MULTI-DISCIPLINARY TEAMWORK IN AN ADMISSION UNIT OF A PSYCHIATRIC INSTITUTION

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STELLENBOSCH

Study leader: Prof S Green **March 2000**

DECLARATION

I, the undersigned hereby declare that the work contained in this thesis is my own original work and that I have not previously, in its entirety or in part submitted it at any university for a degree.

Signature

Date

ABSTRACT

This study focusses on Multi-disciplinary Teamwork in a Psychiatric Admission Unit. The admission unit is the first contact unit for any person admitted to a mental institution. This study is important to determine co-ordination and functioning of the team in service delivery.

A descriptive research method was used to conduct this research study. A survey method was chosen as the means of data collection. This method was ideally chosen to reach the targeted population based in the three mental institutions that are far apart from one another. It would be practically difficult to reach the research sample if this method was not utilised.

The participants in this study consisted of social workers, nurses, psychologists, occupational therapists and medical practitioners. All the participants must have worked in the admission units. Students of most disciplines were excluded , except for registrars who are doing specialist training in psychiatry. Most of these registrars have worked in a mental institution before.

It was found in this study that multi-disciplinary teams exist in the admission units. They seem to be well co-ordinated and function efficiently. Certain admission procedures are followed for any incoming person to the unit.

OPSOMMING

Die studie fokus op multi-dissiplinêre spanwerk in 'n toelatingseenheid van 'n psigiatriese inrigting. Die toelatingseenheid is die eerste eenheid waarin enige persoon toegelaat word tot 'n psigiatriese inrigting en daarom is dit die persoon se eerste interaksie met die gesondheidsorg personeel. Die doel van die studie was om 'n teoretiese raamwerk vir die funksionering van 'n multi-dissiplinere span in 'n toelatingseenheid van 'n psigiatriese inrigting te verduidelik en aan te bied.

'n Verkennende beskrywende navorsingsontwerp is in dié studie gebruik. Die opnamemetode is gebruik vir data insameling. Posvraelyste is benut om data intesamel. Die spanlede van drie psigiatriese hospitale in die Wes-Kaap is by die studie betrek.

Die monster van die ondersoek het bestaan uit maatskaplike werkers, verpleegkundiges, sielkundiges, arbeidsterapeute en mediese praktisyns. Al die respondente werk in die toelatingseenheid van die drie psigiatriese hospitale.

Daar is bevind dat multi-dissiplinere spanne in die onderskeie toelatingeenheide bestaan. Die spanne word goed gekoordineer en funksioneer effektief. Bepaalde toelatigingsprosedures word gevolg ten opsigte van enige persoon wat tot die eenheid toegelaat word.

DEDICATION

This thesis is dedicated to my late father, Albert Mthilili Ngqumezi. I know in my heart that you are delighted and wish me well and all the success in my future, both academically and socially. As a young child, you have always inspired and encouraged me to do better in everything I do. You have given me direction and wisdom and the will to succeed. It is for the above reasons that I dedicate this thesis to you with gratification.

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INTRODUCTION

Psychiatric institutions employ different professionals, such as medical officers, psychiatrists, nurses, occupational therapists, psychologist and social workers to provide services to clients who are admitted to the institution for treatment. These professionals usually work together in a team. Each team member has specific roles and tasks to perform in the team. In order to provide a holistic and comprehensive service to clients, the team members are jointly responsible to design the treatment plan for each patient.

The current situation has given rise to questions about :

- the extent to which these different professionals work together as a team?
- The way in which the team is co-ordinated to ensure that high quality services are provided by every member of the team, and
- The kind of admission procedures that are followed in the admission unit of a psychiatric hospital.

The above questions raised a need to investigate how the members of the disciplinary team in an acute admission unit of a psychiatric hospital are operating as a multi-disciplinary team.

1.1 MOTIVATION FOR THE STUDY

The researcher is a member of a team in an acute admission unit in a psychiatric institution. Having worked in an acute admission unit for about three years, the

researcher has first hand experience in working in a multi-disciplinary team within the field of psychiatry.

The researcher registered in 1996 for the MA degree in Medical Social Work at the University of Stellenbosch. The studying of literature in the field of medical social work for the coursework, and the researcher's experience as a social worker in a psychiatric institution has generated an interest in studying and exploring the nature of multi-disciplinary teamwork in a psychiatric institution. The motivation for the study is based on the practical experience of the researcher and the coursework that was done for the MA degree.

Teamwork in the broad sense requires co-operation and collaboration among team members. Team members are compelled to work as interactive parts of a system in an endeavor to solve problems. Brandler (1988) maintains that difficulties in decision making regarding client diagnosis, treatment plans and intervention results from failure of professionals to interact appropriately, to share, to take on leadership roles, to utilize experts, to organize themselves, to risk expressing innovative viewpoints different from current group thought, to challenge and confront and yet work co-operatively. If the above are ignored or not employed by team members, it can impede teamwork and impact on service provision as well. It can also impact on the effectiveness of the services of the team with regard to problem-solving during service rendering.

Communication among team members is experienced by the researcher to be a major obstacle in the functioning of the team. The team, for example, often has difficulty in

deciding on the duration of the stay of the client in the unit. This has an impact on how services are provided by the different team members.

Although the team had procedures in place to ensure effective communication among team members, e.g. a communication book and joint wardrounds, these procedures were not effective enough. The reasons were that the team members were not based in the same ward and that led to lack of immediate access to the communication book for reading and writing messages as required, and also because the compulsory ward-round attendance did not happen.

The result was that interdisciplinary conflict prevailed in the admission unit and this severely hampered service provision. The services became fragmented with the medical personnel focussing more on stabilizing the client for the purpose of discharge, whereas social workers needed more time to assess the clients' situation properly to provide compatible and reflective intervention. The conflict therefore arose when there were differences of opinion among professionals as to when a client should be discharged from the unit.

According to Abramson and Mizrahi (1985) teamwork requires a sacrifice of some degree of autonomy for collaborative problem-solving to take place. In order to sacrifice a degree of autonomy, each professional has to understand the value of each discipline in service delivery. The two authors further maintain that each discipline defines its roles and goals of service differently. They also explain that social work is more concerned with enhancing the quality of life of a person and therefore social workers help clients to use the different social institutions existing in our society to provide for their needs.The medical fraternity usually focuses on curing the illness of the clients. The values of these two professions differ drastically in practice, and if not well understood by each

discipline, it could lead to interprofessional conflict. This situation has the potential to render poor services and to undermine the efforts to bring different professions together in a team working towards the same cause.

Toseland, Palmer- Ganeles & Chapman (1986) have found that more comprehensive treatment programmes can be provided when team members co-operate and share their expertise, knowledge and skills. The diversity of skills from different professionals will benefit the clients. Assessment and planning is done through the utilization of different professionals' knowledge and skills to solve problems. Co-operative teamwork also helps in reducing tension and frustration and to avoid burn out(Toseland, Palmer-Ganeles & Chapman: 1986: 47). This is possible in the well co-ordinated team where all the members are supportive.

The team members in the acute admission unit where the researcher works also workas individuals within a team. This is not a negative strategy if each member is committed to giving feedback during formal wardrounds or cardex rounds. This approach however, can have a damaging effect if there is lack of commitment, co-operation and goodwill among members. Thus the need for the team to be well coordinated by a coordinator or team leader was realized. It is believed that a well coordinated team will have the potential to provide comprehensive and effective services characterized by proper assessment and reflective intervention during the beginning stages of the illness and the admission of a client to a psychiatric institution.

This method of operation of the team would also contribute to reducing the rate of re-admission of patients to the hospital. A literature review reveals conflicting professional

values between professionals in social work and medicine. Roberts (1989)and Abramson & Mizrahi (1985) identified various sources of strain between physicians and social workers; Lister (1980) examined the role expectations of social workers and other health professionals; and Sands (1989) examined the socialization process of social workers joining the team. None of these studies however focussed on multi-disciplinary teamwork in an admission unit of a psychiatric institution or on how multi-disciplinary teamwork can ensure effective service provision in such an institution. The researcher therefore through this study seeks to investigate this situation.

1.2 THE AIM AND OBJECTIVES OF THE STUDY

The aim of the study is to present a theoretical framework explaining the functioning of a multi-disciplinary team in an admission unit of a psychiatric institution.

The objectives of the study are:

1. To describe the roles and functioning of a multi-disciplinary team and the coordination among professionals in an admission unit of a psychiatric institution.
2. To determine the responsibility of the social worker for assessment and designing of intervention plans for the clients in an acute admission unit.
3. To investigate the functioning of a team in an acute admission unit of a psychiatric institution.

1.3 RESEARCH METHODOLOGY

Leedy (1989) defines research methodology as an operational framework within which the facts are placed so that their meaning becomes clear. As an operational framework, it gives the clear intentions of the researcher in conducting the study.

In order to achieve the aim and objectives of the study, an explorative and descriptive study was done. According to Babbie (1989) and Grinnell (1990) an exploratory study is conducted when the researcher is examining a new interest and it is used in studies where little is known about the field of study. As stated earlier, few studies related to the functioning of a multi-disciplinary team in an admission unit of a psychiatric institution have been conducted. Thus the utilization of an exploratory research design in this study was aimed at exploring and gathering information in this area.

1.4 SAMPLING

The study population consisted of the teams in the acute admission units of the three psychiatric hospitals in Cape Town viz Lentegeur, Stikland and Valkenberg hospitals. The target population was the members of the teams in these three hospitals which consisted of medical officers, nurses, social workers, psychologists and occupational therapists. The sample was carefully chosen so as to reflect all the characteristics of the study population and to be representative of the total population (Leedy 1989; Oppenheim 1994).

Purposive and probability sampling was employed to obtain the best representative sample of the total population and to ensure that each respondent had an equal chance for inclusion in the sample (Berg-Cross, 1998:28 ; Reaves, 1992: 95). Sampling was done by using the simple random sampling technique (Reaves, 1992; 97). This technique was used to give each respondent an equal chance of being chosen to participate in the research study. The total sample for the study was seventy-five because twenty-five questionnaires were given to each hospital for distribution. The request was that five questionnaires per discipline in each of the hospitals should be completed.

1.5 SURVEY

A survey is conducted when a set of standard questions are asked of a sample of people. These answers are collected and combined to represent the opinions of the entire population (Reaves, 1995: 105). Data for this study was collected by means of a survey.

It was decided that a postal survey would be the most suitable method for reaching the three psychiatric institutions in Cape Town, as they are some distance from each other. The advantages of a postal survey are:

- low cost or savings on data collection
- greater geographic coverage because distance and accessibility pose no problems
- no interviewer bias
- assurance of anonymity
- time saving and low cost of data processing (Grinell, 1990 ; Oppenheim, 1992 & Scheter, Stoker, Dixon, Herbst & Geldenhuys, 1989).

However, the above authors also mentioned some disadvantages of a postal survey. The following disadvantages are noted:

- the high potential for low response
- the limitation of a survey to literate respondents
- the lack of control over the respondents' environment and the manner in which questions are answered
- the possibility that items can be left unanswered
- the lack of an opportunity to correct misunderstandings, to probe or to offer explanations.

In order to counteract some of the disadvantages the researcher attached a covering letter explaining the following:

- the value of the research study for the respondents
- assurance of anonymity of the respondents
- availability of more time to complete the questionnaire
- an incentive, in the form of receiving a copy of the results was offered (Oppenheim, 1992: 104).

The researcher also asked that the questionnaires be sent to the heads of the social work departments at Stikland and Valkenburg Hospitals. At Lentegeur Hospital, questionnaires were left with the sisters in charge in different admission units. These efforts were made to get permission to conduct the survey, and to increase the response rate.

1.6 QUESTIONNAIRE DESIGN

The dendrogram and mind-mapping techniques were used for the construction of the questionnaire. These techniques were used as a basis for formulating various questions for the questionnaire.

Quantitative and qualitative research methods were utilized in the execution of the research (Grinnell,1990). The researcher used a combination of closed and open-ended questions. The closed questions are easy to answer, less economical and less time consuming, whereas the open-ended questions encourage the respondents to formulate and express their responses freely (Schnetler et al, 1989: 47-49). The researcher also made use of a scaling method, to obtain information on sensitive issues and to measure abstract concepts or attitudes. The Likert scale was specifically used to give the respondents a choice of responses from given categories (Schnetler et al, 1989:66-67).

Attention was paid to the layout, formatting and sequencing of the questionnaire to ensure that the questionnaire design does not negatively impact on the response rate and the manner in which questions are answered. The length of the questionnaire was another factor to consider and control carefully in order to attract respondents and increase the response rate (Oppenheim, 1992: 102).

1.7 TESTING OF QUESTIONNAIRE

Oppenheim (1992: 47) states that questionnaires need time for construction, revision and refinement to use them as a data collection tool. A pilot study was done to improve the questionnaires and to ensure they yield the desired information. An informal testing was done through consulting an expert in questionnaire formulation and design to further refine the questionnaire.

Formal testing was done through sending questionnaires to a potential sample for the study. Twenty questionnaires were mailed of which twelve were returned. These respondents were not included in the sample. The respondents who participated in the

pilot study complained about the length of the questionnaire and clarity of some questions. The pilot study or formal testing assisted in dealing with these problems. However, it could be that the respondents were expecting a short questionnaire compared to the six page questionnaire they received. Adjustments were made to the questionnaire based on the comments of the participants of the pilot study.

The pilot study was used to revise and refine the questionnaire where possible because it is usually the only form of communication and interaction between the researcher and the respondents when a postal survey is done.

1.8 SURVEY ADMINISTRATION

Seventy five questionnaires were mailed to the respondents identified as the sample for the study in December 1998 and they were requested to return them not later than the last week of January 1999. The researcher realized that the possibility of staff members going on vacation leave is high during the months of December & January. The return date was extended by a month to the last week of February 1999. It was important for the researcher to change the time frame to increase the response rate. As a result, fifty-one questionnaires were returned.

Special care was taken to ensure that the rules for probability sampling were followed. The questionnaires at Valkenberg and Stikland Hospitals were personally taken to the heads of the social work departments for distribution at the relevant acute admission units. At Stikland and Lentegeur hospitals, a personal visit was paid to different teams explaining the purpose of the study and questionnaire, and at the same time requesting the co-operation of the respondents to complete the questionnaires.

Owing to time constraints and work-related duties, the researcher could not do the same at Valkenberg hospital. The purpose of the study and the questionnaire were explained to the head of the social work department to enable her to answer any questions posed by the respondents.

The researcher maintained constant personal and telephonic contact with the heads of social work departments of the three hospitals to encourage the completion and return of

the questionnaires to the researcher. The returned questionnaires were numbered, dated and processed because the number of questionnaires received at a specific period had to be noted and the information was entered in the excel program. The researcher received 51 questionnaires from respondents achieving a response rate of 68% from the total of 75 questionnaires mailed to the respondents.

1.8 RESPONSE RATE

An extra effort was put into the administration of the survey to obtain an acceptable response rate. Special care was taken to ensure the delivery of the questionnaires to the respondents.
This was done by:-

- Writing a letter to relevant hospital managers requesting permission to conduct the research study.
- Compiling a covering letter to indicate the purpose and value of the study for the respondents.
- Making personal and telephonic contact with heads of social work departments and the sisters in charge of the admission units to promote the execution of the survey.

The personal and telephonic contacts aided in promoting the response rate. This was done because authors like O'Sullivan and Rassel (1989:178) assert that willingness to participate does not guarantee that completed questionnaires will be returned to the researcher. This phenomenon was significantly reduced in the study through the maintained contact of the researcher with the three institutions.

For various reasons, some questionnaires were not returned to the researcher. Upon enquiry, three questionnaires were returned too late for inclusion in the study. One incomplete questionnaire was returned to the researcher, eight questionnaires were left uncompleted in the unit, nine were not returned to the heads of departments, and in three cases it was impossible to locate the staff who had questionnaires in their possession. The sample size was 75, and a total of 51 questionnaires were returned to the researcher. This meant that 68% of questionnaires were returned to the researcher. According to Babbie

1990:182) a response rate of 50% is generally considered adequate for the analysis and reporting of data. A response rate of 68% is considered very good for the study.

1.10 REPRESENTATIVENESS

The representativeness of the survey is reflected by the number of responses per institution as reflected in table 1.1

Table 1.1 Response rate per institution

INSTITUTION	SAMPLE	f	%
1. Lentegeur	25	18	72%
2. Stikland	25	13	52%
3. Valkenberg	25	20	80%
TOTAL	75	51	68%

The response rate indicates that the most questionnaires were received from Valkenberg hospital (80%), followed by Lentegeur hospital (72%). The lowest number of questionnaires were received from Stikland hospital (52%). A total of 68% of questionnaires were returned. This constitutes a significantly high percentage of return of the mailed questionnaires.

The number of the respondents of the various disciplines who were involved in the survey is presented in table 1.2.

Table 1.2 Representation of disciplines

OCCUPATION/DISCIPLINE	f	%
1. Medical Officer	13	25,5%
2. Occupational Therapists.	7	13,7%
3. Nurses	17	33,3%
4. Clinical Psychologists	3	5,9%
5. Social workers	11	21,6%
TOTAL	51	100%

The results show that the most questionnaires17 (33%) were returned by the nurses. This was followed by the medical officers who returned 13(25.5%) and social workers who returned 11(21.6%) of the questionnaires. The occupational therapists and clinical psychologists returned 7 (13.7%) and 3(5.9%) respectively.

1.11 STATISTICAL DATA ANALYSIS

Descriptive statistics are numbers that describe and are only concerned with the sample (Anastos & MacDonald, 1994:431). These statistics therefore are the means of summarizing, condensing and simplifying the information provided by a set of numbers.

The raw data obtained from the questionnaires was entered into an Excel Workbook and organized into spreadsheets. This raw data was entered into an Excel Program directly from the questionnaires. This procedure however did not harm the data analysis in any way.

1.12 PRESENTATION

The next chapter focuses on teamwork in a psychiatric admission unit. The concepts of a team and teamwork are discussed for clarity and better understanding of the two concepts. Different perceptions of teamwork are also discussed.

It was imperative for this chapter to discuss the different approaches to teamwork viz. multi-disciplinary, inter-disciplinary and trans-disciplinary teamwork. These approaches could give a framework from which to understand teamwork. Some guidelines to teamwork are presented for clarity and understanding.

In chapter three, information on patient admission, assessment and intervention is presented. It gives a detailed classification of patients that can be admitted to a psychiatric institution according to the Mental Health Act No. 18 of 1973. Different methods of assessment are presented in this chapter. It gives a clear indication of the target for assessment and intervention. Theoretical approaches or frameworks to be utilized during both assessment and intervention are also presented.

Chapter 4 focuses on the use of a multi-disciplinary team approach in a psychiatric admission unit. In this chapter, the results of the survey that was conducted for this research is presented. In the last chapter, conclusions and recommendations are offered.

CHAPTER TWO

TEAMWORK IN A PSYCHIATRIC ADMISSION UNIT

2.1 INTRODUCTION

Teamwork is essential in any institution where professionals intend to improve their performance and where they strive to render an effective service to their clients. There is a growing realization among the different professionals in institutions that the complexity of human problems that they have to address require teamwork. Teams are also increasingly being used because institutions have a growing need to achieve complex goals swiftly and efficiently and even with fewer resources.

The joint service rendering by persons from different professional backgrounds has advantages and disadvantages. The main advantage is that the different skills and expertise of different members together in an endeavour to solve problems more effectively. A more holistic and comprehensive service can also be provided to the client system when professionals work together in a team. One of the main disadvantages of teamwork is that the different backgrounds of professionals may result in conflict, role blurring and lack of co-operation and commitment among team members.

After a description of teamwork and the dimensions of teamwork, this chapter will focus on approaches to teamwork will be explained. This will be followed by the presentation of guidelines for teamwork, and the description of team functioning.

2.2 DESCRIPTION OF TEAMWORK

Teamwork is a widely used concept referring to different people working together for the same purpose. The concept of teamwork is also used both when referring to a task

committee or a group. In this study, team is used to refer to different professionals working together as a team in an admission unit in a psychiatric hospital/ institution. The multi-disciplinary team normally consists of the social worker, medical officer/psychiatrist, professional nurse, occupational therapist, and psychologist.

Ovretveit (1993) defines a multi-disciplinary team as a small group of people, usually from different professions who relate to each other to contribute to the common goal of meeting the health and social needs of the client/ client system. This definition correlates with definitions provided by authors like Garner (1994) and Pappas (1994). The definitions refer to all professionals from both medical and social sciences. According to these definitions there is an element of partnership and dependency among team members from different disciplines with the aim of providing effective and comprehensive service to the client system or service consumers. The interaction and interdependency on each other need to be nurtured to avoid unnecessary conflict and lack of co-operation among team members.

Garner (1994) is of the opinion that teams differ according to the extent of independence that team members possess. For example, in multi-disciplinary teams, each discipline remains autonomous and makes decisions independently whilst in inter-disciplinary teams the focus is on the team decision making process to establish a plan for the person served (Garner, 1994: 27).

2.3 DIMENSIONS OF TEAMWORK

The realization of the importance of working together gave rise to the notion of teamwork and the restructuring of the approach of professionals to their work. Rees (1991) maintains that teamwork has two inseparable dimensions viz. task and social dimensions that have an influence on team members' approach to their work.

2.3.1 Task dimension

The task dimension of teamwork refers to the work that the team members have to perform, and to the fact that each team member is charged with tasks to carry out and to perform to their best potential. It also refers to the team member who has to perform a certain duty in accordance with the knowledge and expertise that the member possesses to enable him/ her to perform the duty in an excellent and effective manner. Scholtes et al (1998) is of the opinion that the team needs to define the importance of the team's tasks in the larger context of the institution. This will make the team's work purposeful and meaningful to every team member. The task dimension forces the team members to perform their duties well because the entire team puts its trust in each team member. There is usually a great expectation from the team of each member to perform very well and not to disappoint the team at large. This gives rise to the question of team members' accountability to the team. This is an ethical and a controversial issue with which the team members have to deal. Each professional is required by his/her discipline to perform well to maintain the standards of the profession. Though in a team situation, this can be complicated because of different styles of socialization of the various team members during their professional training (Rees, 1991; Scholtes et al, 1998).

Conflict in a team situation can arise and lead to lack of co-operation and disintegration of unity (Garner, 1994 ; Pappas, 1994). It must however, be realized that the development of any one member of a team can either be enhanced or inhibited by the interaction with those with whom he/she engages even in a conflict situation. This learning process can also extend the repertoire of skills and knowledge of the team members (Ovretveit, 1993).

2.3.2 Social dimension

The social dimension of teamwork refers to how team members feel towards one another and their membership to the team (Rees, 1991: 42). Choosing team members is vital in situations where the team is striving for effectiveness in service delivery and striving to achieve a high level of productivity. However, in psychiatric institutions the respective

departments usually allocate a member to the team, rather than the member being chosen by the team. Choosing of team members is therefore of little importance in psychiatric institutions, but how team members adapt in a team situation is very important.

The reliance of professionals on the team and teamwork is due to the perceptions that teams can be: -

- more responsive to the needs of the client system
- provide comprehensive services
- realize the complexity of the socio-medical problems (Garner,1994; Ovretveit, 1993).

Wellins, Byham & Wilson (1991) believe that employee empowerment and the energy that accompanies the feeling of ownership are necessary prerequisites for continuous improvement of team functioning. This is particularly vital also for the team functioning in health and social sciences environments. Ownership, in many instances, brings about loyalty and commitment for the provision of effective service. However, in order for this to happen, ownership requires sharing of information and knowledge as an incentive for maintaining a high morale and a sense of belonging to a team. Garner (1994) is of the opinion that teamwork means a collective working relationship in which daily communication ensures consistency and that major decisions are made through consensus and that a sense of equal partnership prevails in the team.

2.4 APPROACHES TO TEAMWORK

Teamwork is vital in providing a quick and comprehensive service to the client system. It also co-ordinates different professionals' efforts to help the clients. Different teams use different approaches in their functioning viz. multi-disciplinary, inter-disciplinary and trans-disciplinary approaches (Garner, 1994; Orelove, 1994; Pappas, 1994). The different approaches adopted by teams determine how a particular team works, how decisions are made and what kinds of communication patterns are used and what the autonomy of each discipline in the team would be (Mears & Voehl, 1994).

2.4.1 Multi-disciplinary teamwork

The multi-disciplinary teamwork approach seems to be the most commonly used approach in general, surgical and some health and psychiatric institutions. This model is based on the inclusion of professionals from multiple disciplines who share a common task or work together with the same individual or client. Garner (1994) explains that this model was originally developed from the medical model whereby a physician received information from different disciplines that served the same client in order to determine the treatment plan.

This approach advocates for each discipline to remain autonomous and to make independent decisions about how best to serve the client. Thus each discipline is given the freedom to assess and plan independently and then share vital information with other team members (Garner, 1994; Ovreitveit, 1993).

According to various authors (Garner, 1994; Mears & Voehl, 1994; Toseland,Palmer-Ganeles & Chapman, 1986) there are key elements in the functioning of multi-disciplinary teamwork that have an impact on the effective operation of the team. In this regard Garner (1994) explains that team membership vary according to how actively involved the team members are in the specific case. He also states that team members are usually sensitive to change in team membership because it can have an influence on the team members' experience of partnership, togetherness and bonding in the team. This can consequently have an impact on the members' sense of identity as a team, and their belonging to and working together in a team.

Garner (1994) also states that the primary loyalty of team members is usually to their disciplines or departments and not to the team. This often creates problems for members to be accountable to the team and for the team to function effectively. Divided loyalties can bring about tension and destructive competition among team members that are not to the benefit of the team and the client system.

Another key element that can influence the team functioning is the distance between team members. The opportunities for formal and frequent communication is cut down when team members do not share the same general space (Garner , 1994; Rees, 1991). Pappas (1994) is of the opinion that multi-disciplinary teamwork becomes more viable as individual professionals gain competence and confidence in their discipline. This may presuppose that the team members working together, need to have had experience and exposure to working with colleagues of their own discipline before joining a multi-disciplinary team. An increased understanding and appreciation of each discipline's contribution lead the way to more open and co-operative working relationships (Garner,1994; Pappas, 1994).

Garner (1994) also maintains that when relative independence prevails, communication and sharing of information is valued, but that the team seldom makes decisions that all team members are expected to follow. In such teams, each discipline maintains and retains its autonomy. Garner (1994) therefore suggests that decisions that bind each team member are vital for effective team functioning. These decisions need to be taken by the whole team and should satisfy every member in order for them to be implemented with success.

Decision-making in case management requires that each discipline should depend on other members for information in order to perform their duties properly (Garner, 1994). This requires active involvement by all the other members of the team in the management of the case. Each team member has a shared responsibility in case management. By so doing, each member is able to make recommendations to the team for a final decision about how to manage the case (Pappas, 1994; Rees, 1991).

2.4.2 Inter-disciplinary teamwork

An alternative to a multi-disciplinary approach is the inter-disciplinary team management of clients. Pappas (1994) defines inter-disciplinary teamwork as a process by which team members from a variety of disciplines focus on a problem in an integrated, cohesive and comprehensive fashion. It can be said from this definition that there is continuous and

consistent communication and sharing among team members with the view of providing effective service to clients through rational planning done by the whole team. This suggests that the team work as a close entity or net. The individual roles and behaviours are directed or focussed on meeting the identified needs of the client system. Then the work becomes purposeful and goal directed. As the team does assessment and planning, it increases involvement and commitment to problem- solving.

Garner (1994) explains that inter-disciplinary teams usually accept the fact that the knowledge, skills, roles and responsibilities of its team members often overlap which require routine discussions and clarifications. These joint discussions will prevent role blurring and will pave the way for the effective use of professional resources available to the team. The supportive environment which is created by this kind of operation allows for individual members to make contributions and to express concerns. It also allows time for feedback, leading to improved team performance. In this model, teamwork and team member's contributions are highly valued and this is precipitated by the team decision-making in assessment, planning and implementation (Garner, 1994; Pappas, 1994).

2.4.3 Trans-disciplinary teamwork

The trans-disciplinary approach is a relatively new teamwork concept. Orelove (1994) defines trans-disciplinary teamwork as related to the transfer of information, knowledge and skills across disciplinary boundaries. This can be a tricky process especially if a team member lacks confidence and experience in his/her field or discipline. Pappas (1994) views trans-disciplinary interaction as occurring when one team member agrees to take on responsibility for implementing a positive programme. Role release becomes the keystone to this approach. Releasing one's role is not seen as relinquishing accountability, but rather as a transition to learning from other disciplines.

This kind of transition may be stressful to some members, and this requires collaboration and team cohesiveness to enhance the learning process. In this model, the team member as a learner is viewed holistically and thus the learner's educational programme is more cohesive, unified and thus beneficial to the learner's specific needs. The programmes are

therefore structured to meet the unique needs of the learner (Orelove, 1994; Pappas, 1994).

In terms of application, the assessment of the client needs is done collaboratively. Collaborative planning, summarization and implementation of assessment by the team, via comprehensive report, is the keystone of this model (Pappas, 1994). Collaborative programme planning and service delivery therefore forms the major focus of this approach (Orelove, 1994).

2.5 GUIDELINES FOR TEAMWORK

In order to understand how teams operate, knowledge about principles that guide the facilitation of teamwork is needed. Knowledge about principles is fundamental for team members to resolve conflicts that may arise, and to develop an understanding of individual team members' behaviour within the team. Well known authors (Mears and Voehl 1994; Cormier and Cormier, 1991; Fine and Glasser, 1996) identified the following guidelines for teamwork:-

2.5.1 Listening and clarification

Attentive listening and clarification are principles that are fundamental to any working relationship. Various authors (Mears & Voehl, 1994; Cormier & Cormier, 1991) maintain that all team members should pay attention and be responsive to the direction taken by the person/ team member talking. It is therefore imperative to listen attentively and to clarify issues in order to respond appropriately. This will avoid two persons going into two different directions, or any ambiguous statement going unclarified. Poor attention and listening may lead to loss of vital information necessary to problem-solving (Cormier & Cormier, 1991; Fine & Glasser, 1996).

2.5.2 Supporting

The principle of supporting involves encouraging team members in creating a conducive and comfortable environment for constructive criticism and support in strenuous moments

(Cormier & Cormier, 1991; Fine & Glasser, 1996). This can be fostered by a belief that team members are valuable and can contribute positively to team growth and maturity. This requires the team members to undo their negative stereotypes and work on their positive sides and open- mindedness (Mears & Voehl. 1994).

2.5.3 Differing and confronting

Differing and confronting are principles that are difficult to implement, as they tend to trigger defensiveness and negativism among people working together (Fine & Glasser, 1996; Mears & Voehl, 1994). When and how to confront are of particular importance when working in a team (Maddux, 1994; Mears & Voehl, 1994). These can be linked to assertiveness whereby one states his/her opinion without becoming aggressive and/or threatening any individual. It is good to differ so as to generate more ideas and alternatives before any decision is taken (Hepworth & Larsen, 1993; Pappas, 1994).

2.5.4 Quality

Quality assurance of service delivery is another principle to use in teamwork (Mears & Voehl, 1994; Pappas, 1994). Striving for excellence is essential in boosting the morale of each team member. Success will motivate and create a sense of commitment and willingness to achieve better results. It will also make members feel more equipped and empowered to engage in rendering a better quality service and challenging activities. To strive for excellence also serves to help members to gain inner or personal control over their actions and to become engaged in developing competence, confidence and trust in themselves and other team members (Mears & Voehl, 1994).

2.5.5 Feedback

Regular feedback is also an essential principle for effective teamwork (Cormier & Cormier, 1991; Fine & Glasser, 1996). Team effectiveness and efficiency may often be disguised by its success. It is therefore important for the team to assess and evaluate their

performance and actions and to consider other techniques and strategies in problem-solving which might be more relevant. Constant observation of each other's roles and feedback about these may also lead to improved performance of the team members (Pappas,1994).

From the above discussion, it can be seen that it is imperative that the team be knowledgeable about the principles discussed and that they should be able to utilize them in team functioning.

2.6 TEAM FUNTIONING

The manner in which a team is functioning determines the nature of the relationship among the team members. Elements such as the team composition, leadership, co-ordination, facilitation and team building are essential in the functioning of any team(Garner, 1994; Mears & Voehl, 1994).

2.6.1 Team composition

The team composition is vital for the team to be effective in its job performance. The composition of the team determines the expertise and competency of the team (Garner, 1994; Mears & Voehl, 1994). The composition of a team normally found in the acute admission units of the psychiatric hospitals includes a psychiatrist, social worker, professional nurse, psychologist and an occupational therapist. The role descriptions of these health professionals as team members will be discussed.

3.6.1.1 Psychiatrist

The psychiatrist is a very important member of the team in a psychiatric institution. Phares (1992) explains that the psychiatrist steps out of a tradition where they are required to develop a psychoanalytic system of thought where they had little or nothing to do with medicine. Because of the medical background of the psychiatrist, they may prescribe

medication, treat physical ailments and perform physical examinations of patients. It could be argued that this kind of performance is re-medicalization of psychiatry. The role of the psychiatrist is the provision of effective management strategies for the treatment of patients. He/she assists the team in making major decisions about the management of the treatment of patients in the admission unit. He/she is also responsible for direct patient assessment during ward-rounds (Halleck, 1991; Mittler, 1990). The psychiatrist plays a major role in the education of the registrars in psychiatric training as well as in the education of the team members as regards psychiatry in general.

2.6.1.2 Social worker

Another member of the multi-disciplinary team in a psychiatric institution is the social worker. Phares (1992) is of the opinion that psychiatric social workers conduct psychotherapy on an individual or group basis and contribute to the diagnostic process. In the past, social workers used to deal only with social forces and the external circumstances that were contributing to client's difficulties. Currently, they take case histories, interview employers and families, make arrangements for vocational placements and counsel parents of the patients (Cormier & Hackney,1987; Germain, 1984). Despite the psychosocial information relevant for the diagnosis, social assessment is done to get to the core of the problem (Hepworth & Larsen, 1993; Mattaini, 1997). This is done with the help of the family and other important role players. In the case where the patient is unable to make rational decisions, the family is vital in making a contribution to the planning of intervention plans for the patient. The social worker has the responsibility of keeping constant contact with the family (Berg-Cross, 1998; Combrinck-Graham, 1989). The social worker is also responsible for providing counseling to both the patient and the family. The social worker also identifies the community resources relevant to the management of continued services for the patient on discharge from the hospital (Germain, 1984; Germain & Gitterman, 1996).

2.6.1.3 Professional nurse

The professional nurse also plays an important role in the health care team in a psychiatric institution. The nurse assesses the overall health and safety of the patient whilst in the admission unit. The nurses also provide the nursing care of the patient which includes the administering of the patient's medication as prescribed by the medical doctor. They are also responsible for writing daily reports on the progress of patients in the unit, and this is done through regular observation and assessment of the mental status of the patients (Toseland et al, 1986).

2.6.1.4 Occupational therapist

Another important member of the team in the psychiatric institution is the occupational therapist. The occupational therapist assess the intellectual, cognitive and physical abilities focussing on the motor skills and possible delays in the development of the patient that could have an impact on the intellectual and physical functioning of the patient (Matthiowetz, 1992). The occupational therapist engage the patient in orientation and training, the improvement of social skills and in reminiscent groups which test the patients' level of functioning and the interpersonal skills the patient possesses.

2.6.1.5 Psychologist

The psychologist is an important member of the team. The psychologist normally provide a psychological perspective to the problem that the patient present with (Phares,1992). They also perform psychological test to the client which further helps understand the problem more deeply, and mainly from the intellectual functioning of the patient.

2.7 Leadership

In many organizations and in structures in society, there is consensus that leaders are needed to lead the teams. The team leader normally co-ordinates the activities of all the team members, and assists them in accomplishing the responsibilities of the team (Wellins, Byham & Wilson, 1991:38). The leadership style and orientation of the team

leader determines how well the team leader executes his/her duties. Brody (1993) identifies two leadership orientations, viz. directive and participative leadership orientations.

2.7.1 Directive leadership orientation

The directive leadership orientation places responsibility on the team leader for making major decisions (Brody, 1993). The team leader acts as a taskmaster to get things done. This might limit contributions from other team members for alternative solutions to the problem at hand. It also places the team leader above everyone in the team. This type of situation may lead to tension and disagreements among the team members resulting in lack of co-operation among team members.

2.7.2 Participative leadership orientation

According to the participative leadership orientation the team leader presents ideas and invites feedback from team members, but retain final decision making authority. The active involvement of the team members is encouraged in the decision making process (Brody, 1993). It must however be realized that whatever leadership orientation is used, the nature of leadership depends on the breadth of knowledge, expertise and experience of the team leader.

This poses the question of who is most suitable to lead the team, and what qualities and skills such a team leader should possess. Brody (1993) believes that the leader should be a person who is an innovator, has a long-range perspective, challenges the status quo and does the right thing. This requires a task centered individual, who will use the power of knowledge in achieving the desired goals. One of the qualities of a good leader is that of being assertive, flexible but firm in his/her approach. According to Brody (1993), the team leader should possess the following skills:-

2.7.2.1 Facilitation

The team leader should be skillful in facilitating the effective operation of the team. Spinks and Clement (1993) view facilitators as enablers or encouragers of learning, who seek to achieve this by focussing on the experiences and activities of the learner. This viewpoint implies that work is focussed on developing team members, and the learning process is unique and grounded on the needs and experiences of the individual team members. Kinlaw (1993) identified four core competencies in team managed facilitation viz. using the facilitation model, keeping the team conscious, modelling quality communication, and listening to understand.

- **Using the facilitation model** incorporates setting goals for the team so that facilitation is directed towards a set of intermediate and final goals, and to guide intervention (Kinlaw, 1993:103). Setting goals could mean that facilitation is outcomes based, and activities are geared towards accomplishing tasks. This requires innovation and the use of resources to achieve the set goals. The success of the team is likely to boost the morale and confidence of members thereby increasing or enhancing performance. Spinks and Clement (1993) emphasize the need to plan and implement activities that are directed at the achievement of desired outcomes. This implies that activities are directed towards specific goals. Concrete and clear communication amongst team members about the attainment of the desired goals should be maintained at all times.

- Another core competency is **keeping the team conscious** of their actions (Kinlaw, 1993: 106). It is imperative for the team members to be conscious of what they are doing at all times in order to be productive. Constant feedback to the leader, and from and to team members is vital as a motivating factor for the team members. Vague communication and misunderstandings can prove daunting, and can result in unproductivity. Team-centered, factual and accurate communication limits the scope of unconsciousness and confusion that may prevail in the team.

- **Modelling quality communication** that is not vague is vital for the team's success and provision of quality service (Kinlaw, 1993: 107). Quality communication is centred around what the team needs to achieve. Communication should lay a foundation for the free flow of information relevant to the needs of the team. This will encourage participation and the expression of ideas amongst team members without any prejudices from other team members. However, the team should guard against destructive criticism from each other as that could severely affect the functioning of the team. Ambiguous statements or messages could harm the team and hamper the development and productivity of the team.

- **Listening to understand** requires the leader to use techniques like summarization and reflection and the acknowledgement of ideas of other team members (Kinlaw, 1993:108). This requires congruent communication that realistically reflects the emotions of the team members. The skill to listen also develops one's ability to challenge positively and think more broadly and rationally.

A team leader who possesses the above competencies should be able to ensure the active participation of the team members.

2.7.2.2 Team building

As mentioned earlier, the team leader is responsible for promoting team building (Brody, 1993). Team building is imperative to facilitate the working of the team. Mears and Voehl (1994) distinguished between groups and teams. They describe a group as a collection of individuals who are in an interdependent relationship with each other, whilst the team encourages its members to share in the ownership of the team's functioning and direction. These descriptions show that there is consensus, shared leadership and responsibility in teams which is usually lacking in groups. The latter seems to have more loose associations and limited authority in group functioning and direction.

2.7.2.3 Decision making

In order to maintain consensus in a team, the team leader should guide the members to make realistic decisions (Brody, 1993). How decisions are made in a team reveals a great deal about a particular team (e.g. level of cohesion, developmental stage of the team). However, decisions (bad or good) have to be taken by the team to ensure continuity in the functioning of the team. Maddux (1994) maintains that the team should build an atmosphere conducive to open communication, co-operation and trust. In order to achieve this kind of atmosphere, conflict needs to be resolved positively by the team. Collaboration among team members will reinforce mutual support and commitment to achieve desired goals. Kelly (1994) further maintains that members who participate in the decision-making process are more likely to implement the decisions taken.

The question arises as to why it is necessary for decisions to be made on a team basis. Kelly (1994) states that decisions made on a team basis produce solutions that are of greater impact. This suggests that individual team members will give their own opinions and ideas and that the team is giving them a wider scope from which to choose the most suitable solution. Crow & Allan (1994) are of the opinion that different solutions posed by team members lay the foundation for the proper analysis of the most suitable solutions. During the analysis phase, it is important that members maintain an objective viewpoint with respect to the solution under discussion or analysis. Engagement in the decision-making process allows members space to obtain the maximum amount of data and diverse opinions from team members that enable them to solve problems.

2.7.2.4 Conflict resolution

The team leader needs to be skillful in conflict resolution (Brody, 1993). It is necessary for any team to resolve conflict that may hamper or hinder progress in the team. Rutledge (1994) describes conflict as the active striving for one's own preferred outcome which, if attained, precludes attainment by others of their own preferred outcome, thereby producing hostility. This suggests self-centeredness and selfishness that exist among team

members. This is destructive to teamwork, and may lead to inactive and passive team members.

It is important for any team member to identify the sources of conflict before they can be dealt with. This will ensure that the real conflict is resolved and it will minimize the chances of falling into the trap of dealing with the symptoms rather than the real problem. Effectively managed conflict will stimulate and motivate team members, and may result in their displaying initiative and innovation. This will also increase the team's ability to achieve its goals (Brody, 1993).

2.8 SUMMARY

Teamwork is of vital importance if managed well. It promotes comprehensive services being provided to the client system. It gives an opportunity for the comprehensive use of the vast and well developed knowledge and expertise of different health professionals for the benefit of the client system. Different approaches to teamwork can be adopted by teams in an endevour to minimize conflicting situations that may hamper the progress of the team. In each approach, it is vital for team norms to be clearly specified in order to avoid confusion and role blurring. It is important for different professionals that constitute the team to understand that their roles may overlap, and that this may need to be dealt with positively by the team.

Team principles, such as listening, supporting, and feedback are vital in maintaining cohesion and developing confidence among team members. This tends to promote personal and professional growth. However, this can only be achieved in a supportive environment in order to encourage learning and exposure to new experiences.

The way a team functions determines the productivity of that particular team. Leadership of a team plays an imperative role in team building and the successful functioning of the team. Team leadership may be permanent or rotated depending on the developmental stage of the team and the confidence that team members have developed. It is important for the team members to share ownership of the team in order to ensure participation and commitment to operating successfully as a team.

CHAPTER 3

PATIENT ADMISSION, ASSESSMENT AND PLANNING INTERVENTION

3.1 INTRODUCTION

Patient admission and assessment and the implementation of intervention are the main tasks of the health team in an admission unit in a psychiatric institution. The admitted patients depend on a multi-disciplinary team, comprising of a social worker, doctor, nurse, psychologist and occupational therapist for effective intervention. The tasks that the social worker have to perform regarding assessment and planning is relevant for the purpose of this study. As a team member, the social worker has to share the outcomes of the assessment and planning done jointly with the client, with the team members. This will contribute to the holistic assessment and planning that will be done by the team.

The admission of patients to a mental institution is guided by law legislated in the Mental Health Act no. 18 of 1973. The Act provides guidelines for patient admission to a mental institution under different sub-sections.

The chapter focuses on the criteria used by the team for admitting a person to a psychiatric institution. Classification of the patients is discussed to illustrate how the patients are classified when admitted to a psychiatric institution. The classification of patients is according to the Mental Health Act, No. 18 of 1973. The chapter also discusses assessment done by the social worker as a team member in the admission unit of a psychiatric institution. It spells out the different theoretical approaches that could be utilized by social work practitioners in making their assessments of the situation of their clients. Lastly, it focuses on the intervention of the social worker with the patients. The different targets for intervention are discussed.

3.2 ADMISSION OF CLIENTS TO A PSYCHIATRIC INSTITUTION

A patient is usually admitted to a psychiatric institution in terms of the Mental Health Act No. 18, 1973. The subjection of a person for psychiatric treatment creates distress, pain and strain for both the person involved and the family. The observation of the person's behaviour and experience, mainly by members of the family, often serves as a basis to define and clarify psychiatric disorders (Halleck, 1991:2). In many instances, the subjectively judged person does not perceive his/her behaviour as aberrate, devious and inappropriate. This is compounded by the linkage of "abnormal" behaviour to functional impairment. The whole scenario precipitates conflicting tendencies between the concerned person and the family. Authors like Miller and Rose (1986), and Isaac and Armat (1990) wrote extensively about the violation and ignorance of the rights of the citizens in psychiatry, and the abandonment of the mentally ill by law and psychiatry respectively. They question the moral values and grounds for a person's subjection for psychiatric intervention which are seemingly entrenched in the laws of civil society.
The law, through the legislated Act, intervenes by setting guidelines for admission to a mental institution. In South Africa, the Mental Health Act no. 18, 1973 defines **circumstances** under which a mentally ill person comes into contact with psychiatric services.

Section 1 of the Mental Health Act (1973) defines a patient as a person mentally ill to such a degree that it is necessary that he/she be detained, supervised and controlled and treated, and includes a person who is suspected or alleged to be mentally ill. The use of concepts or words like control, detain, supervise, suspect and allege has a negative connotation as it takes away the peoples' freedom to exercise their rights as citizens. It also takes away a person's dignity and damages a person's self-confidence and self-image. The subjection of a person to unwanted psychiatric services is in direct contrast to the enforcement of democratic practices for all citizens. The different sections of the Act stipulate the circumstances under which a person can be admitted to a mental institution. Various critiques are posed with regard to the circumstances leading to an admission, and the mandate given to a person who commits another person to psychiatric intervention. It

is in the subjection context based on lay and professional observation and expertise, that fundamental human rights are abused.

Miller and Rose (1986) are of the opinion that psychiatry and law also contribute to the creation of a group of intellectually disabled individuals who are dependant on professional expertise, and who are unable to function in the world outside mental institutions. The latter is however, changing with the launch of the de-institutionalization of the mentally ill and handicapped person (Associated Psychiatric Hospital document on Psychosocial Rehabilitation, 1998). Presently, there is a visible shift in the mindset from institutionalization to de- institutionalization and community-oriented services in South Africa.

The lack of community-based resources to deal with the needs of mentally ill persons is however, still a problem that needs to be addressed. Families and communities are often caught unprepared to deal with the therapeutic needs of the mentally ill person. Berg-Cross (1988) however, maintains that a family needs to provide its members with an emotional buffer against a very complex and demanding world. Longress (1990) explains that communities as social systems also have a responsibility to provide care for its members. The above views emphasize the significant roles that families and communities should play in developing emotional bonding, and creating a sense of belonging for its members. The performance of these roles is very difficult for dysfunctional families and locational communities. Longres (1990) defines locational communities as based in a common residence/territory, and bonding and attachment is rather to the place than to the community. Their inability to sustain and maintain the necessary resources to deal with the needs of their mentally ill members further complicates any attempt to deal with the problems at hand.

The size and interest of the community determine and pre-empt cohesion likely to be displayed by the community, and its perception, strengths and weaknesses to deal with the problems encountered by them. It is imperative to note that different families and communities respond differently to the psycho-social and economic problems of their members. Individuals, too present with different psychological symptoms in response to socio-environmental stressors. Unfortunately these psychological, behavioural and

experiential symptoms are in themselves viewed as inappropriate and pathological (Halleck, 1991:2). Devore and Schlesinger (1996) maintain that an awareness of the importance of varying behaviours that occur from birth enhances the possibility for success. This suggests that a person's developmental history influences how he/she responds to life transactions. It is therefore vital for the family to nurture and provide an emotional buffer and social care for its members.

3.3 CLASSIFICATION OF PATIENTS (CLIENTS)

The Mental Health Act No. 18 of 1973 **classifies** patients according to the mental status and age of a person at the time of admission. The Act also classifies patients according to sections that reflect the conditions under which the person can be admitted. The following classification of patients that can be admitted to a psychiatric institution is described in the Mental Health Act No 18 of 1973.

3.3.1 Voluntary patients

In Section 3 of the Mental Health Act(1973), it is explained that a person can voluntarily submit himself /herself for psychiatric treatment. There is no forceful submission for psychiatric services by any person. In the case of a minor person, the parents or legal guardian may make such application for admission on behalf of the minor patient. The latter follows the trend and has the perception that the state is the guardian of all minor children. Therefore the protection of all minor children lies with the state which thus enforces this through laws that parents/guardians have to carry out. The law also requires that the person concerned must understand the meaning and effect of such an application.

3.3.2 Patients by consent

Patients by consent as referred to in Section 4 of the Mental Health Act No 18 of 1973, are sometimes referred to as involuntary patients. This section requires that the concerned

person be referred for psychiatric intervention by any person designated by the Minister of Health and Welfare. The person concerned must understand the meaning and effect of such application.

3.3.3 Admission by reception order

The admission of the person can also be done by a reception order. The reception order can only be issued by an area magistrate after the thorough examination of the concerned person by at least two medical practitioners. Depending on the availability of medical practitioners, only one practitioner may examine the person concerned (Mental Health Act,No.18,1973:). It is however important for the person concerned to be present for the magistrate to observe in addition to the medical practitioner's examination before the reception order can be served or issued. The Mental Health Act(1973) however, makes provision for the reception order not to be served if 14 days have lapsed following the medical assessment. The Act also makes provision for the person concerned not to be put in police cells unless impossible to remove immediately.

3.3.4 Cases of emergency or urgency

This Section of the Mental Health Act No.18,1973 comes into effect when it is expedient for the welfare of the person concerned, or it is in public interest that the person cocerned be forthwith placed under care and treated in a mental institution. However, the latter must be accompanied by a medical certificate stating the urgency of the case.

3.3.5 State President's patients

The Minister of Health and Welfare is granted powers to commit a person to a mental institution for treatment under section 27 of the Mental Health Act(1973). Section 27 describes these persons as dangerous. Section 30 of the Act calls for the Minister of Health and Welfare to instruct the area magistrate to cause an enquiry into the mental

condition of a prisoner. These persons are also referred to as forensic cases, and are placed in forensic wards.

From the above discussion, it is clear that the Mental Health Act (1973) provides guidelines for the admission of patients to a psychiatric institution. The team members should be knowledgeable about the requirements of the Act and the use of these guidelines.

3.4 ASSESSMENT

Assessment forms a vital facet in any social work contact with the client system, and it serves as a basis for any effective problem-solving or intervention in social work (Compton & Galaway, 1994; Hepworth & Larsen, 1993). It is ethically imperative to assess the situation of the client properly as assessment sets a precedent for intervention. A poor assessment may result in poor intervention. As an engine and driving force behind intervention, it must be noted that it is a continuous and an ongoing exercise as the problem of the client unfolds throughout therapeutic intervention. The social worker as a team member is required to assess the situation of the client and to share the findings with the team members in order to design a holistic intervention for the client.

3.4.1 Description

Various authors (Compton & Galaway, 1994; Hepworth and Larsen,1990) conceptualize assessment as both a product and a process. They describe assessment as the thoughtful analysis of new information and providing a working hypothesis open for reframing as greater understanding of the client system unfolds. As a product, assessment serves as a working document designed to provide a road map for collaborative work. This process requires both the social work practitioner and the client system to reach a mutual agreement on expectations during intervention. As a process, assessment refers to collecting and synthesizing information about the functioning of the client system and to

formulating a working statement of the presenting and underlying problems that can serve as a basis for the planning of intervention.

The social work practitioner requires comprehensive and accurate data to make an adequate assessment which will be shared with and used by the team to plan accordingly. The data can be collected through observation, studying previous recordings of personal and family interviews, mental state examinations and by taking of personal and family histories (Compton & Galaway, 1994; Hepworth & Larsen, 1993). In psychiatry, it is imperative to consider a patient's personal and family developmental history as this will provide the social work practitioner with vital information about significant events in the life of the patient and his/her family, and the family's strengths and functioning. The information will also shed light on circumstances leading to help-seeking by an individual and the family (Beavers & Hampson, 1990 ; Berg-Cross, 1988).

4.4.1 Theoretical Approaches

The theoretical orientation of the social work practitioner determines from which angle the client's problem will be perceived, analyzed, interpreted and dealt with. This serves as a foundation from which the social work practitioner will intervene in problem-solving. However, human problems differ and are experienced differently as well. It is therefore important for the social work practitioner to contextualize the problem and to put it into perspective with the assistance of the client. Three perspectives or approaches namely the ecological perspective, general systems theory and the social psychological approach (Payne,1977; Sheaffor, Horejsi & Horejsi, 1994) are relevant for the assessment of clients in psychiatric institutions.

3.4.2.1 Social psychological approach

The social psychological approach can be utilized as a frame of reference by the social work practitioner. This approach is concerned with the assessment of the cognitive, affective and behavioural components of human interaction (Longres, 1990; Shea, 1988). According to Payne(1991) and Shea(1988) these three components are applicable when working with and assessing the functioning of a mentally ill person on a one-to-one basis.

Shea (1988) maintains that auditory hallucinations remain the trademark of the psychotic process, and the presence of voices is practically synonymous with madness. He also maintains that these hallucinations must be substantial in the sense that they seemed real and had many of the perceptual qualities of reality. The hallucinations normally impair the cognitive functioning and judgement of the patient. The social work practitioner must understand that what transpires during the interview is the response to the meaning of transaction.

The assessment of the affective component of the patient's functioning is concerned with the emotional life of the individual (Longres, 1990:25). In the assessment the focus should be on the drives and feelings that motivate or encourage the person to behave in a certain manner. If the client's problem is affective in nature, then the patient's adaptation to a crisis will be the concern of the therapist.

Longres (1990) also identifies that the behavioural aspects of the client's functioning should be a cause for concern during assessment. The behaviour displayed by the client usually reflects both the cognitive and affective components of the person's functioning. The social work practitioner should critically analyze and understand these behaviours and their aetiological factors when compiling an assessment.

3.4.2.2 General systems theory

The general systems theory can be used by social workers for the assessment of clients in psychiatric institutions. Pincus and Minahan (1973) used the systems theory as a basis for social work practice and the assessment of the functioning of the client. The systems theory moves from a premise that people depend on systems in their immediate social environment. Therefore, the social worker needs to work with different systems to understand, assess and address the problems of the clients. These authors identified four systems namely the change agent, client system, target and action systems which are involved in the helping process and whose functioning should be assessed by the social

worker. Payne (1997) maintains that the aim of the social worker is to help people perform life tasks, alleviate stress and achieve aims and values which are important to them.

Greene (1994) maintains that the general systems theory is a comprehensive model for analyzing and assessing the interaction and relational qualities between and among the components of the client system. It is an effective means of conceptualizing and assessing the mutual inter-relatedness of the individual, family, social groups, community and the society. The practitioner gains a clearer perspective of the reciprocal influence among the individual and family groups and the environment when this approach is used for assessment of the functioning of the client (Devore and Schlesinger, 1996).

Another assumption of this approach is that because each family has a history of working together and maintaining homeostasis , its structure, energy exchange and organization, and its system of relationship vary (Greene, 1994).

3.4.2.3 Ecological perspective

The ecological perspective is another approach that can be used by the social worker for assessment of clients in a psychiatric institution. Germain (1984) is the pioneer and promoter of this approach. Germain and Gitterman (1996) suggest that ecological thinking focusses on the reciprocity of person-environment exchanges, in which each shapes and influences the other over time. It entails that there are transactions between the person and the environment, and the nature of these transactions determine the person's adaptive capacity to the environment.

On the contrary, the environment needs to be supportive and responsive to the needs of the person (Germain, 1984). The ecological thinking is therefore concerned with the consequences of the person-environment fit rather than the causes. Rausch (1993) and Garvin and Seabury (1997) support this view by maintaining that maladaption arises out of the complex transactions between the person and the environment. The dis-equilibrium and the internalization and acceptance of negative images sent to a person by an environment results in the person's withdrawal from meaningful social contact and the

development of negative traits that fulfill the negative image. The social work practitioner therefore seeks to bring back equilibrium to foster the positive self-image, adaptation and coping of the client.

The Mental Health Act(1973) and the mere admission to a mental institution do not prescribe the type of intervention a person will receive. Therefore, assessment is a vital task because the team members have to compile a holistic intervention plan for the person.

Assessment in psychiatry can be classified as a two-fold process. It is concerned with assessing to make a diagnosis and to determine suitable intervention. The former is associated with the medical practitioners/psychiatrists who will look for symptoms that warrant admission. The mental state of the person therefore plays a vital role in determining admission. The latter goal is concerned with the assessment of the presenting problem and its impact on the functioning of the person, and in many instances, the family or the people who live with, and are in constant interaction with the person concerned. This goal is imperative as it incorporates the social environment that the person interacts with in the assessment process.

The social work practitioner's theoretical orientation will determine how the client's problem is analyzed and interpreted and thus how the problem will be dealt with. It is important for the social work practitioner to contextualize the problem, and its cause with the help and assistance of the client system. Many approaches, like the psycho-cognitive, behavioural and ecological, are extensively supported in literature, but a social work practitioner needs to match the client's problem with a certain approach in order to deal with the client's problem effectively. Cormier and Hackney (1987) are of the opinion that selection of an effective strategy involves not only assessment of the client's problems and desired goals, but also of the client's preferences, personal characteristics and learning style.

3.4.3 Data collection

Data collection is an important facet of understanding, knowing or assessing the problem of the client. A lot of information about the client's problem can be confusing and fragmented. Therefore data collected should be specific, relevant and accurate to make a specific assessment and to plan intervention (Compton & Galaway, 1994; Hepworth & Larsen, 1993). It is also important for social work practitioners to trace the data obtained in a disciplined and interpretive manner. This suggests that data needs to be purposefully collected and analyzed to crystalize the problem. There are many ways in which to collect data, but for the purposes of this study, these will be restricted to (1) interviews, (2) mental state examination and (3) history taking, as these three ways are mostly used in a psychiatric institution.

3.4.3.1 Interviews

Interviews form an important component in the data collection process (Cormier & Cormier, 1991; Fine & Glasser, 1996). Interviewing a client puts the social work practitioner in touch with the feelings and perceptions of the presenting problem of the client. During interviews, the practitioner also has a chance to observe and interact with the client system. Various authors(Cormier & Cormier, 1991; Fine & Glasser, 1996; Shea, 1988) describe interviewing as a verbal and non-verbal dialogue between two and more participants whose behaviour affects each other's styles of communication, resulting in specific patterns of interaction. From this description, it seems that the process of interviewing is purposeful and intended to influence the outcomes of the transaction between the practitioner and the client.

In psychiatry, it is important to know who the client is. This view is supported by Fine and Glasser (1996) who assert that the state of mind of the client will determine what new information will be given. This helps the practitioner to prepare effectively for an encounter with the client. This does not necessarily apply in psychiatry only, but also in any professional encounter with the client system. Functional and emotional preparation

gives the practitioner confidence and a sense of direction and helps to focus throughout the interview.

Cormier and Cormier (1991), Twist (1992) and Fine and Glasser (1996) all agree that **listening** is fundamental to any interview situation or process. Listening helps the interviewer to coherently understand the client. Twist (1992) explains that clients who feel heard and understood are encouraged to co-operate in the helping process. This co-operation of the client is encouraged and reinforced by the interviewer's emphatic understanding of a client's problems and emotions that accompany the perception of the problem. Cormier and Cormier (1991) further explain that effective listening involves three components or elements viz. sight (visual), sound (auditory) and experience or touch (kinestetic). These three modalities effectively put the practitioner in a good position to listen and to respond appropriately and emphatically to verbal and non-verbal cues given by the client. Twist (1992) suggests that the practitioner needs to concentrate, actively participate, observe and take into account the client's feelings in order to respond emphatically to the needs of the client.

Cormier and Cormier (1991) maintain that clients might be vague and confusing in their presentation of the problem. It is therefore important for the practitioner to utilize the listening responses in clarification, paraphrasing, reflection and summarization. Cormier and Cormier (1991) explain the listening responses as follows:

- **Classification** is used by practitioners or interviewers to make messages explicit and to confirm accuracy of perception. It is important for the practitioner to maintain a clear understanding of the messages or information received from the client. The latter helps prevent misconceptions that could lead to both practitioner and client heading in diverse directions. The incorrect assumptions about issues during interviews can lead to misunderstanding and to the practitioner's failure to respond appropriately and emphatically to the emotions of the client.

- **Paraphrasing** is another listening response which can be used by a practitioner to tell clients what is understood during the communication process. It is important for

clients to know that they are understood and heard. This may promote their participation and commitment to problem solving. Although active participation and commitment to problem-solving should be contracted with the client at the beginning, paraphrasing further enhances the commitment of the client.

- **Reflection** helps the client to feel understood, and encourages clients to tell more about their problems to foster an ability to manage their feelings. Through reflection, communication and understanding of the client's feelings about his/her problem, the client's trust in the practitioner can be enhanced.

- One of the important listening responses is **summarization.** This is appropriate especially when ending an interview. According to Cormier and Cormier (1991) summarising is about tying together multiple elements of a client's messages and feedback. Normally interviews (therapeutic) can last up to an hour. Summarization by either the therapist or client leads to a feeling of being heard and understood, and demonstrates active listening and following of the interview process.

3.4.3.2 Mental state examination

Kaplan and Sadock (1981) defines mental state examination (MSE) as classifying and describing the areas and components of the mental functioning of the client involved in making diagnostic impressions and classifications. It covers the general description and observation of the client's mood and affect, perceptions, thought processes, level of consciousness, orientation, memory and impulse control. If the assessment of the client's mental state does not meet the acceptable standards, it will result in an admission of the client to a psychiatric institution. Owing to medico-legal factors it is mandatory to note that such a patient is mentally intact and capable of signing treatment consent. The testing of the patient's capability to perform this task is done through the mental state examination.

Renshaw (1997) maintains that one of the objectives of the mental state examination is to evaluate the patient's insight or awareness regarding the illness for which attention is

sought, and his/her capacity for consent and cooperation with health care professionals. It is therefore important for the practitioner to sit down and interview the patient personally and to do a proper assessment. The patient's understanding of the interview situation and immediate environment and the illness provides the practitioner (to some degree) with some insight into his/her reason for requesting help, how the illness is perceived by the patient and possibly the medical treatment (in a form of psychotropic drugs) that can be provided for the patient.

3.4.3.3 History taking

Fine and Glasser (1996) are of the opinion that it is important to get a pertinent history of the difficulties that brought the client to ask for help. The information should include events and situations relevant to the presenting problem as viewed by the client. It is therefore imperative to elicit information about the client's background, especially as it may relate to the current presenting problem. The taking of a client's history serves as a retrospective baseline measure for the client and a way to help identify cognitive and behavioural antecedents that still exert an influence on the problem behaviour that might otherwise be overlooked (Cormier & Cormier, 1991 : 172). This view is supported by Fine and Glasser (1996) in their assertion that cultural legacies and psychological/behavioural trends from the past exert an influence on the persistent presenting problems of the clients.

The taking of the developmental history of a person helps the practitioners to determine the causal factors of the current problems. It is however significant for this developmental history taking to be focussed on relevant factors that contribute to the current presenting problem. History taking helps practitioners understand the client's life transactions and utilization of coping mechanisms in dealing with stressful and crisis situations. It will provide a picture of the strengths and weaknesses of the client or client system (Cormier & Cormier, 1991; Fine & Glasser, 1996).

3.4.3.4 Other forms of data collection

There are various other forms of data collection that can be used. Previous records in files about the client also serve as a form of data gathering. The previous records present information about how the problem was perceived and handled in a therapeutic milieu. It could also give information about the nature of intervention received in the past. This could set a precedent as to alternative intervention as a way of preventing repetitive intervention (Berg-Cross, 1988; Compton & Galaway, 1994; Hepworth & Larsen, 1993).

In a case where the client is admitted to a mental institution, observation can be used as a form of data collection. The social work practitioner has an opportunity to get first hand information about how the client behaves in certain situations (Halleck, 1991). The social work practitioner could also makes inter-agency contacts to gather information about the client.

The data collected in these ways by the social work practitioner should be shared with other team members to ensure that comprehensive services can be rendered to the client. The social work practitioner should however be cautious in getting a client's consent in doing so (Hipple & Hipple, 1983). It is more than likely for a psychiatric client to be in contact with other mental health services at primary level.

3.4 TARGETS FOR ASSESSMENT

It is important for the social work practitioner to assess the client's presenting problem and to share the assessment with the team members. However, the person regarded as the target client is in daily contact or interaction with social systems such as family, friends and neighbours in the community that may have a major influence on the life of the person. The clients problems may centre around interaction with immediate family members, hence it will be significant for the family to be included in the assessment. Families themselves are functioning within a community context and structures that provide services.

According to the literature (Compton & Galaway, 1994; Hepworth & Larsen, 1993; Sheafor et al. 1994), various systems can be regarded as the target for assessment. These systems can be the client (individual), family or the community.

3.5.1 Assessing individuals

The individual or client concerned is the prime source of information during asssessment. It is important to involve or engage the client in information gathering in order to build a positive and collaborative working relationship with him or her. Mattaini (1997) maintains that the social work practitioner should act as a non-punitive audience by letting the client be the source of information, by telling his/her story. The social work practitioner should however avoid reinforcing pathology. This is especially applicable in psychiatry in order to gain or develop the trust and confidence of the client.

Longres (1990) approaches assessment of the client from a psychological viewpoint. He divides this approach into the assessment of cognitive, affective and behavioural aspects.

Firstly, the assessment of the cognitive sub-system is concerned with processes (like thoughts, memory, perceptions, intelligence) to which the client assigns and attributes meaning and to understanding of the world. This assessment helps the social work practitioner to understand that the client exchanges his or her human experiences, and the meaning it has for him or her during the working relationship with the social work practitioner. The social work practitioner should therefore interpret the client's experiences in the working relationship, and intervene in reshaping the way in which the client understands his/her life.

Secondly, the assessment of the affective sub-system is concerned with the emotional life, the motivations, needs, drives and feelings of the client, and the interest in relation to a crisis the client may be experiencing during adaptation to a crisis. The focus and concern of this approach to assessment is on the illness and well being of the client. There is a tendency among clients to relate their problems to their feelings. The social work

practitioner therefore needs to promote the well-being of the client by dealing with the client's emotions.

Thirdly, the assessment of the behavioural sub-system concerns the way in which an individual expresses himself or herself in action. The undesirable behaviour of the client is usually the presenting problem and is linked to the client's perception of self and/or what others say regarding his or her behaviour. The client's behaviour is usually congruent with the way (s)he feels. The social work practitioner must constantly understand and analyze these behaviours during assessment.

As explained above, the psychological approach to assessment regards thought processes and feelings as elements that can make clients seek help from health professionals. It is therefore important for the social work practitioner to understand the reason for referral of the client. This will give an indication of the kind of approach the social work practitioner will need to utilize.

Gavin and Seabury (1997) however hold another view to assessment based on the fact that an individual is faced with continuous life transitions. During the developmental life span, the client therefore has to fulfill certain roles, (e.g. pregnancy and the mother role), and the client may not be prepared for such roles because of a lack of capacity to handle the responsibilities and expectations of the new roles. This is potentially overwhelming and may create serious social dysfunctioning of the client.

Garvin and Seabury (1997), Germain (1984) and Rausch (1993) agree that the client seeks to find balance between life transitions and environmental realities. The social work practitioner needs to know that the process of finding equilibrium gives rise to stress. These stressors can often be interpreted as negative messages. When these negative images are internalized, clients tend to withdraw from meaningful social contact and develop negative traits and behaviours that correspond with negative images sent to them by the environment. The outcomes of the assessment of the client should be shared with the team members.

3.5.2 Assessing Families

The family system of the institutionalized client is often the main target system of assessment for the social worker. The other team members often use the social worker's assessment of the family as a starting point for their planning. There are different types of families in every society. Some family units are reluctantly accepted into the social fibre of the society. Gay and lesbian families are in-fact battling to establish themselves as family units due to stereotypes that exist and the general attitude of society towards gay and lesbian couples (Bloch, Haffner, Haran & Smitler, 1994).

The family is a small natural group of people in which members are related by birth, marriage or other forms that create a home or household unit (Combrink-Graham, 1989). This description is inclusive of all types of families as long as the members function as a close net or unit. However, this definition excludes the African definition of family and the meaning attached to the concepts. From an African perspective, those with the same clan name are regarded as family, even though there are no blood relations. Ethnic identity therefore plays a vital role in describing a family. However, Longres (1997) views the family as a social institution that involves examining what the society believes is the good and correct way to create and maintain life. According to this description, a family reflects the name and values of that particular society. It takes into cognizance the societal role in determining and sanctioning human behaviour. The social work practitioner needs to take these descriptions into consideration when assessing the families of institutionalized clients.

Garvin and Seabury (1997) are of the opinion that social work practitioners must make hypotheses about the family when dealing with the assessment of the families' functioning. The hypotheses will help the social work practitioner to formulate ideas about family conditions based on interactions with the client, and to focus on the family rather than on the individual. It is therefore significant to gather information about the history of the family and its relationship to other systems in its environment, because there is an interdependence among these systems.

Shea (1998) holds the view that psychosis or illness of a family member is a family matter because the illness may affect the functioning of the entire family. For example, in a case of the breadwinner developing a mental illness resulting in loss of his/her job and income, it will affect the financial state of the whole family. The collapse in social networks, e.g. the person's job, may result in more stress and the malfunctioning of the family. The social work practitioner has the duty and obligation to understand and assess the subcultures within the family to be effective in intervention.

Walsh (1998) further suggests that ethnicity influences a person's thinking, feelings and behaviors in both obvious and subtle ways. It plays a major role in determining how to relate to each other and how to celebrate rituals. Therefore, each family will adopt its unique ways of functioning in this regard, and need to be treated with respect and dignity. The philosophy, norms and values of each family is reflected in the way they interact with each other and in relation with the others.

It is inevitable that social work practitioners should assess the family structure, its strengths and resources (Rausch, 1993 : 43). The structure of the family will reflect who is the head of family, their relationships, communication channels and who are the main and minor person within the family. The social work practitioner can use the genogram to get to know the family (Hartman, 1978). The practitioner must also enquire about relational issues, the status the family holds and the roles that each family member plays, from the family itself. The strengths of the family will inform the social work practitioner about internal resources within the family that are put into action in order to maintain balance in the family. It is important for the social work practitioner to encourage and harness these inner resources.

Although the patient is the one the social work practitioner is involved with, it is clear that the functioning of the family and their involvement with the patient should be assessed. The family will help to substantiate the historical material provided by the patient. The historical information can assist and help the social work practitioner in identifying alternative treatment possibilities (Beavers & Hampson, 19 ; Berg-Cross, 1988). It is therefore important to work with the family for assessment purposes as members are in constant interaction with the concerned person.

3.5.3 Assessing the community

Any practitioner and also the social worker in a psychiatric hospital, who works in a community must know the resources that exist in that area, and what the community's attitudes and perception of these resources are. Crow and Allan (1994) are of the opinion that this is important in order to sustain supportive community networks, promote community development, and to promote a sense of common identity.

Garvin and Seabury (1997) describe a community as a set of people who share either locality, identity, history or other social status and who perceive this commonality as a basis for significant interdependence. Willmott (1986) also identified the element of community spirit, which he terms "community of attachment" as an element contributing towards the creation of a sense of community. The community can, therefore, be defined by the geographical location, the people's interests and the people's attachment to one another.

The definitions of community pose a great challenge to the social work practitioner in-terms-of knowing the community. The effectiveness of intervention for individual clients and families also depends on the utilization of community resources. Garvin and Seabury (1997) proposes that the process of community assessment should be performed by taking the following aspects into consideration.

- History

Authors (Garvin & Seabury, 1997; Sheafor et al. 1994) maintain that the history of a community provides social indicators, and data helpful in defining the community needs. This information is useful in order to gain insight into the social class and status, and attachment the community members hold. It also sheds light on the functioning of the community, and its response to the needs of the community.

- Geographical location

The geographical location of the community determines accessibility to major social institutions, and the form of transport utilized to get to the area. It also presents the practitioner with the layout of the community, and the strategic placement or location of community resources (Sheafor et al. 1994).

- Norms and culture

The norms and culture of a community determine the interaction that is likely to be displayed by members of the community. It is from this interaction that the solidarity and homogeneity in the community can be determined (Garvin & Seabury, 1997; Longres, 1990). The close network and working together determines how well the community members deal with their problems. It is this type of behaviour displayed by the community members that makes a community different from the next.

- Institutions and resources

It is important for any practitioner to have a map or a booklet of social agencies and institutions in the community (Crow & Allan, 1994; Sheafor et al. 1994). The map will give an indication of the location of agencies and institutions in the community. The distance from one point to another determines the accessibility and utilization of these agencies and institutions by the community. It is of no use to have agencies and institutions that do not effectively meet the needs of the community. The effectiveness of these institutions and agencies is determined by the community's awareness of their functions and the strategic location of these institutions and agencies in the community. Crow and Allan (1994) emphasize the importance that agencies should be aware of the impact of their decision-making processes on the provision of services in the community. It is therefore important for social institutions and agencies to review their policies constantly and to know how they could jeopardize service provision.

- Power and authority

Community leadership plays a vital role in the community. Community leaders can be the most powerful and influential people in the community because they can express the needs of the community for developmental purposes. Sometimes, the people look up to their leaders for opportunities for development, and in that way give them the mandate to do so. The social work practitioner should therefore determine during assessment who those leaders are, and in which structures can they be found.

The assessment done by the social work practitioner and client jointly, should be discussed with the other team members and should be used by the team to plan a comprehensive plan of intervention for the client.

3.6 INTERVENTION

Intervention is the product of careful assessment and planning by the social work practitioner. It should reflect the mutually agreed upon issues to be addressed by both the social work practitioner and the client system (Compton & Galaway, 1994; Hepworth & Larsen, 1993). Rausch (1993) is of opinion that the goal of intervention and the role expectations of the role players should be clearly stated. The intervention plan should also be accompanied by a well defined method of evaluation. The goal must be clearly stated to give direction to the implementation of intervention and to avoid confusion. The goals of intervention should also be attainable so as to encourage the active participation of the client throughout the intervention process. Evaluation in any human service intervention is inevitable. This helps to gain understanding as to what went wrong during the intervention process. The evaluation of the intervention could also serve as a layout and basis for alternative problem-solving (Compton & Galaway, 1994, Sheafor et al. 1994).

It must be noted that intervention is a mutual effort between the client system and the social work practitioner. It is not a one sided effort but collaboration between the client system and the social work practitioner. Therefore, both the social work practitioner and the client system must pledge their commitment and willingness to participate towards

problem-solving. The social worker should share the intervention plans with the team members to ensure that holistic services will be rendered to the client.

Various authors (Compton & Galaway, 1994; Hepworth & Larsen, 1993; Payne, 1991; Sheafor, 1994) describe how intervention can be directed at the individual, family and the community.

3.6.1 Individual intervention

Casework or individual intervention is imperative in psychiatry as the psychiatric illness may present some medical symptoms. The concerned person might either be an in-or outpatient. In either case, many psychiatric illnesses require medication in a form of psychotropic drugs (Mace, 1995; Mittler, 1970). It is much easier in the case of in-patient treatment to prescribe treatment in the form of drugs, because there is constant supervision and a set routine for taking of medication. The individual's responsibility for taking medication lies with either the individual or the family. The individual's responsibility and willingness depend mainly on the individual's understanding and acceptance of the illness. The social work practitioner is often left with a lot of uncertainty about whether the individual will actually take the prescribed medication. Regarding the family's responsibility to administer the person's medication, it needs to be taken into consideration that the family might be at the centre of the person's illness, and they may be perceived as perpetrators of the illness. Hipple and Hipple (1983) maintain that the family needs to be taught about mental health issues, and be provided with general support. The family needs to be specifically educated about its member's illness and how to identify signs and symptoms before a relapse.

Mattaini (1997) is of the opinion that there are certain elements that the practitioner can take into consideration when dealing with individual intervention viz (i) exposure to new experiences, (ii) cognitive and other private events, and (iii) skills training.

3.6.1.1 Exposure to new experiences

According to Mattaini (1997), human behaviour is shaped and maintained by contingencies within which it is embedded. He also states that the most powerful and direct route to improve the quality of life and to change behaviour is exposure to different arrangements of environmental antecedants and consequences. The client is therefore given an opportunity to decide on the new experiences to which he/she would like to be exposed. Based on the researcher's experience, caution should be taken when working with psychiatric patients, because they first need to identify and acknowledge instances and behaviours that cause distress before they can be exposed to new experiences. For example, a patient who is perceived as aggravating the illness by not consistantly taking medication should acknowledge this first, and then learn to take medication on appropriate times as prescribed. This kind of behaviour is likely to induce change in others in terms of their attitude. This may result in more opportunities to interact with others, thus reducing distress and isolation. In this way, a client's confidence can be boosted and may be accorded with a degree of self-determination.

3.6.1.2 Cognitive and other private events

Within the boundaries of handling the case, the social work practitioner is directly involved in the cognitive and emotive modalities of the client's and others functioning. Choices and consequences, and self-talk are some of the interventive strategies that can be used in working with the cognitive elements or components of the client's functioning (Mattaini, 1997 : 57). He also believes that choices and consequences are of a more technical nature and require a "normal" thinking person. This technique is therefore not applicable when dealing with a cognitively and judgementally impaired person. The client's disturbance in thoughts and judgement may result in making poor choices and may trigger and reinforce the client's negative images about the self. The client may not be prepared to handle the consequences of his/her choices, and this may damage the effectiveness of intervention.

Self-talk, as Mattaini(1997) maintains, can change a patient's emotional reactions. Self-talk is mainly geared towards changing negative perceptions of the self that lead to

difficulties in dealing with new experiences and contingencies. A patient who believes that nothing can change, allows his/her abilities and objectivity to be clouded by negativism. Such a person can be best helped by promoting a positive self-image and confidence in his/her capabilities and abilities. The latter requires a change in attitude, and the person him/herself is the champion of that change and shift which is required in his/her attitude.

3.6.1.3 Skills training

Mattaini (1997) explains that skills training is important because many clients have not learned effective repertoires of achieving an adequate fit with the environment, or do not use their existing repertoires on appropriate occasions. It is in the light of this that skills training is vital and it forms an imperative part of working with the mentally ill person. A skills-training programmes should include the agreed upon desired behaviour of the client, and advantages of learning new skills. Communication skills can be taught and used as a tool to avoid and to manage conflict. The approach needs to be instrumental and presented in the form of role-plays to be effective. The client should be able to use these real life situations that can be relived in therapy. Skills- training is one of the most effective ways of working with individual clients.

3.6.2 Family intervention

Family intervention is an integral part of the treatment plan of the patients in psychiatric institutions. Life with the mentally ill is almost unendurable because of no refuge in sleep, and the strain of maintaining self-control which goes on around the clock (Isaac and Armat, 1990:250). The process of mental illness disrupts the family's functioning and brings the whole family into distress. Sometimes it even leads to role reversal because the mentally ill person might be one of the parents and might suddenly assumes the sick- role which requires one of the other family members to assume the role of parent to care for the children. Combrinck-Graham (1989) believes that mental illness brings about unpredictability and frequent chaos of the family environment. The periods of disruption

may lead to periods of relative and actual neglect of some, or all of the family needs and individual roles within the family.

It is important to note the impact of the mental illness on the family's functioning. Shea (1988) explains that some family members are assaulted and become objects within the patient's delusional system. This then causes tension among family members. Family counselling may be necessary to diffuse such tension (Berg-Cross, 1998). According to Hipple and Hipple (1983), the family may need a vacation from the client as they may be burnt out from dealing with a dysfunctional family member. Hospitalization of the client may come as a relief to the family in alleviating guilt for requesting such hospitalization. Walsh and Anderson (1988) maintain that intervention with the family is geared towards reduction of the stressful impact of the chronic disorder on the family. Crisis intervention with the family may be indicated in times of distress and the therapist should be available at all times for support. A sense of urgency and collapse in family fibre may be due to exacerbation of symptoms by the family.

Walsh and Anderson (1988) are of the opinion that the social work practitioner should provide information to the family on the patient's psychiatric condition, abilities and limitations and the prognosis. This is useful and helpful as the family may not know and understand what is going on in the life of the mentally ill family member. This will foster understanding and lead to lower expectations and standards that are set for the person concerned. The family needs this information to alleviate their own fears and anxieties about the illness and the person concerned. The family needs guidance and instructions on how to deal with the psychiatric condition that their family member is experiencing. Hipple and Hipple (1983) support the idea of giving information to the family by emphasizing the positive effect of this on the immediate family's emotional health as well as on their long-term planning. This implies that the family needs psycho-education about the illness of the family member and the eventual management of the illness.

The family also needs concrete guidelines for stress reduction and problem-solving (Walsh and Anderson, 1988:13). An educative session about signs and symptoms of the specific illness of the client, and the medication that the client consumes can reduce stress in the family. The family needs to know the type of medication, what it does and when to

consult the doctor for side-effects of the medication. This requires knowledge about resources existing in the community that could be utilized by the family for support. The family therefore needs to be linked with supplementary services to support their efforts to maintain their member in the community (Walsh and Anderson, 1988:13).

Anderson (1982), Steinglass, Bennet, Wolin and Reis (1982) and Zarit and Zarit (1982) all maintain that multiple family groups provide a vital network function for families who have common problems and are isolated and stigmatized by the client's chronic illness. This is important as long as these families share experiences, support each other, and possibly advocate for the needs and rights of the mentally ill. These clients and families need to be re-integrated into the social fibre of the society.

3.6.3 Community Intervention

The client and family functions within the context of the community in which they live. The community, through the existing resources and institutions, plays a vital role in their functioning. Greene (1994) maintains that the focus of intervention is on identifying, supporting and mobilizing natural resources for the client. The social networks in the community are viewed as mutual aid systems and resources. The absence of needed resources serves as a basis for social work intervention (Devore and Schlesinger, 1996:142).

The people in the community cannot be linked to resources that do not exist in the community. This hampers the work of the social work practitioner badly. The social work practitioner has a major role to play in advocating for the rights of the client. It is in the constitution of the country, that every citizen has the right to basic health and welfare services. These resources should be accessible to clients in terms of the geographic location and transport.

Neugeboren (1996) maintains that any social work practitioner should take the physical environment in which the agency is located into account as well as the accessibility of the agency. The social work practitioner should also consider how the physical features of the

agency impinge on the needs of the service users. A multiple level mental institution cannot accommodate acute psychotic patients on the second floor without proper preventative or protective mechanisms used, such as window burglar bars. The patients/clients run a risk of falling from the windows when they are in an unstable mental state. The physical features of an institution convey powerful messages to the service users about safety, care and what to expect.

According to Neugeboren (1996), state policies should take environmental factors into account in the achievement of system goals. Social policy that encourages co-location of agency services would facilitate service accessibility to more services users. This challenges planners at community level regarding the location and designing of the institutions so that they could be user friendly.

The social work practitioner should explain the proposed intervention plan to the team members to involve them in the joint planning of service rendering to the client.

3.7 SUMMARY

This chapter offered a brief introduction to the Mental Health Act(1973). This Act guides the interaction between the mentally ill person and the service providers. The classification of persons according to the severity and nature of the illness helps to identify these patients and the treatment which is likely to be provided.

In any human service agency, the client's problem needs to be thoroughly assessed and intervention should be planned. The social worker should share the assessment done and the intervention that is planned with the team members. The team needs the information to design a comprehensive action plan for the client.There are many ways of data collection that could be employed to assist the social work practitioner in assessment. It was also explained that assessment is not a once off activity, but a continuous activity throughout the working relationship between the social work practitioner and the client and should be shared with other team members.

The intervention is the culmination of proper assessment and it should reflect the plans of the social work practitioner. It is important that the social work practitioner should know with whom to intervene and the reason for that. Different theoretical approaches determine how the client's problem is perceived, analyzed and interpreted. It is therefore important for the practitioner to place the problem in context and to explain it to other team members.

CHAPTER 4

THE USE OF A MULTI-DISCIIPLINARY TEAM APPROACH IN A PSYCHIATRIC ADMISSION UNIT

4.1 INTRODUCTION

The aim of this study is to present a theoretical framework for the functioning of a multi-disciplinary team in an admission unit of a psychiatric institution. The objectives of this study are:- to describe the roles and functioning of a multi-disciplinary team in an acute admission unit of a psychiatric institution, to describe the co-ordination that can be achieved in such a team, to determine the joint responsibility of the team for assessment and the designing of intervention plans for the clients in an acute admission unit; and to explain the procedures followed by a team in an acute admission unit of a psychiatric hospital.

The results of the study will be discussed in this chapter. The purpose of the discussion is to present the findings of the study and to relate them to relevant literature and previously conducted research.

4.2 PLACE OF STUDY

The empirical study was conducted in the three psychiatric hospitals in Cape Town, viz. Lentegeur, Stikland and Valkenberg hospitals. The study population was the teams in the acute admission units, which consists of the nurses, doctors, social workers, psychologists and occupational therapists. This sample for the study was drawn from these multi-disciplinary teams.

4.3 THE EMPIRICAL STUDY

The study population consisted of 75 team members in the three psychiatric hospitals. Twenty five questionnaires were sent to each hospital for completion by the team members in the acute admission unit. An equal number of questionnaires was sent to each hospital to ensure an equal distribution of the questionnaires to the three hospitals. Only 51 respondents completed the questionnaires (appendix A)which were mailed to the three hospitals. This represents a percentage of sixty eight of the total questionnaires that were sent away. This is a significantly high number or percentage of questionnaires that was returned to the researcher. Grinnell (1990), Schnetler et al (1989) and Oppenheim (1992) all assert that, with the use of postal questionnaires, there is a high potential for a low response rate. The researcher requested that the completed questionnaires be sent to the heads of social work departments, and the researcher was in constant contact with them for the collection of the questionnaires. The researcher also personally collected some of the questionnaires. This was done to counter-act the usually low response rate associated with the postal survey. The researcher also did this to obtain a reasonable number of questionnaires for analysis.

4.4 RESULTS OF THE RESEARCH

The data obtained from the completed questionnaires will now be discussed in the same sequence as presented in the questionnaires. Tables are mainly used to present the responses to close-ended questions. The respondents' responses to open-ended questions, which were used to obtain quantitative data, were analyzed and categorized. This data is presented in a descriptive manner.

4.5 IDENTIFYING INFORMATION

In this section, the number of questionnaires completed by the respondents from the three hospitals is presented in table 4.1. Twenty-five questionnaires were sent to each hospital.

Table 4.1 Number of questionnaires completed

Hospital	f	%
Lentegeur	18	35%
Stikland	13	26%
Valkenberg	20	39%
TOTAL	51	100%

N=51`

The findings in table 4.1 indicate that Valkenberg hospital returned the highest number of questionnaires(20 or 39%); followed by 18(35%) from Lentegeur hospital and 13(26%) from Stikland hospital.

4.5.1 The occupation of respondents

The occupations of respondents were investigated and are reflected in table 4.2.

Table 4.2: The occupations of respondents

Occupation	f	%
Medical Officer	13	26
Occupational Therapist	7	14
Nurse	17	33
Clinical Psychologist	3	6
Social Worker	11	22
TOTAL	51	100

N=51

The largest number of respondents were nurses, namely 17(33,3%), followed by medical officers 13 (26%) and 11(21.6%) social workers. Seven (14%) respondents were

occupational therapists and the psychologists were 3(6%). Fifty of the respondents (N=51) were working in the admission units of the three hospitals. Only one participant did not indicate in which unit he/she was working. Forty (78%) of the participants had psychiatric training, ten(20%) did not and one(2%) participant gave no answer. The respondents indicated that they have an average of 8 years experience in applying their psychiatric knowledge. All the respondents are currently part of a multi-disciplinary team.

4.6 TEAM FUNCTIONING

4.6.1 Team composition

The respondents were requested to indicate the representation of the various disciplines in the multi-disciplinary teams in which they are serving.

Table 4.3 Composition of team

Member of Team	f *	%
Psychiatrist	51	100
Social Worker	50	98
Medical Officer	42	82,4
Prof. Nurse	51	100
Occ. Therapist	44	86,3
Psychologist	0	0
Clerk	35	69

N=51

*Respondents could give more than one answer.

It is imperative to note that all (51 or 100%) respondents mentioned that, in the teams they are participating in, a psychiatrist is present as a team member. According to Phares (1992), psychiatrists are important members of a multi-disciplinary team due to their background in medicine. It is clear from the results of this study that psychiatrists form an integral part of the multi-disciplinary team in the three hospitals where the survey was done. Although the

psychiatrist and medical officer as members of the team are mentioned as separate occupations in the questionnaire, there is a possibility that some of the respondents could confuse the occupations of psychiatrist, medical officer and the registrar. Accepting the results of the questionnaires at face value, 42(82.4%) of the respondents mentioned that there was a medical officer present as a member in their teams.

Fifty (98%) respondents stated that a social worker is serving in their teams. From the researcher's experience and the results of the study, it is unlikely that a team will function without the services of a social worker. These findings are in accordance with Phares (1992) in his assertion that social workers play a vital role in multi-disciplinary teams. He further asserts that social workers have assumed a different role compared to the past. He points out that not only do social workers deal with the social circumstances of the clients, but they also extend their role to interviewing employees and families and taking case histories.

The results show that 44(86,3%) respondents reported that an occupational therapist is a member of the multi-disciplinary team. The results also show that all the respondents 51(100%) stated that there is a nurse functioning in their team. This is likely as nurses form the foundation of any hospital. All the respondents (51 or 100%) reported the absence of a psychologist in the multi-disciplinary teams in which they function. Thirty-five (69%) respondents reported that there is a clerk serving in the team. The results of the investigation reflect the representation of a fair number of disciplines. Ovretveit (1993) states that multi-disciplinary teamwork consists of a small group of people, usually from different professions who relate to each other to contribute to the common goal of meeting the health and social needs of the client system. team. Phares(1992), Cormier & Hackney(1987) and Germain(1984) state that social workers play an important role in a

multi-disciplinary team. The results also show that 42(82,4%) respondents reported the presence of an occupational therapist functioning in their teams.

Scholtes (1996: 1-5) is of the opinion that teams need to have the right human resources to complete the work assigned to them. The composition of the team reflects a variety of professionals with different useful skills to perform their duties in a psychiatric admission unit. It is clear from the results that the multi-disciplinary team members possess expert skills and knowledge to perform their tasks. However, the use of these skills needs to be well co-ordinated to effect change in any situation. Garner(1994) & Mears & Voehl(1994) are of the opinion that the composition of the team determines the expertise and competency of the team.

4.6.2 Adequacy of team composition

The respondents were requested to evaluate the adequacy of the team composition. The results of the survey is presented in table 4.4.

Table 4.4 Adequate composition of team

Adequate composition of team	**f**	**%**
No	20	40
Yes	30	60
Grand Total	50	100

*N=50

*One respondent did not answer the question.

The results reflect that 30(60%) respondents indicated that the team composition is adequate. Twenty (40%) respondents stated that the team composition is inadequate.

4.6.3 Size of the team

The respondents were asked to indicate the number of people in the multi-disciplinary team. The results are presented in table 4.5.

Table 4.5 Number of people in multi-disciplinary teams

Number of people in teams	f	%
5	16	39
6	8	20
7	6	15
8	3	7
9	4	10
10	1	3
11	2	5
16	1	3

N=41*

*Only 41respondents answered this question.

Sixteen (39%) of the 41 respondents who answered this question reported that the team size is five members. Eight (20%) respondents reported that their team is

composed of six members. Six (15%)respondents indicated their team size is seven members, and four(10%) indicated a team size of nine members. The teams with the most number of people in the team is eight(7%), followed by 11(5%), and then 10 & 16(3%) respectively. The findings indicate that most teams in the admission units of the psychiatric hospitals that participated in this study consists of either five/six/seven team members. These three categories constitute 30(74%) of the total responses in this question.

4.6.4 Presence of a team leader

The respondents were requested to indicate the presence of a team leader. The findings are shown in table 4.6

Table 4.6 The presence of a team leader

Team leader	f	%
Yes	49	98
No	1	2
Total	50	100

N=50*

*one respondent did not answer this question.

The findings reflect that the majority (49 or 98%) of the respondents reported the presence of a team leader in the teams in which they function. The results support the assertion and findings by Wellins et al (1991) and Smith (1984) that a team becomes effective when a leader is present to coordinate and assist the team in accomplishing its tasks.

4.6.5 Selection of a team leader

Respondents were requested to indicate the manner in which the team leader is selected.

Table 4.7 presents the responses of the respondents to this question.

Table 4.7

Selection Procedure	***f**	**%**
Seniority	10	20
Voting	4	8
Experience	8	16
Qualifications	16	31
By appointment	9	18
By virtue of discipline	28	55
Departmental Selection	48	94

N=51*

*Respondents could give more than one answer to this question.

The findings show that the team leader is mainly selected through departmental selection, because 48(94%) of the respondents indicated that this procedure is followed. It can be deduced from the findings that the actual team members therefore do not participate in the selection of the team leader. The findings are in line with the findings of Harrison, Drolen, & Artherton(1989) who explain that it is unlikely that team members in a state institution would be afforded the opportunity to choose who will join the team depending on the skills and expertise of the person.

Twenty-eight(55%) respondents indicated that the discipline which the team members belong to plays a vital role in the team leader selection while 16(31%) indicated that the

qualifications of the team leader is an important factor that is taken into consideration. The results indicate that voting as a selection procedure was regarded by 4(8%) respondents as a least factor that determines the selection of the team leader. Eight(16%) respondents indicated that the experience of the team leader is taken into consideration when a team leader is selected. These findings may be due to the fact that voting as a selection procedure and the experience of the team leader give no guarantee that they will influence a team member's selection for a team leadership position.

4.7 FUNCTIONS, ROLES AND RESPONSIBILITIES OF TEAMS

The respondents were asked to indicate the functions that they are fulfilling within the multi-discipinary team.

4.7.1 Assessment

The first function that team members can fulfill is assessment, which involves three facets i.e. clerking the patient, assessing the presenting problem and assessing the patient for admission. The findings of the study are presented in table 4.8.

Table 4.8 Assessment

Function	*f	%
Clerk the patient on admission	20	39
Assessing presenting problem	39	77
To assess for admission	16	31

N=51

The respondents could indicate more than one function that they fulfill within the team.

Table 4.8 shows that thirty-nine(76,5%) respondents reported that they assess the presenting problem of the client on admission of clients to the admission unit. From the researcher's experience, it is very likely that most of the team members working in the admission units would assess the presenting problem. The team members need to perform these assessments carefully to avoid duplication that could lead to exhaustion of the clients because psychiatric clients are very sensitive and require careful management. However, assessment is imperative as it sets a precedent for interventive plans. Assessment is a continouos process, and it provides a hypothesis that is open for re-framing as greater understanding of the client system unfolds (Rausch, 1993:31).

Twenty (39%) respondents indicated that they clerk the patients on admission as part of their assessment function. Clerking in psychiatry refers to the initial gathering of information about the client in a structured way using a standardized sheet/form meant for clerking.

Sixteen(31%) respondents mentioned that they assess patients for admission. The occupations of the respondents reflect that only 13(26%) respondents have a medical background, therefore giving them the mandate to subject a person for psychiatric intervention (See table 4.2, page 62). It is therefore very unlikely that there are 16(31.4%) of the respondents who are eligible to subject any person for psychiatric intervention. The current Mental Health Act No.18 of 1973 does not give a mandate to any government employee in a psychiatric institution to subject a person for psychiatric intervention, except for medical officers and the magistrates.

4.7.2 Data collection

This question was asked to ascertain the methods that team members use to collect data in making their assessments. Six questions were asked about the methods of data collection. Compton & Galaway(1994) and Hepworth & Larsen(1993) assert that data collection should be specific, relevant and accurate to make a specific assessment and plan for intervention. Table 4.10 provides findings on forms of data collection used by respondents.

Table 4.9 Data collection

Function	f	%
Interview with patients	46	91
Interviews with families	42	82
Contact with agencies	39	77
Peruse previous records	33	65
Mental state examination	29	57
History taking	36	71

N=51

Table 4.9 reflects that 46(91%) respondents reported conducting interviews with clients as part of their data collection function. Forty-two(82,4%) respondents interviewed families of the admitted clients. Cormier & Cormier(1991) and Fine & Glasser(1996) are of the opinion that interviews form an important function in the data collection process. In so doing, it puts the practitioner in touch with the feelings and perceptions of the presenting problem from the client's viewpoint.

Thirty-nine(76,5%) respondents reported that they make contact with other agencies for data collection purposes. It is important for workers in a psychiatric institution to work in partnership with other agencies in the community. Inter-agency collaboration is imperative, as psychiatric issues require more than the services provided in the hospital. Berg-Cross(1988), Compton & Galaway(1994) and Hepworth & Larsen(1993) assert that previous records contain information about how the client was perceived and handled in a therapeutic milieu. Thirty-six(71%) respondents mentioned that they take the history of the client. The history could be about the client's social development, psychiatric or alcohol related. This is a general and seemingly adopted way of data collection in psychiatry (Fine & Glaser, 1996).

Thirty three(65%) respondents reported that they peruse previous records as part of the data collection process. This will enable the perusor to get an idea of previous interventions provided to the client at any one stage of psychiatric encounter. This has become a general trend in psychiatry (Berg-Cross, 1998). However, the practitioners

should avoid being influenced by previous findings and interventions. The results show that 29(57%) respondents do mental state examination with clients. It is important in psychiatry to perform mental examination as frequently as possible to determine progress with the interventions(Renshaw, 1998).

Compton & Galaway (1994) and Hepworth & Larson (1993) all assert that data collected should be specific, relevant and accurate to make assessment and to plan intervention. The data collection phase is therefore very important for any intervention to follow.

4.8 INTERVENTION

Seven facets were investigated to determine the different functions performed by the team members with regard to intervention. The relevant information is provided in table 4.10. Various authors (Compton & Galaway, 1994; Hepworth & Larson, 1993; and Rausch, 1993) assert that intervention is a product of careful assessment and planning by the practitioner. It should reflect the mutually agreed upon issues to be addressed by both the practitioner and the client system. Table 4.9 reflects the findings of the study.

Table 4.9 Intervention

Function	**f**	**%**
Planning for intervention	41	80,4
Prescribe Medication	14	27,5
Intervention/ therapy/ treatment	44	86,3
Liase with outside agencies	35	69
Refer patients to other agencies	37	72,5
Follow-up intervention	33	64,7
Escorting patients	17	33,3

N=51

The results in table 4.9 show that respondents plan for intervention and are involved in the actual therapy with the client system. This is reflected by 41(80.4%) and 44(86.3%) respectively.

Only 14(27,5%) respondents reported that they prescribe medication as part of intervention. This function falls outside many of the respondents' professionals duties except for the medical officers.

The team's liason with other agencies is of great importance in the execution of the intervention process. This is supported by 35(69%) of the participants. Psychiatry do not function in a vacuum, but functions within the different social and welfare structures of the society. The focus in South Africa is currently on community intervention rather than on institutional care. Thirty-seven (72.5%) respondents mentioned that referral to other agencies is imperative.

Follow-up intervention becomes very important in working with psychiatric clients as indicated by 33(64%) of the respondents. Psychiatric patients need to be followed up by psychiatric staff in the community clinics to the client's use of their medication, and to do the checking of the levels of drugs in the blood of the patients (Resnick & Tighe,1997). These authors emphasize the importance of community clinics who are staffed by multi-disciplinary teams in managed care systems. Escorting patients to different hospitals becomes an important factor for nurses as part of their functions.

4.9 ADMISSION PROCEDURES

The admission procedures are very important for any purposeful work and intervention with the client system. It was very necessary to consider this issue as it forms the pillar of any organization that serves the public.

4.4.7.1 Mission statement

The respondents were requested to mention whether they are aware of the mission statement in their workplace. They were also required to state whether their work is in line with the mission statement. Table 4.10 provides the results to these questions.

Table 4.10 Awareness of the mission statement

Mission statement	f	%
Yes	35	69%
No	16	31%
Total	51	100 %

N=51

According to table 4.10 thirty-five(69%) participants are aware of their hospitals' mission statement. Brody(1993) holds the view that it is important for employees to be aware of the organization's mission statement to purposefully direct their work/tasks.

Table 4.12 Work in-line with mission statement

Work in line with mission statement	f	%
Yes	33	65%
No	18	35%
Total	51	100%

N=51

Table 4.11 reflects the thirty-three(65%) of the respondents indicated that their work is in line with the mission statement. This seems to be consistent with the writings of Wellins et al(1991) in their assertion that teams need to focus and direct their work in accordance with the mission statement of their organization. Knowledge of the hospital's mission helps in directing the work of the team. The team's work becomes purposeful and could lead to job satisfaction. Jennings & Wattam (1998) allege that one reason a person joins the group is that the group can help to achieve individual goals. The agreement about

goals and the extent to which group goals complement individual goals will have an impact on group cohesiveness and the performance of individual team members. It could also serve to motivate members and create opportunities for continuos learning. It will improve the quality of work of the team. The team could also develop a mission mentality and eagerness to succeed in their work.

4.9.2 Procedures and responsibility

The participants were asked to indicate if they are following prescribed admission procedures in their hospital. The respondents were also asked to indicate the person who takes responsibility for drafting the procedures if they have them in place. The findings are presented in table 4.12 and 4.13 respectively.

Table 4.12 Prescribed admission procedures

Prescribed admission procedures	**f**	**%**
Yes	51	100
No	0	0
Total	51	100

N=51

According to table 4.12 a hundred percent of the participants reported that they have specific prescribed admission procedures in the units in which they work. Kaplan & Sadock (1994) support the notion of having admission procedures that guide the team members in admitting a client to the unit. The team works according to these prescribed procedures. This will help in negating any confusion that may arise out of not knowing some expectations from team members.

Table 4.13 presents information on the person responsible for drafting the admission procedures.

Table 4.14 Responsibility for drafting of procedures

Person responsible	Pre-scribed Procedures	
	f	%
Admin. Team	50	98
Administration	0	0
Other	0	0
No Response	1	2
Total	51	100

N=51

The findings in table 4.13 show that the team is responsible for setting these admission procedures. The findings are in-line with the observations of the researcher ever-since working in psychiatry. However, it is very likely that there exists different admission procedures in the three psychiatric hospitals involved in the study.

4.9.3 Effectiveness of admission procedures and monitoring of procedures

The respondents were asked to specify whether the admission procedures are effective, and to indicate who takes responsibility for monitoring these procedures. Table 4.14 reflects the responses of the respondents.

Table 4.14 Effectiveness of procedures

Who monitors the procedures	Effectiveness of procedures	
	f	%
Doctor	8	18
Nurse	19	43
Other	17	39
Total	44*	100

N=44*

*Only 44 respondents answered this question.

The findings in table 4.14 show that 19(43%) of the respondents indicated that the nurses are mainly responsible for monitoring whether these admission procedures are followed. This is consistent with the assertions by Kaplan & Sadock(1994). Seventeen (39%)

respondents however mentioned that other staff members are responsible for monitoring the effectiveness with which admission procedures are followed. Seven (14%) respondents did not answer this question.

4.9.4 The use and maintenance of the structured program

The respondents were requested to indicate whether they have a structured program followed by team members in the intervention process with the clients. A structured program becomes imperative in the management of clients in the admission unit. The findings are reflected in table 4.15.

Table 4.15 Structured program

Structured program	f	%
Yes	51	100
No	0	0
Total	51	100

N=51

Table 4.15 shows that all the respondents51(100%) stated that of a structured programme for the management of patients is used. This is consistent with the findings of Proctor, Morrow-Howell, Kitchen & Wang (1995) who explained that a structured program is imperative for the management of patients. It is also needed to clarify which team members should be responsible for certain tasks specified in the programme.

4.9.5 Maintenance of the programme

The respondents were requested to indicate the person who is responsible for maintaining the programme in their teams. Table 4.16 reflects the responses of the respondents.

Table 4.16 The maintenance of the program

Member responsible for maintaining the program	f	%
Doctor	3	6
Nurse	40	78
Social worker	8	16
Total	51	100

N=51

The results show that 40 (78%) respondents reported that a structured program exists which is maintained by the nurses in the ward. This is followed by eight(16%) respondents who indicated that social workers are responsible for this task and 3 (6%) respondents who indicated that medical officers are also responsible to maintain the structured programme.

It is important for clients to be engaged in different activities during their stay in the admission unit (Bateson, Oliver & Goldberg, 1989:458). The results indicate that the nurses are mainly responsible for the maintenance of the ward program. This could be to the detriment of the team effort as the success of the programme depends on the contribution of all the team members.

4.10 DYNAMICS OF THE TEAM

The dynamics of the team are discussed in chapter two of this study. Garner (1994:127) suggests that teams differ in the extent of independence that team members possess. The independence determines the nature of interaction and the functioning of the team as a whole. The dynamics of the team are discussed under different sub-headings as reflected in the questionnaire. All the facets under the dynamics of the team are measured using the provided scale. The meaning of the rating scale is explained below.

Scale:- **1=strongly agree**

2= agree

3= neither agree or disagree (neutral)

4= disagree

5= strongly disagree

4.10.1 Team Roles

The respondents were asked to rate statement about the clarification of team roles according to the rating scale. Table 4.17 show the responses of the respondents.

Table. 4.18 Team roles

Role clarification	**1 Strongly agree**	**2 Agree**	**3 Neutral**	**4 Strongly disagree**	**5 Disagree**
Own role clearly defined	24(47%)	17(33%)	2(4%)	3(6%)	4(8%)
Other members' roles clearly defined	20(39%)	24(47%)	2(4%)	3(6%)	1(2%)
Role determined by team	6(12%)	8(16%)	11(22%)	17(33%)	7(14%)
Role determined by profession	26(51%)	18(35%)	1(2%)	2(4%)	1(2%)

N=51

- **Own role clearly defined**

Twenty-four(47%) respondents strongly agree that their roles are clearly defined within their teams. Seventeen (33%) also agree/stated that their roles are clearly defined in the teams they participate in. The findings support the assertions of Scholtes et al(1988) that the team turn to function efficiently when the team members' roles are clearly defined within their teams. The findings suggest that the team members are aware of other team members' expectations from them.

- **Other team member's roles clearly defined**

The findings reflect that twenty(39%) respondents strongly agree that other team members' roles are clearly defined. Twenty-four(47%) respondents also agree that other team members' roles are clearly defined. It appears from the results that every member of the team know what is expected of others in the team. Scholtes(1988) and Smith(1984) support the findings by asserting that team members should be aware of each others' expectations and in so doing minimize role blurring within the team. The team is likely to function effectively and efficiently when they perform the expected tasks.

- **Role determined by the team**

The findings show that seventeen (33%) respondents disagreed that the team determines their roles. Seven (14%) respondents strongly disagree that the team determines their roles. These results are in contrast with the suggestions of Garner(1994), Kinlaw(1993) and Lister(1980) who indicated that the team should determine the roles of other team members. Garner (1994) explains that knowledge, skills, roles and responsibilities of team members often overlap and require routine discussions and clarification.

- **Role determined by profession**

Twenty-six (51%) respondents strongly agreed that their roles are determined by their profession. Eighteen (35%) respondents agreed that their roles are determined by their profession. These findings support the findings of Aviram(1997) who explained that social work as a profession should work in collaboration with other disciplines in psychiatry.

4.10.2 Team Meetings

Team meetings are imperative for the effective functioning of the team. The team can use the team meetings as a platform to give feed-back about the tasks assigned to them

by the team. The respondents were asked to rate their responses according to the rating scale. Table 4.18 show the responses of the respondents to the questions on team meetings.

Table 4.18 Team meetings

Team Meetings	**Rating**				
	1 Strongly agree	**2 Agree**	**3 Neutral**	**4 Strongly disagree**	**5 Disagree**
Often have team meetings	19(37%)	25(49%)	4(8%)	2(4%)	1(2%)
Regular feedback meetings	26(51%)	15(29%)	3(6%)	3(6%)	3(6%)
Open & honest discussion	20(39%)	15(29%)	13(26%)	1(2%)	1(2%)
Contribution valued	18(35%)	22(43%)	9(18%)	1(2%)	1(2%)

N=51

- **Often have team meetings**

Nineteen (37%) respondents strongly agreed that the team often held team meetings. Twenty-five(49%) also agreed that the team often hold team meetings. The findings support the suggestions of Garner(1994) and Maddux(1994) that teams should hold regular meetings for the different reasons which are relevant to the team.

- **Regular feedback meetings**

Twenty-six(51%) respondents strongly agreed that the teams in which they function have regular feedback sessions. Fifteen (29%) agreed that their teams have regular feedback sessions.

- **Open and honest discussions**

Twenty (39%) respondents strongly agreed that discussions within their teams are open and honest. Fifteen (29%) respondents agreed that discussions are open and honest in their teams.

- **Contribution valued**

Eighteen (35%) respondents strongly agreed that their contributions are valued by other team members. A further twenty-two agreed that the team values their contributions.

These findings are consistent with the suggestions of Scholtes(1988) and Kinlaw(1993) that the team members should hold regular meetings and value the contributions of others. However, these authors also warn that team members should be open to criticism from other team members. Garner (1994) suggests that decisions that bind to each team member are vital for effective team functioning.

4.10.3 Problem identification and decision making

Problem identification and decision-making are imperative for effective team functioning. It is especially important to engage all the team members in decision-making processes as they are likely to implement the decisions taken (Kelly,1994). Maddux (1994) further maintains that the team should build an atmosphere conducive to open communication, co-operation and trust. The respondents were requested to rate their statements regarding problem identification and decision making according to the scale. The results in this section is presented in table 4.19.

Table 4.20 Problem identification and decision making

	1 Strongly agree	2 Agree	3 Neutral	4 Strongly disagree	5 Disagree
Individual problem identification	14(28%)	29(57%)	3(6%)	2(4%)	2(4%)
Open problem discussion in team meeting	18(35%)	22(43%)	7(14%)	3(6%)	1(2%)
Conflict situations dealt with constructively	9(18%)	20(39%)	13(26%)	6(12%)	1(2%)
Willingness to compromise	7(14%)	25(49%)	13(26%)	4(8%)	2(4%)
Openness to feedback/criticism	9(18%)	17(33%)	19(37%)	4(8%)	2(4%)
Decisions taken collectively	9(18%)	22(43%)	8(16%)	10(20%)	2(4%)
Decisions efficiently carried through	10(20%)	25(49%)	8(16%)	7(14%)	1(2%)
Communication channels effective	7(14%)	22(43%)	12(24%)	7(14%)	1(2%)
Problems identified by the team	10(20%)	26(51%)	10(20%)	3(6%)	0(0%)

N=51

- **Individual problem identification**

Fourteen (28%) respondents strongly agreed that individual team members identify problems. Twenty-nine (57%) respondents agreed that problems are identified by individual team members.

- **Problem discussion in team meetings**

Eighteen (35%) strongly agreed that these problems are discussed in team meetings. A further twenty-two(43%) respondents also agreed that the problems are discussed in team

meetings. These findings are consistent with the assertions of Scholtes(1988) who suggested that team members should identify problems and openly discuss them in team meetings. The openness in team discussions is very important for the emotional and professional development of the individual members of the team. This could enhance confidence and team member's performance within the team (Pappas,1994).

- **Dealing with conflict situations**

Nine(18%) respondents strongly agreed that conflict situations are dealt with constructively by the team. Twenty-two(43%) respondents also agreed that conflict situations are dealt with constructively by the team. Brody(1993) has found that a team leader should be skillful in conflict resolution and fight anything that may hamper the progress of the team. Brody(1993) also asserts that the team members should identify the sources of conflict before it can be dealt with by the team.

- **Willingness to compromise**

Seven (14%) respondents strongly agreed that team members are willing to compromise, and twenty-two(43%) respondents also reported that team members are willing to compromise.

- **Openness to feedback/criticism**

Seven(14%) respondents strongly agreed that team members are open to criticism, and 17(33%) respondents also agreed that team members are open to criticism. Scholtes et al(1988) and Kinlaw(1993) warn that team members should be open to criticism. However, the team members who criticize others should do so sensibly.

- **Collective decision making**

Nine(18%) respondents strongly agreed that decisions are taken collectively by the team. Twenty-two(43%) respondents also agreed that decisions are taken collectively by the team. Maddux (1994) maintains that collective decision-making and collaboration in

teams reinforce mutual support and commitment to achieve desired goals. Jennings & Wattam (1998) believe that an effective team is the one that takes decisions collectively.

- **Carry through the decisions**

The results also show that decisions that are taken by the team are carried through. Ten (20%) respondents strongly support this view. Twenty-five(49%) respondents also agreed that decisions taken by the team are carried through.

- **Effectiveness of communication channels**

Seven(14%) respondents strongly agreed that communication channels used by their teams are effective. Twenty-two(43%) respondents also agreed that their communication channels are effective. Kinlaw(1993) maintains that the team should model quality communication, and it should be centered around what the team wants to achieve.

- **Problem identified by team**

The results indicate that ten (20%) respondents strongly agree that the team identifies the problems. Twenty-six (51%) respondents also agreed that the team identifies the problems.

4.10.4 Team leadership

Team leadership is vital for effective functioning of the team. The success of a team depends on its effective co-ordination by the team leader. The respondents ranked their responses in this regard according to the rating scale. Table 4.20 reflects the responses of the respondents.

Table 4.20 Team leadership

	1 Strongly agree	2 Agree	3 Neutral	4 Strongly disagree	5 Disagree
Leader emerges from team	8(16%)	13(26%)	6(12%)	10(20%)	7(14%)
Team leader effectively co-ordinates daily activities	6(12%)	9(18%)	17(33%)	10(20%)	8(16%)
Team delegates tasks among its members	8(16%)	28(55%)	7(14%)	4(8%)	2(4%)
Team is effectively facilitated/guided	11(22%)	25(49%)	6(12%)	2(4%)	5(10%)

N=51

- **Leader emerges from the team**

The results show that eight (16%) respondents strongly agreed that the team leader emerges from within the team. Thirteen (26%) respondents also agreed that the team leader emerges from the team.

- **Coordination of the daily activities**

The results also reflect that the team is effectively co-ordinated by the team leader. This is confirmed by six (12%) respondents who strongly agreed with this statement, and a further nine(18%) who agreed with this this statement. The findings are supported by Brody(1993) that the team leader is a taskmaster who co-ordinates the team to ensure that tasks are performed by team members.

- **Delegation of tasks**

Eight (16%) respondents strongly agreed that the team delegates tasks among its members. Twenty-eight(55%) respondents also agreed that the team delegates the tasks

among members. Mears & Voehl (1994) believe that when action is taken, clear assignments are made and accepted.

- **Facilitation of team**

The results also reflect that 11(22%) respondents strongly agree that the team is facilitated effectively. Twenty-five (49%) respondents agreed that the team is facilitated effectively. The findings are supported by Wellins et al(1991) who maintained that the team leader assists the team members in accomplishing the responsibilities of the team.

4.10.5 Team effectiveness

The team should constantly measure its effectiveness. This helps in ensuring that the team provides relevant services. The respondents ranked their responses in this regard according to the scale provided. Table 4.21 presents the responses of the respondents.

Table 4.21 Team effectiveness

	1 Strongly agree	2 Agree	3 Neutral	4 Strongly disagree	5 Disagree
Adequate supervision provided by the team	12(24%)	23(45%)	6(12%)	8(16%)	2(4%)
Good co-operation within the team	13(26%)	25(49%)	8(16%)	4(8%)	1(2%)
Team allows for professional differences and work ethics	16(31%)	21(41%)	8(16%)	4(8%)	2(4%)
Time managed efficiently	7(14%)	24(47%)	12(24%)	7(14%)	1(2%)
Members developed within the team	10(20%)	28(55%)	10(20%)	3(6%)	0(0%)
Members learn from the team	18(35%)	26(51%)	3(6%)	3(6%)	1(2%)
Members accountable to the team	16(31%)	30(59%)	4(8%)	0(0%)	1(2%)
Team work well together	16(31%)	25(49%)	7(14%)	3(6%)	0(0%)
Members accountable to department	19(37%)	31(61%)	0(0%)	0(0%)	1(2%)
Team functions efficiently	13(26%)	26(51%)	8(16%)	4(8%)	0(0%)

N=51

- **Supervision provided by the team**

Twelve (24%) respondents strongly agreed that there is adequate supervision provided by the team. Twenty-three(45%) respondents also agreed that the team provides adequate supervision. The findings are consistent with the findings of Smith(1993) that adequate supervision should be provided to the team members.

- **Team co-operation**

The results show that co-operation exists within the team. Thirteen (26%) respondents strongly agreed to this, and twenty-five(49%) respondents also supported this statement.

- **Professional differences and work ethics**

Sixteen (31%) respondents strongly agreed that the team allows for professional differences and work ethics, and twenty-one(41%) respondents also believe in this statement. Mears & Voehl (1994) assert that because team members act as resource leaders without power a struggle. The issue is not about who controls the team, but instead on how to get the job done.

- **Time management**

The results show that the team manages time efficiently. Seven(14%) and twenty-four(47%) respondents strongly agreed and agreed with the fact that efficient time management by the team. It is important for team leader to ensure that the team manages its time efficiently (Kinlaw,1993).

- **Development of members**

Ten(20%) respondents strongly agreed that they developed within the team. Twenty-eight(55%) respondents also agreed that they developed within the team. Eighteen(35%) strongly believe that they have learnt from the team.

- **Learning from the team**

Twenty-six (51%) respondents indicated that they have learnt from the team. Ovretveit(1993) maintains that the learning process extends the repetoire of skills and knowledge of the team members.

- **Accountability to team**

Sixteen (31%) respondents strongly agreed that they are accountable to the team. Thirty(59%) respondents also agreed that they are accountable to the team in which they function. The findings are in contrast with Garner's assertion that the primary loyalty of the team members is usually to their disciplines rather than to their teams(Garner, 1994).

- **Team working together**

Sixteen (31%) respondents strongly agreed that their teams work well together. Twenty-five(49%) respondents also agreed that their teams work well together. Pappas(1994) also maintains that the team should work collaboratively to effect change.

- **Accountability to departments**

Nineteen(37%) respondents strongly agreed that they are accountable to their departments. Thirty-one(61%) respondents also agreed that they are accountable to their departments. This is in line with Garner's (1994) opinion that the primary loyalty of the team members is to their departments rather than to their teams. However, the results indicate that the team members are accountable to both their teams and departments.

- **Team functioning**

Thirteen (26%) respondents strongly agreed that their teams function efficiently. Twenty-six(51%) respondents also agreed that their teams function efficiently. Mears & Voehl(1994) suggests that the team should strive for excellence, should help team members gain inner and interpersonal control over their actions, and to become engaged in developing competence, confidence and trust in themselves and other team members.

4.11 SUMMARY

The results show a fair representation of participants from the three psychiatric institutions involved in the study. It also reflects the different disciplines working in a psychiatric institution.

The study shows that the many of the teams in the admission unit in a psychiatric institution consist of five team members. This seems to be an adequate composition for a team as indicated by the respondents in the study.

Most teams have team leaders who effectively co-ordinate these teams. According to the respondents in the study, a team leader is selected by virtue of his/ her discipline.

The respondents indicated that all team members engage in different activities and tasks to ensure quality service provision to the clients. These tasks are performed according to expertise that different team members possess.

The teams in the admission unit work according to prescribed admission procedures. These admission procedures are constantly monitored mainly by the nurses in the admission units.

The teams seem to function reasonably well with the co-ordination of the team by the team leader. Mechanisms, like team meetings, are put in place to effective and efficient functioning of the team.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Multi-disciplinary teamwork aims to provide a comprehensive service to the client system. The aim of the study was to present a theoretical framework explaining the role of a social worker in the functioning of a multi-disciplinary team in an admission unit of a psychiatric institution.

The objectives of the study are the following:-

- To describe the roles and functioning of a multi-disciplinary team and co-ordination among professionals in an acute admission unit of a psychiatric institution.
- To determine the responsibility of the social worker for assessment and the designing of the intervention plan for the client in an acute admission unit.
- To investigate the functioning of teams in an acute admission unit of a psychiatric institution.

The first objectives was attained in chapter two of the literature study. The second objective was obtained in chapter three of the literature study. The last objective was

reached by the execution of the empirical investigation which was described in chapter four.

The researcher drew some conclusions from the results of the study. Recommendations will also be made and presented in this chapter.

5.2 CONCLUSION

The following conclusions were drawn based on the findings of the study.

5.2.1 Composition of the team

Based on the findings of the study, it is concluded that the three psychiatric hospitals that participated in the study have multi-disciplinary teams. There is a fair distribution of professionals from different disciplines represented in the multi-disciplinary teams. These different professionals work in collaboration with one another for the benefit of the client system. The average team consists of five to six team members and functions adequately. The teams have a leader to co-ordinate their activities in performing their tasks.

5.2.2 Functions, roles and responsibilities of the multi-disciplinary teams

The team members perform different functions and roles according to their areas of expertise and training. However, these functions and roles seem to overlap which might lead to role blurring and, in extreme cases, even professional conflict.

All the team members perform assessmentS as part of their functions, although assessment is done for different reasons. A great proportion of the respondents assess the presenting problem of the clients while a small proportion of the respondents assess the clients for admission to a psychiatric hospital.

The findings also lead to the conclusion that data collection is done by every member of the multi-disciplinary team. The results also reflect different sources from which information about the client can be obtained.

The results also reflect that the team members are involved with planning and implementing intervention for clients. The intervention plans for clients involve different aspects that reflect the specialization of different disciplines working in the admission units of a psychiatric hospital.

5.2.3 Admission procedures

The conclusion can be drawn that a mission statement exists in the psychiatric hospitals. There is an awareness among the team members of this mission statement. It is also indicated that the teams work in accordance with these mission statements. Over and above the awareness of the mission statements, the teams work according to certain prescribed procedures developed by the teams. The nurses however, take a leading role in maintaining the procedures. These procedures are viewed by the respondents to be effective.

The teams have structured programs for the management of the patients admitted to the admission units. The nurses are the members most responsible for monitoring the implementation of the program.

5.2.4 Dynamics of the team

The roles of the team members are clearly defined and so are those of other team members. These roles are defined their departments rather than by their teams.

The teams often have team meetings whereby different team members give feedback about their activities. In these meetings, team members are open and honest about their feelings and arguments. It can be deduced that team members try to be objective in their assessment of issues within the team. All team members identify problems and discuss them in team meetings. Decisions are taken collectively in these meetings therefore bindings to all members of the team.

The teams seem to be well co-ordinated by the team leader who is normally a doctor by virtue of his/ her profession.

6. RECOMMENDATIONS

The following recommendations are based on the conclusions drawn from the findings of the study.

It is recommended that:

6.1 Team composition

- The composition of the multi-disciplinary team should be carefully planned according to the needs and expertise required for the effective performance of tasks in the acute admission unit of the psychiatric hospitals. It is also recommended that the team members should be consulted about which team members should join the team..

6.2 Team leader

- The team leader should be a person that is capable of co-ordinating a team of different professional groups and should not necessarily be a person with a medical background.
- The team should actively participate in the selection of a team leader in order to build a sense of belonging and respect for the leader and members of the team.

6.3 Accountability

- The different professionals who provide a service in the acute admission units and hospital management should clarify the team members' accountability to the team and to their professions.

6.4 Role performance

- The team members should clearly define their roles to render effective services to clients and to avoid role blurring.

6.5 Team membership

- Team members should be allocated to the team rather than selected by the team. The team members should indicate the expertise and kind of experience they require in their teams before a person is allocated to it. The team should also be sensitive to the learning needs of the members joining it at any stage of the process.

6.6 Team meetings

- Team meetings should be structured in such a way that they address the developmental needs of the team members, and the clinical or psychiatric needs of the client system. Sensitive issues that have a potential for conflict should be addressed carefully in meetings specifically designed for such issues.

FURTHER RESEARCH

- An explorative study should be done on multi-disciplinary teamwork in a psychiatric institution and focus groups should be used for data collection.

- Research should be done on the implications of the proposed Mental Health Care Act of 1999 and the results should be used to design a training program for social workers who want to work in the field of psychiatry.

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Multi-disciplinary Teamwork in a Psychiatric Admission Unit

University of Stellenbosch

MULTI-DISCIPLINARY TEAMS QUESTIONNAIRE

A BIOGRAPHICAL INFORMATION

Could you please fill in the following:

Hospital: _____

Department: _____

Please answer the following questions:

1. What was/is your current position in the hospital? _____
2. What are your qualifications? _____
3. Do you have any specific training in psychiatry? YES NO

   If YES, what is the nature of training? _____
4. Do you have any experience in applying your acquired knowledge in psychiatry *(Please tick ✓ the applicable block)* YES NO

   If YES, how many years of experience? _____
5. Have/ are you ever worked in an admission unit? YES NO

   If YES, How long? *(years or months)*? _____
6. Did /do you have a multi-disciplinary team in your admission unit? YES NO
7. Were/Are you part of this team? YES NO → Why not?

   _____

   _____

B COMPOSITION OF THE TEAM

8. How many people were/are there on your multi-disciplinary team? *(Please tick ✓ the applicable block)*

2 people	3 people	4 people	5 people	Other *(Please specify number)*:

9. Which of the following people were/are there on the team? *(Please tick ✓ the applicable blocks)*

Psychiatrist	☐
Social worker	☐
Medical Officer	☐
Occupational Therapist	☐
Nurse	☐
Clerk	☐

Others *(Please specify)*: _____

10. In your opinion, was/is the composition of the team adequate in its current state? ☐ YES ☐ NO

If NO, provide a reason for your answer: _____

11. How do you see your-self in the team? _____

12.

12. Did/do you have a leader or co-ordinator or for the team? *(Please tick ✓ the applicable block)*

☐ YES ☐ NO

13. Who was/is the leader of the team? *(Specify the discipline of the leader)* _____

14. How was the team leader selected? *(Please tick ✓ the applicable block)*

Vote	☐
Seniority	☐
Qualifications	☐
Experience	☐
By appointment	☐
By virtue of discipline	☐
Departmental selection	☐

Other *(Please specify)*: _____

15. How did you become a member of the team? *(Please tick ✓ the applicable block)*

Allocated by Department ☐ Other *(Please specify)*: _____

16. How long has your team been functioning? *(Please tick ✓ the applicable block)*

Less than 6 months	6 months to 1 year	1 – 2 years	More than 2 year

C FUNCTIONS, ROLES & RESPONSIBILITIES

17. What functions do you fulfill within the team? *(Please tick one or more of the following functions below and provide some specific details)*

BROAD FUNCTIONS	✓	***Please provide some specific details:***
a) Assessment		
Clerk the patient on admission		
Assessing presenting problem		
To assess for admission		
b) Data Collection		
Interviews with patients		
Interviews with family and/or other		
Contact with other agencies		
Peruse previous records		
Mental State Examination		
History Taking		
C) Intervention		
Planning for intervention		
Prescribe medication		
Intervention / treatment / therapy		
Liase with outside agencies		
Refer patients to other agencies		
Follow-up intervention		
Escorting patients		
Other *(please specify)*		

18. What is your role in the team? _____

_____

_____

19. What are your responsibilities in the ward? _____

_____

_____

20. In your view is your team effective compared to other teams within the institution ?

_____

_____

_____

21. Do you see your team as unique compared to other teams in the hospital? YES NO
Please explain your answer: _____

_____

_____

D ADMISSION PROCEDURES

22. Are you aware of the mission statement of the institution? YES NO

If YES, Was/is the team's work in line with this mission statement? YES NO
If NO, please explain your answer:

_____

_____

_____

_____

23. Did/do you have specific prescribed admission procedures? YES NO

If YES, who is responsible for drafting the specific procedures?

Admission team	Administration	Other *(please specify)*

24. Were/ are these specific procedures effective? YES NO
Please explain your answer _____

_____

_____

25. Who was/is responsible for checking that the admission procedures are followed?

Doctor	Nurse	Other *(please specify):*

26. Was/is there a structured program for the management of the patients? YES NO

27. Who was/is responsible for maintaining the program?

Doctor	
Nurse	
Social worker	

Other *(please specify)* _____

28. In your opinion, was/is the structured program effective for the management of the patients? YES NO

Please explain your answer:_____

_____

_____

DYNAMICS OF THE TEAM

29. Please rate the following statements about the dynamics of the team using the following scale:

= Strongly agree
B = Agree
C = Neither agree nor disagree
D = Disagree
E = Strongly disagree

STATEMENT	RATING *(Circle the applicable letter)*				
TEAM ROLES					
Your role was/is clearly defined within the team	A	B	C	D	E
Other team members roles were/are clearly defined	A	B	C	D	E
Your role was/is determined by the team	A	B	C	D	E
Your role was/is determined by your profession / discipline	A	B	C	D	E
TEAM MEETINGS					
You often had/have team meetings	A	B	C	D	E
There were/are regular feedback sessions / meetings	A	B	C	D	E
Discussions within the team were/are open and honest	A	B	C	D	E
Your contribution was/is valued by the team	A	B	C	D	E
PROBLEM IDENTIFICATION AND DECISION MAKING					
Problems were/are identified by individual team members	A	B	C	D	E
Problems were/are openly discussed in team meetings	A	B	C	D	E
Conflict situations were/are dealt with constructively in the team	A	B	C	D	E
Team members were/are willing to compromise	A	B	C	D	E
Team members were/are open to feedback/criticism from other members	A	B	C	D	E
Decisions were/are taken collectively	A	B	C	D	E
Team decisions were/are efficiently carried through	A	B	C	D	E
Communication channels were/are effective	A	B	C	D	E
Problems were/are identified by the team	A	B	C	D	E

TEAM LEADERSHIP	A	B	C	D	E
The leader emerged/emerges from within the team	A	B	C	D	E
The team leader effectively co-ordinated/co-ordinates your daily activities	A	B	C	D	E
The team delegated/delegates tasks among its members	A	B	C	D	E
The team was/is effectively facilitated / guided	A	B	C	D	E
TEAM EFFECTIVENESS	A	B	C	D	E
Adequate supervision was/ is provided by the team	A	B	C	D	E
There was/ is good co-operation within the team	A	B	C	D	E
The team allowed/ allows for professional differences and work ethics	A	B	C	D	E
Time was/ is managed efficiently by the team	A	B	C	D	E
You had/ have developed within the team	A	B	C	D	E
You learnt/ learn from the team	A	B	C	D	E
You were/ are accountable to your team	A	B	C	D	E
The team worked/ works well together	A	B	C	D	E
You were/ are accountable to your department	A	B	C	D	E
The team functioned/ functions efficiently	A	B	C	D	E

Please post or fax the questionnaire to: Ms Thulisile Gannyaza
B562 Mbolwa Crescent
Khayelitsha, 7784

OR

Head of the social work department in your respective hospital.

THANK YOU FOR YOUR PARTICIPATION IN THE RESEARCH!