impossible. After the granting of the tenders to a local businessman, the additional step of making all the table tops reversible further extended ease of repair and the life expectancy of the wood tables.

Offices were designed to function and not to staff assignment. Emphasis was placed on soundproofing and comfort. No emphasis was placed on individuality, or private ownership of office space because the emphasis was to be on staff providing services in, and to, the community. The desks were designed to take up as little space as possible, in favour of the therapeutic use of the space

for individual and family therapy sessions. To accommodate the small size of the offices, compensation was made in terms of the size of furniture used, and the inclusion of a large window to give a feeling of openness and freedom.

An interesting process occurred regarding the purchase of chairs. The interior design consultant presented to the Committee the specifications for chairs, selecting each kind of chair according to function. As a result of the ensuing discussion, the cost consultant made it clear that the Manitoba Health Services Commission would not pay for so many different chairs, and stated the user would have to come up with a different plan.

This issue was one of the more interesting and unusual examples of my role with the Chairperson and Planning Committee in a planning and facilitating capacity. It appeared that the Committee had reached an impasse. The interior design consultant presented his expert recommendation on chairs and the cost consultant refused to pay. The architect, who had selected the interior design consultant, supported his recommendation. This discussion occurred near the end of the life of the committee, and although each member made his stand clear, it was fairly easy to suggest that we consider all possible options to the problem facing the Committee as a whole. This open discussion resulted in permission from the architect and cost consultant for the user to negotiate directly with the furniture manufacturer, in an attempt to find a chair that could serve multiple functions and thereby reduce costs.

Prior to visiting the various furniture manufacturers, the Chairperson and I reviewed the Planning Committee minutes and interior design consultant specifications to identify what would ideally meet the functional needs. The

Chairperson's previous experience in negotiating with building and furniture companies, facilitated successful resolution with a basic set of chairs being designed to meet the specialized needs of the Treatment Centre.

In this example, the cost consultant's absolute refusal to accept the cost resulted in an appropriate second look at a previous decision, and a compromise decision which ultimately improved the quality of the product, the functional usage, and reduced the costs. The cost consultant was pleased because the costs had been reduced, the architect was satisfied that his recommended intervention had been successful without jeopardizing the integrity of the functional plan, and the user was satisfied because of the benefits of exploring directly with the manufacturer the functional requirements and of having them reflected in the final product.

IV. THE SECRETARIAL AREA

External consultants regarding the design of the secretarial area recommended closing off of secretaries and their supervisors, for reasons of confidentiality and privacy. The decision previously made, based on the philosophy, was that everyone who worked in the organization must be committed to therapeutic involvement with the adolescents. Because of the decision to employ patients in office-training positions, and the desire to create a therapeutic environment, the issue of confidentiality was considered to have less priority, and the secretaries were placed in an open administrative area, readily accessible to

staff and patients. Consideration was given to a compromise of having the supervisory secretary enclosed in an office. Space limitations and philosophy resulted in the compromise of placing that person in the open area, but somewhat apart from the other work stations to facilitate some measure of confidentiality, and still retain the ability to communicate with the other secretarial stations and patients.

V. LANDSCAPING

The discussions regarding the landscaping of the grounds exemplified the issue of professionals from disparate backgrounds with individual goals having to find consensus on a group goal. These discussions occurred in the latter part of the planning process and the issue represented the last major opportunity to achieve individual goals prior to the letting of tenders for construction.

The Planning Committee had agreed that the landscaping of the grounds, i.e. creating an ambience around the building was a necessary part of the design process.

Early discussions with the Manitoba Health Services Commission focused on the advantages and disadvantages of letting a separate tender for site development. The cost consultant stated the architect's estimated cost for landscaping was too high. He called a meeting for the Chairperson and me, and at the cost consultant's request, the Manitoba Health Services Commission architect also attended this meeting on a consultant basis. The Chairperson countered with the recommendation to remove landscaping from the total budget and to let a separate

tender for it later, thereby allowing the marketplace to determine the amount of money remaining after the granting of construction tenders. If the tenders came in low, there would be more money for landscaping. If they came in high, landscaping would be curtailed, and the decision would not have effected the structure of the building, by making a premature decision to cut certain items out of the Construction Budget.

The Chairperson summarized the positions of each professional on the Committee as recorded in the meeting of September 14th, 1982.

> "The architects are responsible for design; Manitoba Health Services Commission is responsible for providing quality control and equitable expenditures of the Province's money, and the User Group is responsible for the function, making decisions without compromising principles, and prioritizing items from essential to ancillary." (Boyd, "Planning Committee Minutes"14/09/82)
>
> The Manitoba Health Services Commission architect replied, " the issue is political in that it is seen as evident that the present market will result in lower tenders and in Manitoba Health Services Commission saving money for the Province, and that this facility's landscaping should be seen as similar in costs to those of others recently built in the community." (Boyd, "Planning Committee Minutes"14/09/82)

The cost consultant agreed with the M.H.S.C. architect that he would be uncomfortable explaining why the first facility owned by Manitoba Health Services Commission had a higher quality of landscaping than other hospitals.

The meeting concluded with the cost consultant agreeing to a separate tender for landscaping, and with his feeling that the Chairperson understood his stance and would support him in the next meeting with the architect.

The plan, as stated in the Minutes, was as follows:

> "The tender for construction and F.F. & E. will be let. The tender for landscaping will be let at some future point and will indicate which areas are essential, i.e. requiring large equipment, and which areas are optional, i.e. residents can complete." (Boyd, "Planning Committee Minutes"20/09/82)

The architect attended the next meeting and reviewed the process he had followed in arriving at the landscaping plan. He argued that the amount of landscaping was minimal compared to similar facilities in Calgary and Vancouver, and that the purpose of the landscaping was more than aesthetic. The courtyard component of the outdoor area, which will not be seen by the public, was to be designed according to the design criteria of home-like atmosphere, spatial flexibility, and a setting to teach life skills and work skills. The psychiatrist supported the development of this outdoor therapeutic space and stated, "that the decision to cut is a dollar decision, not a decision based on the functional plan." (Boyd, "Planning Committee Minutes"20/09/82)

The Minutes record the discussion as follows:

> "The group discussed this building in comparison to a private home, and other health care facilities, i.e. nursing homes, institutions and small hospitals, in an attempt to compare the landscaping provisions and usage to an existing facility. It was not possible to compare. It was concluded, rather, that decisions have to be reached based on the functional plan. However, the group acknowledged the position of Manitoba Health Services Commission to account for the dollars spent in this time of restraint." (Boyd, "Planning Committee Minutes"20/09/82)

With this decision, the issue was put on hold for approximately one year, until June 22nd, 1983, when it re-surfaced with many of the same concerns.

The discussion in this meeting was reminiscent of earlier discussions - is this facility a hospital? or is it a large group home? Despite my continued emphasis with the Committee to make decisions according to the Functional Plan and design criteria, the natural attempt was to find "something" to use as a basis of comparison. With landscaping being the most visible proof of money spent, the cost consultant wanted assurances that other hospitals would not accuse him of overspending because it was "his building". Although he agreed, in principle, that this facility was not "just a small hospital", he believed he would still be subject to criticism by those in the community who defined it as a "hospital". An interrelated factor which I recorded in the Process Notes was a comment by the Manitoba Health Services Commission architect that "there are no guidelines for determining costs when estimates are low. Usually costs are controlled by prices." (Boyd, "Process Notes"58)

By the time of the next major Planning Meeting on landscaping, the Chairperson and I had discussed, and agreed upon, the feasibility of letting a contract for the heavy work, such as the laying of sod, and holding back money for planting costs only, with labour to be supplied by residents and staff. This work project was seen as an ideal opportunity to increase positive feelings for the setting, and to encourage staff and adolescents in the developing of relationships and specific work skills.

The Minutes of the June 22, 1983 meeting record the results of the tender process.

> "It had been agreed that a final decision on expenditures for landscaping would be postponed until the project tender was granted. The tender came in low. In principle, it was agreed that landscaping be designated as a work project to be completed by residents and staff. However, the reality of having staff and residents complete this immediately after opening would depend upon the season of the year, number of staff and residents, etc. It was agreed that the grounds should be aesthetically pleasing, and that where possible, residents and staff should participate in the landscaping." (Boyd, "Planning Committee Minutes"22/06/83)

At the end of the meeting, a sub-committee meeting of the Chairperson, cost consultant and I, was held to prepare a reply to the landscaping architect's cost estimate of $30,000.00 The reply stated that the costs were too high and requested him to submit a basic plan. When this also came in very high, the Chairperson and I made further cuts and reduced the costs to just over $1,000.00, with an amount to be left in a contingency budget for residents to complete the planting.

Throughout the process, the cost consultant and architect intensified their lobbying and invited the Chairperson and I to attend meetings with them. The cost consultant stated that the landscaping costs were outrageous and an attempt to "pad" on the part of the architects; the architect stated that we were under-budget, and we could afford to have landscaping in keeping with the building. This was one of the last major issues to be resolved, and the last attempt to establish power and status and to achieve individual goals, as we moved to the construction phase. The cost consultant's individual goal was to bring the project in under budget, and the architect's individual goal was to build an aesthetically pleasing and functionally operational centre.

Interestingly, the negotiations resulted in the price dropping so low that the cost consultant was concerned that the Chairperson was trying to make him look "foolish" in the eyes of the Minister of Health when he came to open a building that was surrounded by blowing dirt. This became yet another occasion on which the Chairperson literally said to the cost consultant "you have to trust me. I won't embarrass you." (Boyd, "Process Notes",32) He assured the cost consultant the money would cover sufficient landscaping costs to open, thereby allowing us to follow the original plan of actively involving residents and staff in the planting of the grounds.

The landscaping issue was the first time in the day-to-day planning process that the senior architectural partner became involved. This changed the dynamics of the group and left the Committee architect caught between what the senior partner recommended and the open style of working he had established with the Planning Committee, and in particular with the Chairperson.

In this situation, the User Group and the facilitator-coordinator took a very active role in resolving the conflict between the goals of the architect and those of the cost consultant. When the sketch plan was returned from the landscaping architect the second time, with few of the requested changes, the Chairperson decided that he and I would simply re-do the landscaping plan. Because of the assumed conflict position that the Committee architect was placed in by involvement of his senior partner in sub-contracting with the landscaping architect, the previous style of discussion with Committee members would not have been effective. However, by the Chairperson taking over directly and saying specifically what the user group wanted done by the landscaping firm, the architect was in the position of having to acquiesce.

CHAPTER VI - EVALUATION PROCESS AND RESULTS

The method of evaluating my role with the Planning Committee was planned with my Practicum Advisory Committee. It was agreed that the principal members of the Planning Committee would be interviewed on audio tape. Consideration was given to who should conduct the interview, because of possible bias resulting from my conducting the interview. However, after much discussion and revision of the questions, the Advisory Committee recommended that the Structured Interview should be conducted by myself. In addition to the taped interview material, each member was to be requested to complete a Performance Rating Scale of my performance in each function of my role, which was to be mailed directly to my principal advisor. This was then correlated to the comments given in the Structured Interview.

The process was as follows: I contacted each Planning Committee member by phone and requested their assistance in completing an evaluation of my involvement with the Planning Committee. Interviews were scheduled and all conducted at the member's place of work. The Structured Interview itself lasting from forty-five minutes to one and a half hours, was audio recorded and later transcribed verbatim, and copies were sent to my principal advisor. All Committee members completed the performance rating scale and mailed it directly to my principal advisor.

It was agreed by my Advisory Committee that I would interview five Planning Committee members. The order of the interviews was random, according to the

availability of the member. Structured Interviews were conducted with the psychiatrist (Chairperson, User Group) both representatives from the Manitoba Health Services Commission, and the architect and his support staff, the draftsman for this project. The architect and psychiatrist were actively involved throughout the complete time frame, with the Manitoba Health Services Commission represented by two staff, according to required function. The decision to include the architectural support staff was based on his involvement as the "job captain" for the architectural firm on this project. He was not an active participant in meetings, but attended design meetings to amass the information he needed to complete detailed drawings, etc. Because of the specificity of his involvement, it was postulated that he might have different expectations and interpretation of my involvement.

A) STRUCTURED INTERVIEW QUESTIONS

The Structured Interview was divided into five sections. Please refer to Appendix A for a copy of the "Evaluation Instrument".
The session began with fairly structured questions and then moved on to less well defined areas.

With each Committee member, I began by reading the preamble. The purpose of the preamble was to identify the reason for the interview, its structure and process, and to inform Committee members that their comments would be included in my practicum report.

SECTION I:

This question was an ice-breaker, to allow each member to consider the preamble which I had just read, and to give him an opportunity to give a general overview of the planning process during the time of my involvement.

SECTION II:

The questions focused on the expectations members of the Planning Committee had of me, and whether these had changed over time, were fulfilled or not.

SECTION III:

The questions focused on the specific functions that I had proposed to fulfill when I began my involvement with the Committee. At the beginning of this part of the "Structured Interview", I provided each Committee member with a typed copy of "Coordinating and Facilitating Functions" with a description of each. Members were given time to review this information and to refer to the typed sheet throughout this series of questions.

The first question asked the member's opinion on the importance of each function in the achievement of the Committee's goals. The Committee

members had not previously been given information as to the specific details of each function I had proposed to fulfill. The second question was designed to assess whether the members were aware at the time of my performing any of the listed functions, and/or aware of my performing functions not listed. The third and fourth questions asked for a performance evaluation on each function, including their opinion as to how successful I had been and their recommendations for improvement.

SECTION IV:

This was the Performance Rating Scale which members were asked to complete independently and mail to my principal advisor.

SECTION V:

These questions gave each Committee Member the opportunity to make further comments and to ask questions, and to give their opinion as to whether they would participate at some point in the future with a social work practicum student as a member of a planning committee. This question was designed to provide an opportunity for the members to comment on the involvement of graduate students generally, without having to specifically comment on my involvement. A positive answer would be indicative of the member's satisfaction with my level of performance.

B) REVIEW OF TRANSCRIBED ANSWERS

I will now review the transcribed comments of the members and the Performance Rating Scale for each of the proposed functions.

SECTION I:

There was agreement by all members that the planning process had gone well. Most frequently mentioned was that "(it) was unique to the Province", (Taped Interview,1) and the stress and excitement related to that, and the impression that "the planning went very well, exceptionally well because of the people involved.".

SECTION II:

Members of the Committee had differing expectations of my involvement with them. This was related to the time at which they and I had joined the Committee, their understanding of the role of a graduate student in a practicum placement, and how they perceived my helping or hindering their efforts in reaching their individual goals. The psychiatrist most clearly saw the role of the student, likely because he had been directly involved in discussions with my principal advisor, and in requesting the group's permission for my involvement.

1 - Answers by the Planning Committee members to the questionnaire were transcribed and are quoted verbatim throughout Section B. In sequential order, they refer to the following references: B1, D1, E4, B1, B2, C2, D1, D3, D3, B1, B3, E5, B4, E5, D4, A5,2, E6, B4, C6, E6, A6, A7,8, A9, A9, E7, E7, D8, D2, D2, D2, D5, D5, E7, D5, D6, E9, D9.

> "I started with an expectation that this would be for your education and for whatever you might add to the Committee from a community mental health worker and a social worker's perspective... I was most specifically concerned about the efficiency with which you were able to listen to a lot of different people's opinions, who were not necessarily trained in a single type of training, and to be able to translate all of the different languages of construction planners, architects, psychiatrists, and social workers, into specific detail which could be agreed to and understood by all people involved in the planning process. The particular thing that I looked for in addition to the input that you made with regards to the clarity of description, was a significant input from the social worker's point of view of how psychiatric programs could be translated into architectural design."

In contrast, the senior Manitoba Health Services Commission representative had not remembered after the initial introduction, that my involvement was as a student. "I was somewhat surprised that you were involved as a student", and had based his expectations on "I thought you were there as an experienced staff member."

The cost consultant and draftsman became involved part way through the process after I had already established myself as a member of the Planning

Committee. Their expectations were based more on what they observed me doing, as a member of the Planning Committee, "I guess I became dependent on what you were doing by virtue of communications with our office."

The architect's basic expectations were that I would provide "another view from a medical point of view, from the user point of view which allowed more than a two way exchange", document the decision making and planning process, which "keeps the project on track a lot easier when everyone can refer to the Minutes as to actually what was said or who had to do what", and that you would become,

> "very much a part of this design group and that's really what we're saying here, is that this was a design team, which is the only way that a building like this can be resolved, is that every participant in the design team, he gives his all, then we arrive at a better solution and hopefully that will show in the final building."

The question "in what ways did I fulfill, and/or not fulfill your expectations," is predicated on the previous one, in the sense that the original members of the Committee had general expectations that they felt I met. The architect states, "I think you pretty well fulfilled our expectations, actually more than we had thought."

The senior Manitoba Health Services Commission representative, basing his answer on what he would expect from a staff member comments,

> "I think you handled yourself well with the various disciplines that were involved, from engineering to architectural to construction people to administrative people.... Even on reflection, I don't think I ever had a thought you weren't doing what you were supposed to do and doing it very well."

In addition to indicating that I satisfactorily fulfilled his expectations of me with the Committee, the Chairperson added his thoughts on my role with him,

> "As the process evolved, I've found that your involvement was invaluable... where I was unsure of whether I was overstepping a boundary for which I did not have expertise, the significant value in being able to bounce that off yourself, and realizing more and more that you both had an interest in administration, and in this kind of endeavour n addition to your social work training, and having a considerable expertise as well."

SECTION III AND IV

As stated earlier, I provided each person with a typed copy of the "Coordinating and Facilitating Functions" and descriptors, to refer to during this part of the interview process. In my review of this section, I will compare the comments made in the interview situation with the written comments and rating on the Performance Rating Scale, Section IV, which was completed by each participant at a later date.

The first function listed is the documentation of the planning meetings. Three of the Committee members rated my performance on this as very satisfactory, two as satisfactory. The senior Manitoba Health Services Commission representative gave the following assessment,

> "I think the Minutes reflected what working Minutes should reflect, what was agreed upon, what was not quite agreed upon, and what the next steps were and who was going to do the next steps, which I think is often sadly lacking in sort of working Minutes, and what's left to do and who is going to do it, and when they have to be done by."

For the psychiatrist, or Chairperson, the Minutes were a working tool. As has been discussed previously, the Minutes were consulted at the Committee level and in pre and post meetings between the Chairperson and I.

> "What I found was that it was absolutely invaluable to have someone who had the ability to translate accurately programmatic information into a language that could be understood by someone who is not part of the same generic training or program. And that these Minutes, or this process documentation, had such clarity that it enabled me to consensually evaluate my own thinking, even though that thinking had taken place as long ago as a year, and also allowed me to be able to check, or call the other individuals in our planning process when they indicated later that they really hadn't understood, then the ability to refer to these notes was in my estimation an absolutely invaluable piece of information."

The architect and draftsman also commented favourably several times throughout the Structured Interview, "we were very impressed with that", "always concise, to the point, and accurate."

There was some contradiction in the response of the cost consultant who rated my performance as very satisfactory on the Performance Rating Scale, but expressed both negative and positive comments in the interview situation.

> "Your recording, which I gather is one of your responsibilities, was good."
>
> "They were, the only thing that I found, is that they were verbatim minutes, they weren't basically decision minutes, which I think projects need rather than, because how do you, you may not quite agree with the way someone has described a particular meeting and they may not have picked up the intent that certain individuals around the table were saying and you can always see that editing takes place."

Based on comments that he made regarding the Minutes on other occasions, my assessment is that his concern was that I would record him saying something that he preferred not to be recorded. When he was feeling pressured in a meeting, I was often the recipient of comments such as "here's Mrs. Minutes again." Each member of the Committee, at some point in the process, expressed uneasiness about the "power of the written word", exhibited by direct comments of "don't write that down." To maintain credibility, these comments were never recorded in the Planning Minutes, but they were recorded in my process notes and provided me with additional information for analysis. The editing of the Minutes after each meeting was a time consuming project. Material was divided into official Minutes, process notes, and content notes. Included with the official Minutes was the Planning

Chart, which was updated after each meeting. The original handwritten notes, recorded at the meeting, were kept in my files for future reference.

The second function, "arranging for consultants and resource material", has been discussed earlier as being the solution to the identified problem of the architects, of having too many people attending each planning meeting and giving conflicting messages. This function was a liaison one of facilitating communication and information flow between the Planning Committee and the consultants identified by the user group, or requested by the architect. I did not serve this function of liaison with consultants who were on staff of the Manitoba Health Services Commission, such as the kitchen consultant.

The Chairperson saw this as a delegated function that allowed him to,

> "extend myself as the principal from the programmatic point of view much further than I would otherwise have been able to do."

The architect stated that this "was handled very well and we never had any cause for comment against that, that meetings weren't being held when we wanted them or the right people, we weren't able to get a hold of."

The rating for this function of "arranging for consultants" was satisfactory according to three participants, and very satisfactory according to two participants.

The function of "assisting group maintenance functions" was rated as satisfactory by four members, and very satisfactory by one member. The psychiatrist commented on how my involvement in the group process affected him,

> "with regards to the morale of the group, in my estimation, recognizing that I work with groups and have worked with groups in the past, your particular benefit to me was a stabilizing influence."

The cost consultant stated that the Manitoba Health Services Commission is,

> "very satisfied with the outcome of the project. Design wise, quality wise and cost wise, and cost control wise, and if thats a morale booster I'm happy about that because I think that's what the whole object of the thing is, without selling the farm or building something that is absolutely ridiculous."

As stated previously, this Committee saw itself as a group with a task to complete. During the planning process itself, the cost consultant expressed dissatisfaction most frequently, that being a concern that we were spending too much money. By the time of this interview, it was obvious that tenders were coming in at cost, and that the Manitoba Health Services Commission would save money on the project which would reflect favourably on the cost consultant.

The next three functions relate to my involvement in the decision making process and will be discussed as a unit. Four of the people rated "Facilitate Decision Making Process" and "Facilitate Conflict Resolution" as satisfactory, one person rated each of these as very satisfactory. "Support Consensus Testing" was unanimously rated as very satisfactory.

The cost consultant stated that initially he had concerns about the process,

> "I thought at the beginning... that it would be a struggle, but as the project progressed, I found that there was a lot of give and take."
>
> "Initially, I felt it was sort of a one way street by the user, and that everything was geared up all around strictly program, and after awhile I started to understand the individuals that were involved, and things started coming into place and then people were taking the budget that we had established seriously, and that it was going to come in under that, and that the budget was established as a budget, and I felt that it was no use causing hard feelings amongst people until we saw numbers, and then we could take serious steps in which your involvement and the psychiatrist was to get the best that you could, but also look at the reality of the provincial tax dollars."

These comments are in keeping with the cost consultant's concern at not having been involved from the beginning of the process, and his initial feeling of "being left out". Later in the process he identified more with the group goal, but continued to see his involvement as being more linked with that of the Chairperson, the user.

> "I think as far as yourself and the psychiatrist and the user side of it and the Commission, there was the least amount of disagreement..., but I think there was a lot of tension in regards to our cross-involvement through the architectural organization."
>
> "That's from my perspective, and in my discussions with the psychiatrist, we're finding that we have to, and yourself, we have to stick together in the decision making without them taking it away from us or telling us they know everything."

As the cost consultant began to identify more with the user, he perceived the architectural firm as attempting to operate within the historical role of telling the client what to do, and he objected to this style of working relationship.

The psychiatrist also comments specifically on my role in facilitating conflict resolutions,

> "there were many times when there would be difficulty between the architect and the Manitoba Health Services Commission, more than between the program and the architect."

The psychiatrist discussed the value of my role in assessing the situation and possible approaches for him to utilize in resolving the conflict.

> " it was very often that prior to going to the meeting I would be totally briefed on the particular position, whether it was in variance or in agreement with my own position with all the other principal players. It was invaluable for me in facilitating conflict resolution when I had been so accurately briefed and it made conflict resolution for me that much easier. I was able to clarify a process of resolution at least for myself, which facilitated, that we got what we wanted."

The architect discussed the delays that result when members of a design team antagonize each other. He comments favourably on my

> "reaction to problems, for example, if there was an error or whatever in the final drawings. The fact that you very professionally analyze the problem and were willing to deal with it as a professional, rather than reacting negatively to one of the design team members, or looking to blame or scapegoat for that purpose."

He discusses at some length, the importance to the architect, of the user who

> "will be a client that we can relate to and also that the user can recognize other problems than his own, meaning problems of architecture, quotes, costs, and be flexible enough to allow for a kind of negotiated solution in some cases."

He discusses the advantages from the architectural perspective of " having someone other that the architect challenge some of these things." He sees this as having been particularly important on this project, because the psychiatrist was a user group of one, and,

> "the fact that you were very active in the philosophy of some of the concepts, allowed us to have this dialogue and to initiate us into some of your problems which is the other problem architects have. We are building a facility to house these functions, but we have to have it clearly explained to us what actually we are housing and sometimes that's very difficult. Some users have trouble putting that across or become so dogmatic or just one-sided .... if you hadn't been there, we might have had a lot more difficulty in trying to communicate the user needs."

Regarding consensus testing, the architect states,

> "it is interesting the third person, especially in the fact that you weren't an architect, you weren't a psychiatrists, but coming at it from a social work function, you had an input that maybe caused the other two to react differently than if you hadn't been there, and so I think that supported the whole design function and I think that it made everyone's job a little easier."

The Chairperson again comments on the importance of this function to his particular role,

> "the consensus testing of being able to consenually validate what other people were thinking and saying in the group, and coming up with some understanding through discussion with you, both in the group and in the post-group, made my position that much stronger, and also effectively helped me to be more influential in getting our psychiatric programs translated into optimal architectural design."

The architect comments on the resulting consistency at the working drawing stage from my intervention in the decision-making process,

> "if you didn't agree with something, you held up a red flag, and said, well, maybe we should either look into that, or think about that a bit and the fact that the chairperson would respect your decision on points like that, and you were both open for our comments and in challenging our designs and our philosophy which were sometimes made from a non-professional, as far as medical reasoning is concerned."

He comments further on the uniqueness of this project, and the fact that the design team was breaking new ground.

> "The fact that it was so new, the treatment philosophy was always being analyzed throughout the two years, and I think we were always challenging it, and I think from the security point of view which was one important thing, and the suicide decisions that we had to make, or how far to carry the building as far as being secure and to stay away from going overboard, I felt that you and the chairperson were consistent and yet were always trying to rationalize that everything was handled properly and that you weren't going overboard one way or going overboard the other way. It sometimes changed our approach on the actual building as we went along, when we kept challenging everything and making sure over and over again that we were doing it the right way. So I think that we were consistent in the fact that we always were questioning earlier decisions, especially when we were looking at them from a different viewpoint, and I think that's important in any design."

SECTION V:

This last section of the questionnaire was designed to provide a forum for the interviewee to add any comments, and to speculate about the role of a practicum student on the planning committee. All the members stated they

would have no problems being involved in a similar process in the future. The Chairperson specified that the ability of the person to perform the function would be the deciding factor for him, not whether the person was a student,

> "I personally would probably not go into this kind of an arrangement again without having somebody in your capacity. I believe that this is an absolute essential person in a planning process of this type."

The architect's recommendation was that the student should not be in the same professional field as the user, to allow for some challenging of ideas.

> "If you had been, for example, a psychiatry student, it may not have been as productive as a social worker, because there would have been a tendency to come with too much togetherness, and not get that other viewpoint, which in this case is very appropriate, I thought, because that's a big part of the project."

C) SELF EVALUATION

My basic goals for the practicum were to improve my social work skills in the areas of planning and of group facilitation. The setting was certainly unique, and I felt honoured to have been a part of this "once in a lifetime experience" of planning and designing a facility which had been talked about for so many years.

The sophistication and experience, in their particular disciplines and on planning groups, of the senior staff who comprised the planning committee, provided a challenge to the role of group facilitator. I came to appreciate the intervention of "influence" as discussed by Morris, R. and Binstock, R. when they quote Banfield "by influence we mean the ability to get others to act, think, or feel as one intends". (Morris and Binstock 18) And specifically, "influence which works by improving the logic or the information of the influencee ("rational persuasion"). (Morris and Binstock 117)

As with most groups, the initial reaction to my arrival, was at best skeptical. My initial reaction was a feeling of being overwhelmed and challenged at what I had proposed to do.

One of the first tasks I faced was learning how to quickly and accurately read schematics and working drawings of increasing complexity. Accurate recording of decisions at meetings and interventions in the decision making process were not possible if I couldn't "keep up" with the experts - the architect, Manitoba Health Services Commission representatives, and psychiatrist, all of whom could

interpret the drawings at a glance. A quick course in architectural terms was also in order, or my interpretation of the connection between lack of crawl space and slab on slab, would have lacked more than clarity.

My preference would have been to have had time and opportunity, prior to my involvement with this Committee, to learn some basics of the process of design and the role of Manitoba Health Services Commission in building facilities. This preference comes from my present stance, when I know that the knowledge I now have, would result in my being more cognizant of the different parts of this complex design process, than I was the "first time around." However, there was no time lapse between the availability and approval of this as a practicum site, and the beginning of the Planning Committee Meetings.

Over time, in an unobtrusive manner, I gradually moved from providing the Committee with concrete examples of my competence - completing minutes on time, arranging for resource people, etc. to interventions in the decision making process. Once the Committee established a workable level of trust with me, I found my role to be one which provided much scope and creativity. This I would attribute to the sense of excitement and uniqueness associated with the project and the working level of the members of the Committee.

My review of the literature was eclectic because there were so few specific writings on the process of designing a mental health setting. In this respect, I express my sincere appreciation to Dr. Bruce Tefft, a member of my advisory committee, who introduced me to Seymour Sarason, "The Creation of Settings", which I read and reread many times, and utilized frequently in discussion with the Chairperson as a predictor of what would happen next, and how to encourage,

avoid it. The literature in the area of environmental design and design process combined with the literature on group process, helped in my understanding of the dynamics of the Planning Committee. Having worked in the area of community child and adolescent psychiatry, both in rural Manitoba and in Winnipeg, I was aware of my bias towards provision of services in the community. Reconciling that bias with the mandate to design and build a psychiatric hospital required much reading, thinking, and planning in the areas of mental health service delivery.

It was not enough to say that the environment of the traditional psychiatric hospital is counter-therapeutic. That part was easy. Decisions on what to replace it with, and where to draw the line between necessary security and institutionalized tradition, were much more difficult. Discussions on the design of the residential bedrooms is one example. Installing solid wood doors might have been drawing the line too far on the side of residential, home-like atmosphere. Could we really make the room suicide-proof, and supplement this with staff attitudes and an atmosphere that would ensure the safety of acutely disturbed adolescents? Was it pushing the concept of rehabilitation too far to refuse to hire maintenance staff, and to expect adolescents to apply for jobs and work with child care staff to keep a building of twenty-five thousand square feet clean? Was it appropriate to build a facility that did not have a secure, locked section, when we knew that some of the referrals would be chronically, mentally ill young adults who might wander out on the street and be hurt?

And, once these risks had been considered and a decision reached, how does one translate that into a physical design that can be accurately interpreted by future staff and residents?

These are examples of questions which have no definite answers - merely, options and further options. I referred earlier to Sarason's description as follows:

> "Creating a physical environment is under the best of circumstances a formidable task. Unlike the administrative chart, a brand new structure cannot be changed, and this knowledge is a stimulus both to anxiety and creativity - under the best of circumstances." (Sarason 163)

Anxiety and creativity are the descriptors of the feelings which attached to my continuing questions as to whether we had made the best decisions and were following the most appropriate direction. What later price might have to be paid because of our continued emphasis on the philosophy of community-based programmes?

Throughout the process, I was most conscious of my role in facilitating the decision-making process -

> "encourage the committee to reach decisions that are consistent with previous decisions and consistent with treatment philosophy and the terms of reference of the group". (Co-ordinating and facilitating functions).

These attempts to facilitate consensus on decisions, and consistency in the decision-making process, permeated all my interventions, from the recording of the group discussions, to direct interventions with the Planning Committee, and to pre- and post-planning strategy sessions with the Chairperson. I carried out the role in different ways depending on the dynamics of the situation. At times, I intervened directly with the Chairperson, Committee member, or group; at other times, I worked through the Chairperson, facilitating his ability to reach consensus with the group on issues that were critical to the identified needs of the user group.

An example of the concrete result of these interventions was the dramatic cost savings resulting from the lack of change orders. Another was my successful intervention in the discussions regarding the role of the residential and industrial kitchens.

I think my proposed role was particularly suited to someone with a social work background. The Committee members comment on this fact in the preceding evaluation comments. Alan Klein, in discussing the "Group Worker and Committees" states,

> "in the committee group, the concern of the worker is with the personal needs of members only as they are related to a well-running committee, the members ability to function effectively on the committee, and the achievement committee goal" (203)

Klein also discusses the complementary roles of the chairperson and the group worker.

> "The chairman and the group worker keep the group working on the job to be done, keep the goals before it, and enable the committee to move forward to get the job done."

These statements by Klein summarize the goals I had proposed for my work with the Committee, that of enabling the Planning Committee to complete its mandated task, and of my goal with the Chairperson, that of enabling the Chairperson to effectively fulfill his role with the Committee, and in this situation, his role as a user group and psychiatric representative of the Planning Committee.

The skills I demonstrated with the Committee in this practicum setting included the following: a planned approach to the Committee which resulted in gaining their acceptance and trust; a demonstrated ability to observe and analyze the dynamic relationships at an affective and content level, among and between

members, and the ability to select the appropriate intervention strategy and time; the ability to modify the functions of my role to the changing needs of the Committee; the ability to assess the group record and to use it for feedback, about and to the Committee as appropriate; and the ability to "give simultaneous attention to the group processes, and to the functioning of the individual members." (Trecker- Social Group Work 236)

In concluding, I wish to express my sincere thanks to the members of my Practicum Advisory Committee, to the Chairperson, Dr. Joe Ryant, to Dr. Bruce Tefft, to Ralph Kuropatwa, and to his replacement, Len Spearman, for their support and assistance during this lengthy process. I also wish to thank xthe members of the Planning Committee - the Chairperson, representatives from the Manitoba Health Services Commission, and the architect and draftsperson, and St. Jude, for giving me the opportunity to participate in this exciting adventure, which resulted, after sixty years of failed attempts, in the successful completion of the planning and construction of the Manitoba Adolescent Treatment Centre.

CHAPTER VII - APPENDICES

APPENDIX A - EVALUATION INSTRUMENT

EVALUATION INSTRUMENT

MBLE

As you are aware, my role with the Planning Committee for the Manitoba escent Treatment Centre was as a graduate student from the School of Social . My functions were basically defined as Coordinator and Facilitator of group process. In performing this role, I hoped to develop certain skills.

One of the requirements for graduate studies is the conducting of an evaln of my performance. With the assistance of my graduate studies advisory ittee, I have prepared a structured interview for the principle members of Planning Committee.

The purpose of taping this interview is to enable me to transcribe the content later date. The material you provide will be included in my final report.

Should you have any comments that you wish to share with my advisor, he I be pleased to hear from you by telephone or in writing. Of course these be held in confidence.

ON I

Reflecting on the past two years since our work first began, how do you feel the planning has gone?

ON II

What were your expectations of my involvement with the Planning Committee?

(a) Did these expectations change over time? Can you comment further?

In what ways did I fulfill your expectations?

a) Can you give me some examples?

n what ways did I not fulifll your expectations?

a) Can you give me some examples?

SECTION III

Here is a list of functions that I proposed to fulfill in my role on the Committee. I will give you a few minutes to review the list, then I would like to ask you some questions regarding it.

(1) How important do you feel each of these functions on this list was to the achievement of the Committee's goals?

(2) At the time, which functions were you aware that I was performing?

(a) In retrospect can you recall any other functions?

(b) Can you think of some examples?

(3) How successfully do you think that I fulfilled each function?

(4) What suggestions could you give me on improving my performance in each of these areas?

SECTION IV

I would like you to rate my performance in each of these functions. Could you please mail this in to my advisor? You may wish to add some written comments at the end of it.

SECTION V

(1) Is there any function that you feel I performed that we have not discussed?

(a) Can you elaborate on that?

(2) If you were asked at some point in the future to participate in a similar arrangement, are there some changes you would recommend?

(a) Can you elaborate on your answer?

(3) Do you have any further comments to make which you believe would be helpful to this evaluation of my performance?

Thank you for your assistance with and comments on this questionnaire.

LB/asq

Leanne Boyd.

III. Coordinating and Facilitating Functions:

FUNCTION	DESCRIPTION
DOCUMENT PROCESS AT EACH MEETING	Accurately record minutes and ensure their distribution.
ARRANGE FOR CONSULTANTS/ RESOURCE MATERIAL	Make arrangements for resource consultants (education, occupational therapy) to attend meetings when their specific expertise is required.
ASSIST IN GROUP MAINTENANCE FUNCTIONS	Increase the personal satisfaction of each member as it relates to his functioning in the group. Enhance group morale through support of a common purpose, shared goals.
SUPPORT CONSENSUS TESTING	Encourage group to explore areas of agreement, suggest alternatives, propose compromise solutions.
FACILITATE DECISION-MAKING PROCESS	- encourage participation by all members - explore whether committee is nearing a decision, caution against premature decision-making and/or delayed or deferred decision-making - encourage committee to reach decisions that are consistent with previous decision and consistent with treatment philosophy and the terms of reference of the group - initiate or propose ideas, actions or procedures relevant to the tasks of the group.
FACILITATE CONFLICT RESOLUTION	Explore disagreements, relieve tension and bring to a resolution.

IV. Performance Rating Scale

Please circle your response:

	Very Unsatisfactory	Unsatisfactory	Neither Satisfactory nor Unsatisfactory	Satisfactory	Very Satisfactory
DOCUMENT PROCESS AT EACH MEETING	1	2	3	4	5
ARRANGE FOR CONSULTANTS/ RESOURCE MATERIAL	1	2	3	4	5
ASSIST IN GROUP MAINTENANCE FUNCTIONS	1	2	3	4	5
SUPPORT CONSENSUS TESTING	1	2	3	4	5
FACILITATE DECISION-MAKING PROCESS	1	2	3	4	5
FACILITATE CONFLICT RESOLUTION	1	2	3	4	5

Additional Comments:

APPENDIX B - PERFORMANCE RATING SCALE

IV. Performance Rating Scale

Please circle your response:

	Very Unsatisfactory	Unsatisfactory	Neither Satisfactory nor satisfactory	Satisfactory	Very Satisfactory
DOCUMENT PROCESS AT EACH MEETING	1	2	3	4	(5)
ARRANGE FOR CONSULTANTS/ RESOURCE MATERIAL	1	2	3	(4)	5
ASSIST IN GROUP MAINTENANCE FUNCTIONS	1	2	3	(4)	5
SUPPORT CONSENSUS TESTING	1	2	3	4	(5)
FACILITATE DECISION-MAKING PROCESS	1	2	3	(4)	5
FACILITATE CONFLICT RESOLUTION	1	2	3	(4)	5

Additional Comments:

I wouldn't go through this again without someone who recorded the particular job function. The trainee did a very competent job of bridging the gap between verbal information and actual construction situations and not encountering any problems.

IV. Performance Rating Scale

Please circle your response:

	Very Unsatisfactory	Unsatisfactory	Neither Satisfactory nor Unsatisfactory	Satisfactory	Very Satisfactory
DOCUMENT PROCESS AT EACH MEETING	1	2	3	(4)	5
ARRANGE FOR CONSULTANTS/ RESOURCE MATERIAL	1	2	3	4	(5)
ASSIST IN GROUP MAINTENANCE FUNCTIONS	1	2	3	(4)	5
SUPPORT CONSENSUS TESTING	1	2	3	4	(5)
FACILITATE DECISION-MAKING PROCESS	1	2	3	(4)	5
FACILITATE CONFLICT RESOLUTION	1	2	3	(4)	5

Additional Comments:

Excellent participant — knows what
Program was all about. Contributed
as expected of a professional

IV. Performance Rating Scale

Please circle your response:

	Very Unsatisfactory	Unsatisfactory	Neither Satisfactory nor satisfactory	Satisfactory	Very Satisfactory
DOCUMENT PROCESS AT EACH MEETING	1	2	3	(4)	5
* ARRANGE FOR CONSULTANTS/ RESOURCE MATERIAL	1	2	3	(4)	5
ASSIST IN GROUP MAINTENANCE FUNCTIONS	1	2	3	(4)	5
SUPPORT CONSENSUS TESTING	1	2	3	4	(5)
FACILITATE DECISION-MAKING PROCESS	1	2	3	(4)	5
FACILITATE CONFLICT RESOLUTION	1	2	3	(4)	5

Additional Comments:

* RESOURCE CONSULTANTS SHOULD BE A BIT MORE SPECIFIC RELATIVE TO PLAN PARAMETERS & BUDGET LIMITATIONS
IN OTHER WORDS PERHAPS 'MORE REALISTIC'

IV. Performance Rating Scale

Please circle your response:

	Very Unsatisfactory	Unsatisfactory	Neither Satisfactory nor Unsatisfactory	Satisfactory	Very Satisfactory
DOCUMENT PROCESS AT EACH MEETING	1	2	3	4	(5)
ARRANGE FOR CONSULTANTS/ RESOURCE MATERIAL	1	2	3	4	(5)
ASSIST IN GROUP MAINTENANCE FUNCTIONS	1	2	3	4	(5)
SUPPORT CONSENSUS TESTING	1	2	3	4	(5)
FACILITATE DECISION-MAKING PROCESS	1	2	3	4	(5)
FACILITATE CONFLICT RESOLUTION	1	2	3	4	(5)

Additional Comments:

FINE CONTRIBUTION AND A PLEASURE TO WORK WITH

IV. Performance Rating Scale

Please circle your response:

	Very Unsatisfactory	Unsatisfactory	Neither Satisfactory nor Unsatisfactory	Satisfactory	Very Satisfactory
DOCUMENT PROCESS AT EACH MEETING	1	2	3	4	(5)
ARRANGE FOR CONSULTANTS/ RESOURCE MATERIAL	1	2	3	(4)	5
ASSIST IN GROUP MAINTENANCE FUNCTIONS	1	2	3	(4)	5
SUPPORT CONSENSUS TESTING	1	2	3	4	(5)
FACILITATE DECISION-MAKING PROCESS	1	2	3	(4)	5
FACILITATE CONFLICT RESOLUTION	1	2	3	(4)	5

Additional Comments:

Re: Manitoba Adolescent Treatment Centre Project

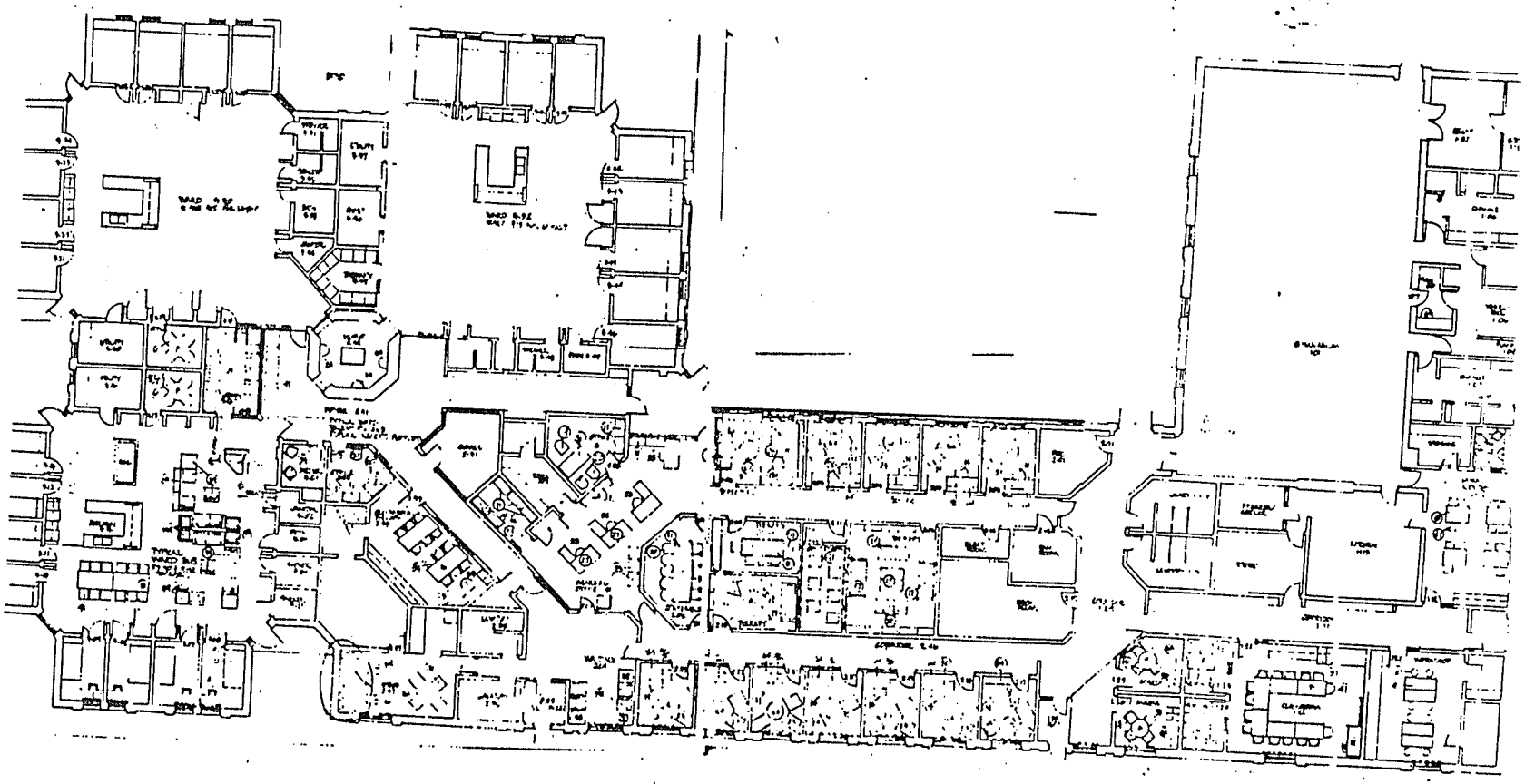
The project development meeting minutes prepared by Jeanne Boyd contained quality information on the various items of discussion by the project planning team. I was very impressed with her involvement pertaining to the furnishing tenders and review process to establish the final cost purchasing contract list.

Project Coordinator MHSC.

Nov. 17/1983

APPENDIX C - ARCHITECTURAL PLAN

ARCHITECTURAL PLAN



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