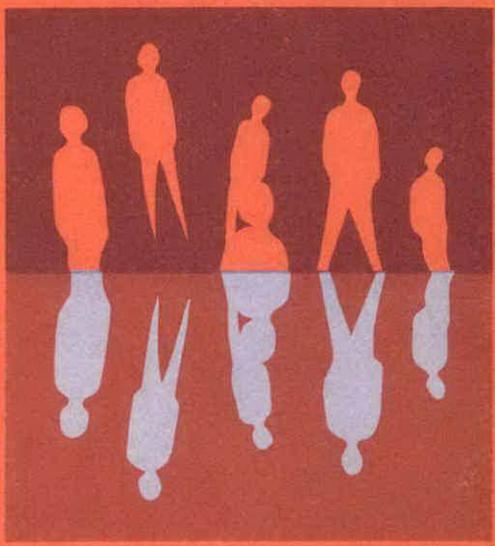


Kane

training for teamwork

with an annotated bibliography of teaching materials



by
Rosalie A. Kane

The Division of Continuing Education and Manpower Development of the Syracuse University School of Social Work conducts manpower research, consultation, curriculum development, and offers training programs for all levels of social welfare personnel.

Please direct inquiries to:

Director
Division of Continuing Education and Manpower Development
Syracuse University School of Social Work
Brockway Hall
Syracuse, New York 13210

This monograph is part of a series of publications which addresses social work manpower issues. The Division is delighted that the distinguished educator and researcher, Dr. Kane, has allowed us to publish this significant study.

1975

TRAINING FOR TEAMWORK
with an annotated bibliography of teaching materials

by
Rosalie A. Kane

Manpower Monograph Number Nine

Rosalee Kene

TABLE OF CONTENTS

Chapter	Page
I. HISTORICAL PERSPECTIVES	1
II. SOME EDUCATIONAL ISSUES	8
III. OBJECTIVES FOR COMPETENCE IN INTERPROFESSIONAL TEAMWORK	16
REFERENCES	27
APPENDIX	31

Chapter I

HISTORICAL PERSPECTIVES

For decades, social work educators have recognized that much of professional practice is conducted on inter-professional teams and, beyond that, that the professionals in the helping and healing services are necessarily interdependent. Translating this conviction into curriculum for social work students has posed a number of ideological and practical problems. Legitimate questions have been raised as to the appropriate point in the social work curriculum for introduction of material related to interprofessional collaboration. It is debated whether such content is best conveyed through courses offered in separate professional schools, through interdisciplinary ventures with students and faculty from a number of professional disciplines, or through a continuing education approach involving more seasoned professional practitioners. Some authorities advocate all of these modalities.

Before learning experiences can be designed, educational objectives are required. Again the social work educator is faced with a dilemma. Does social work practice in interprofessional contexts lend itself to a generic course with a single set of objectives? Or is social work practice so related to particular settings that it must be taught in specific contexts such as health, education, corrections and a myriad of others? This issue is an old one in social work education but it particularly comes to the fore in a consideration of team practice.

In any event, the competencies desired in inter-professional teamwork must be delineated in terms of knowledge, skills, and attitudes, before decisions can be reached about the best curricular arrangements for attaining these objectives. It must be emphasized, moreover, that interprofessional content is just one of many competing concerns that the curriculum planner juggles in designing a social work education program. The amount of attention to the subject in social work educational literature is really rather slight; assembling the comments together as is done here exaggerates the importance of the theme to social work educators.

Professional Interdependence

Since its inception in 1965, The Journal of Education for Social Work had occasionally published articles highlighting the interdependence of knowledge in different professional spheres. In the first volume, the theme was introduced (Duce, 1965) that it is insufficient for each profession to make a unique contribution to modern problems, but rather that "all disciplines must be brought together in a mutually influential way [p. 14]." In a later issue, Lowy (1967) drew attention to the marked similarities of skills and approaches that exist in the professions. Pointing to the widespread existence of interprofessional collaboration in practice, if not in education, he urged social workers to develop skills in communicating as team members. David (1967) developed the same theme, insisting that in our complex society, each practitioner can have only a partial understanding of human problems. He urged that each professional education system take responsibility not only for formally defining its own functions and skills but also for defining the nature of its interrelationships with other human services and for conveying this insight to its students.

From the vantage of his detailed study of social work curricula, Boehm (1968) noted a shared perspective and ideology among human service professions such as education, medicine, law and social work. Referring to a "necessary interdependence of social, economic, legal and political factors," he suggested that students should understand the common perspectives of other helping professions and "the functional differentiation among the major helping professions with which social work comes in contact [p. 22]."

In recognition of the interdependence of knowledge and the close association of social work and other professions, a number of conferences and symposia were held in the fifties and sixties which assembled educators from social work and from other professional disciplines. Explorations were undertaken to determine the relationship between teacher education and social work education (Beck, 1965; Johnson, 1962) and between social work and public health (Public Health Concepts, 1962). Such deliberations not only attempted to identify concepts from other professions which might be utilized in social work education, but also recognized the advantages of exposing social work students to students of other fields. At a conference

devoted to health and disability concepts in social work education, a physician (Haggerty, 1964) urged that medical students, nursing students, and social work students be exposed to models of effective inter-professional teams while in student status and work with these teams in action.

At such conferences, the point was frequently reiterated that the students of one profession should learn the premises and expectations of practitioners of other cooperating disciplines. Referring to teachers and social workers, Johnson (1962) stated that each needed "a set of organized expectations of self-roles and statuses and an understanding of the other person's roles and statuses [p. 167]." A very ambitious knowledge component regarding other professions was suggested as curriculum content in medical social work (Lewis, 1951):

Specialization results in the need for teamwork. The patient is in direct contact with and is being served in some capacity by a variety of persons--not only physicians and nurses, but also laboratory technicians, dietician, physical therapist, occupational therapist, social worker, etc. In order that the comfort and recovery of the patient be kept the focus of all activity, each participant in the care must be able to coordinate his services with those of the others. . . The social worker must know something of the structural organization, educational preparation, responsibilities, common methods, and forms of recording of each professional group [p. 13].

The above is a difficult suggestion. To learn about the structural organization, educational preparation, responsibilities, common methods, and recording forms of each of the many professional groups in the health field is perhaps unrealistic, but the thrust of the argument is clearly in favor of educational preparation for team practice.

Although social work education has not fully espoused plans for educating its students in teamwork skills, the lag is not because the interdependence of professions has gone unrecognized. Perhaps a more urgent agenda of establishing and consolidating a

knowledge base and skill repertoire took precedence. Part of the necessary skill and competence of each team member, according to Horwitz (1959, p. 43), calls for an ability to summarize one's own professional activity concisely in terms of goals, activities, and results of those activities. Such an ability presupposes a firm grasp of the essential social work theory and philosophy.

For many decades social work educators have been preoccupied with development of a body of theory, and have been more concerned with points of distinctness from than similarity with other professions. Kendall (1956) made this point well:

We have been much too occupied--and rightly so at this stage in our development--in forging our own distinctive educational program at the graduate level within the university structure to invite or welcome interdisciplinary and interprofessional educational planning [p. 115].

Feeling that this developmental work of the profession was now largely complete, she urged that social work educators seek out activities with other professional disciplines, especially in health and education, so as to arrive at "cooperative and composite training for all . . . in the fields that 'teach, heal, serve, or nurture' [p. 111]."

Teamwork Objectives in Master of Social Work Curriculum

The 1959 Curriculum Study

The landmark, thirteen-volume study of social work curriculum undertaken in 1959 unexpectedly highlighted the need for content designed to increase skills in interprofessional teamwork. The theme recurred in the material devoted to content in the various methods and in the fields of practice.

The would-be community organization specialist (Lurie, 1969) was expected to develop skills in collaborating with both professionals and volunteers, and was seen as needing concepts in team development and leadership. Similarly the objectives for the administration area (Spencer, 1959) included the ability to work with colleagues of other professions as part of a staff team. In the volume devoted to education for social group work, Murphy (1959) indicated that respondents and commentators had given unexpected attention to the deficiencies of the educational system in teaching students to develop and maintain collaborative relationships. This skill was deemed particularly crucial for the group worker, and schools of social work were criticized for

"perpetuating stereotypes and lack of appreciation of other professions which interfere with the group worker's performance [p. 45]."

Konopka (1959) contributed a statement on teamwork which was appended to the volume on social group work. Group workers, she pointed out, work on teams in clinical and institutional settings and also in traditional neighborhood settings where they must collaborate with nursery school teachers, recreationists, artists, nurses, and, of course, social caseworkers. Even in programs such as camping where the team concept is not highly developed, Konopka felt the future group worker should be able to establish teamwork and identify roles for other professionals. Logically enough, Konopka suggested that the group worker should be able to utilize his knowledge of group dynamics to assist the team process and help each team member maximize his contribution.

The volume devoted to education of social workers for the rehabilitation field (Horwitz, 1959) gave extensive attention to interprofessional teamwork, indicating that students require first-hand experience with teams in operation. The students were expected to familiarize themselves with colleagues of other professions, including their expectations, skills and characteristic approach to problems. In addition, the student should learn to communicate his own goals and expectations as a professional social worker on the team. Attitudinal objectives were also stressed; the student was expected to respect the expertise of colleagues from other professions and to learn that "social workers are not the only ones concerned with 'the whole man' [p. 45]."

Calling correctional institutions "multidiscipline bureaucracies," those examining the competencies needed for social work in the corrections field (Studdt, 1959) gave high priority to interprofessional collaboration. Decisions are made within the framework of the values of the legal profession and then are carried out with teams that include psychiatrists, psychologists, social workers, teachers, medical personnel and religious advisors. Since personnel in corrections tend to work in ways not anticipated in their basic professional training and since all are products of their own professional socialization, communication difficulties ensue and lack of clarity about job responsibilities is common.

A number of educational objectives were proposed to meet the need for competent teamwork in corrections; these objectives were divided into knowledge, skills and attitude components. In the knowledge category, the social worker was expected to understand the interrelationships of systems in the administration of criminal justice, know the roles and functions of various personnel in the

system, and understand the traditions, values, skills, and reference group of the legal profession as well as other professions with whom social workers more traditionally collaborate. The skill objectives included an ability to articulate and implement the social work role and to communicate in "teamwork with sociologists, lawyers, police and custodial personnel as well as representatives from the helping professions [p. 44]." Among the attitudes considered important were an acceptance of the traditions, functions, values and educational background of various kinds of personnel, a willingness to learn from and work with those whose contributions differ from the social worker, and acceptance of the need to work with a structure as well as with individual relationships with clients.

1969 Curriculum Statement

Much emphasis has been placed on the 1959 study because the several volumes did make a beginning of formulating objectives for interprofessional teamwork. These objectives were generally cast in the framework of a particular field or method rather than established in a generic way for the whole profession. They therefore entered specifically into the kinds of professionals with whom the social worker in a given field should be able to work.

Despite the impressive list of objectives derived from the 1959 study, few examples have been found in social work literature which describe attempts to implement them. The 1962 Curriculum Policy statement which emerged from the curriculum studies established the familiar organization of subject matter into core areas and sequences. The concept of continuity and sequencing in learning dominated social work education in the sixties. Perhaps this thrust accounts for the fact that various scholars (Johnson, 1962; Konopka, 1959; White, 1960) stressed that interprofessional content must be cautiously and planfully introduced.

A general belief seemed to prevail that a student must first become confident in his own experiences before he is plunged into interprofessional practice experiences. Dana and Sheps make this point clearly (1968):

Unless the student enters into interprofessional learning with the security such an image and identity provide, he is in the unfortunate position of pooling his ignorance and confusion with the ignorance and confusion of others in what then becomes the collective exercise of irresponsibility [p. 41].

This argument has merit and is still maintained by many educators in different fields. (Briggs & Van Voorst, 1974).. Others, however, believe that interprofessional exposure cannot begin too soon.

Caution about premature exposure to out-of-sequence ideas may have delayed experiences in interprofessional education for social work students in the sixties.

The 1969 statement (Curriculum Policy, 1969) is less prescriptive than earlier versions, and under its aegis many schools have moved away from stepping-stone sequences. In keeping with the general tone of that document, specific content was left to individual schools to develop along broadly indicated parameters. One general objective is relevant to interprofessional collaboration. It states that the student should:

Recognize and appreciate the similarities and differences in the helping roles of various professionals and other personnel and in the problem-solving processes associated with services to individuals, groups, organizations, and communities.

The wording of this statement suggests that interprofessional teamwork exists at all levels of social work practice. The objective is so imprecise, however, that the several schools are left to forge out the specific operational objectives under this heading.

Chapter II

SOME EDUCATIONAL ISSUES

In planning interprofessional education, philosophical and practical issues emerge. Questions arise as to who should teach, what content should be introduced, when in the educational program should the input be introduced, and what learning experiences would best lead to competent team practice. Can interprofessional skills be taught in the classroom or are the learnings more appropriate to field instruction? It has even been suggested that each interprofessional team should undergo extensive training as a unit (Carlin & Carlaw, 1973), and that no generalized education can compensate for a shared learning experience with the actual working team. The extreme of this view suggests that each team is a constellation of personalities as well as of professions, and that teamwork needs to be relearned in each new context.

Does Teamwork Need Specific
Attention

White (1960) has observed that interest in collaboration and eagerness to work cooperatively with other professions is not a characteristic motivation of entering professional students. Educators cannot assume, therefore, that collaborative skills will develop automatically as clinical or other social work skills increase. Deliberate efforts seem to be required to bring about the desired results as far as skills and attitudes conducive to collaboration.

Increasingly teaching for teamwork is being carried out in agencies (Greenberg & Denham, 1968) since it is recognized that the personnel of the various disciplines do not know how to work effectively in teams.

Social work educators and practitioners have been involved with teaching medical personnel, particularly students and residents in medicine and psychiatry, about the social components of illness and the social work contribution to teamwork (Reece, 1965; Tanner & Carmichael, 1970; Phillips, McCulloch, Brown & Hambro, 1971). Accounts of such efforts always cite ways that social work educators have become planfully involved in educating other professions for teamwork through a demonstration of teamwork. There have been suggestions that the social work profession is more interested in teaching than in learning this skill. In a study of nursing schools

and schools of social work, Damman (1972) found that at least 75% of the nursing students learned about social work directly from social work lecturers or teachers, whereas the reverse was true at only 32% of the schools of social work. The author, a nurse, concluded with this criticism:

The social work faculty, it also appears, believed that the casual contact in the academic world and in the work experience situation would give their students sufficient knowledge to facilitate good working relationships with nurses [p. 163].

The problems encountered by team practitioners of all disciplines in working together refutes the assumption that casual contact is sufficient.

Identification with One's Profession

Social work educators cannot approach the subject of inter-professional education in absolute terms; solutions must be compatible with a theory about how students learn and a philosophical stance which assigns priorities to the various objectives of the social work educational programs. In two years of an MSW program, the educator strives to instill in the student the values, ethics, and history of the profession and to equip him with professional skills. Although an advocate of education for interprofessional teamwork, White (1960) puts the issue squarely:

All professional schools have the same curriculum problems; namely to limit the content so that the student has sufficient opportunity to learn what is distinct and essential to the practice for which he is preparing and, at the same time, to broaden his base of learning so that he perceives what is related significantly to his practice [p. 134].

A problem is posed, then, in terms of contradictory goals. David (1967) introduced another paradox of professional education, namely, reconciling the need for professional pride and commitment with the need to understand and respect other professional groups:

Every system of professional education must resolve, however reluctantly, the question of how it is to place in proper perspective the sense of pride, distinctiveness and self-protection that it consciously seeks to instill in students [p. 10].

For some social work educators the problem is complicated by a view that identification has a pivotal function in professional education, both as a goal and as a process. Towle (1964) strongly held that identification with the profession must be an objective; it is essential, she stated, "that learners in a given profession identify more closely with their own leaders than with leaders in related professions [p. 221]." For this reason, contributions of teachers and lecturers from other professions must be filtered through a social work educator to determine their relevance to social work practice.

Towle also believed that material simply borrowed, unaltered, from other professions remained, like a foreign body, unincorporated by the social work student. Identification with social work instructors activates the learning process. Students will identify themselves with their field instructors and model their behavior. According to Towle:

The part the field instructor plays in the collaborative team, in terms of whether he maintains his professional identity or loses it, is decisively important. It is essential that the social work educators be aware that the nature of their collaborative relationships will be pattern-setting for the students [p. 223].

Unfortunately many of the role models available for social work students are less than ideal exemplars of teamwork. Towle's argument is that a poor model of team practice is worse, for educational purposes, than no model at all. Horwitz (1970) would disagree with that position, however, since he contends that a student should be prepared to work in many different team arrangements, not just the best. According to Horwitz:

. . . there may be much to be learned even in team practice situations where status-jockeying presents a model of relationships the student need not be encouraged to emulate [pp. 139-140].

Horwitz does not really address how the lessons of the poor team will be made manifest to the student, especially if it is his field instructor who is demonstrating the undesirable model.

What Are the Objectives?

A recent conference on the relationship between medicine and social work (Rehr, 1974) gave some attention to the question of educational objectives in interprofessional endeavors. Discussion

centered around whether the goal was to teach professionals each other's skills, developing a "hybrid" professional or to develop an appreciation of each other's abilities. The preference of those at the conference leaned towards development of "combined understanding but separate talents [p. 62]."

The furthest extreme of developing shared talents is the joint degree, in which one individual becomes qualified and accredited in more than one profession. There seems to be some movement in the direction of joint degrees, yet questions may be raised about whether this is an economical use of training. Serious evaluation of joint credentialing is scarce in the literature; Curran (1971), however, did study the rather small group of people in the United States and Canada who possess both a medicine and law degree. His findings indicate that these persons rarely were able to use both educations in their work and tended to be regarded with suspicion by both doctors and lawyers.

If the objectives of interprofessional education are to render the delivery of services more rational by allowing for blurred or combined roles, then resistances are bound to occur among various professions. Arbuckle (1967), for example, urged an "ecumenical" movement in the education of school psychologists, school social workers and guidance counselors. Noting that the job descriptions of these personnel are very similar, he suggested a joint training program and a new title, "School Counseling Psychologist." Such a title would obviously be more acceptable to the author, a psychologist, than to a social worker.

A frank treatment of the implications of interprofessional education must at times leave the social worker wondering if such an endeavor is in the best interests of his profession. Social workers, it is pointed out, regard the discovery of social factors by the medical profession as a mixed blessing (Rehr, 1974):

These feelings of doubt are compounded by their uncertainty as to what their role and functions will be if the physician should acquire both the competency and the wish to deal with problems that have traditionally been considered social work's turf. On the one hand, they reject the definition of social work as the 'conscience of the hospital'; on the other hand, they have difficulty in anticipating their unique contribution to the exercise of a collective conscience [pp. 81-82].

Responding to Practice Needs

In a recent article, Andrew (1974) reported an effort at a school of social work to use a Delphi technique to forecast the future needs of social work practice. Participation in interdisciplinary treatment teams was an item with high consensus among the panelists, and participation in interdisciplinary social planning was another predicted task for MSW graduates in 1985. If such prediction tools have any accuracy, the message is a mandate for the development of interprofessional teamwork skills for social workers.

It has already been suggested (Vigilante, 1974) that the MSW level should be one of supervision, consultation, and moving into innovative program areas. It is somewhat paradoxical that the social worker must learn to work better with other professions to prepare himself for modern practice and yet at the same time must prepare himself to compete with other professions for the emerging opportunities in human services professions.

Certainly recent innovations in practice have again accentuated the importance of preparing social workers for teamwork roles. Community mental health centers have emerged in the last decade, and the case has been made that social workers should be prepared in an interdisciplinary fashion for mental health work (Bandler, 1973; Blanchard & Felsenburg, 1972; Smith, 1974). Since Blanchard and Felsenburg consider the ideal mental health team to be a democratic unit, they suggest that social work educators should minimize the student's dependency in the learning situation. Smith identifies psychiatry, psychology, social work, and nursing as the core mental health professions, and advocates a deliberately and carefully designed sharing of learning experiences for students of these professional schools. He cautions that mere permissiveness about shared electives or arranging for students to be thrown together in field work or seminars is insufficient. As he put it, "disciplinary proximity in learning situations does not necessarily constitute interdisciplinary training [p. 109]."

Responsiveness to demands of practice does suggest the current need for an emphasis on interprofessional teamwork in social work education. The question remains as to whether the social work response would be separate for all the fields in which social workers are employed or be cast in a generic framework, or whether both these approaches are needed.

Examples of Interprofessional Education

A considerable and growing body of literature is available describing programs of interprofessional education. Many such projects involve social work students and faculty. Even when social work students have not been involved, the experiences of other professional schools in arranging interprofessional learning experiences have implications for social work.

A common form of interprofessional offering allows students from different disciplines to form themselves into teams and undertake some task, thereby learning both a subject matter of common interest and techniques of teamwork. One such effort described recently (Linn, Stein, Carter & Linn, 1974) arranged for teams of a medical student, a nursing student, and a social work student to follow a geriatric patient upon discharge from a nursing home. The student team begins work in the pre-discharge planning phase and continues to offer primary care, with backup from appropriate faculty. A similar concept (Eichenberger & Gloor, 1969) sent teams of students into rural Appalachian communities to make health studies. In these instances the students commented favorably about the opportunity to engage in teamwork while still students. Tanner and Soularly (1972) report similar findings regarding team activity of medical, nursing and social work students in a family clinic.

Student experience with team activity seems to help them appreciate the interdependence of the various disciplines. This was true in the case of an ambitious project (Smith, 1971) which utilized students from ten disciplines in a program focused on one rural town. The students had the opportunity to recognize that questions raised by a geographer might be amplified by a nurse or a recreationist, or taken into a different tangent by a clergyman or business expert. Another report of a student team effort (Baktenica, 1970) organized student mental health teams in a school, and encouraged the group to examine the total school and community system. In this program, the preceptors were more interested in developing the team into a reference group than having the students practice the tasks associated with their particular profession. This latter activity, in fact, was discouraged so the students could develop a wider perspective.

An extensive experience with student teams is described in a monograph by Eichhorn (1973). Five teams of students, among them social work students, were sent for a summer to five Appalachian communities in unstructured situations where they were expected to develop their own tasks. Most of the students experienced role confusion and all went through a period of considerable crisis.

The students arrived with ideals about democracy and left with an ability to differentiate their particular roles. The students and project coordinator concluded that the experience, although painful at times, produced much learning and personal growth.

Rosenaar and Fuller (1973) report a project in which medical and nursing students were formed into teams and assigned a small patient load for whom they delivered primary care. As the students attempted to develop plans as a team, they encountered several difficulties in defining their roles, taking joint histories, and planning treatment jointly. The nursing faculty, in fact, had to develop a special seminar to help nursing students define roles and develop a history form for nursing use. Even so planning tended to be dominated by the medical student or to take place along parallel and separate lines. One might expect that social work students, plunged in a similar interprofessional program, would also need support from their faculty to achieve satisfactory learning experiences.

Large-scale interprofessional education programs are in existence; an example is in Vancouver where eight health science schools, namely medicine, nursing, dentistry, pharmacy, rehabilitation therapy, and, to a lesser extent, home economics, social work and psychiatry, participate in an interdisciplinary program (Szasz, 1970). A series of courses, workshops, weekend retreats, and other experiences have been arranged and evaluated. Szasz claims that he deliberately attempts to arouse anxiety in the student about the incompleteness of his understanding of human problems to encourage interprofessional affiliations. After several years of experience, the Vancouver program reports that students respond positively to interprofessional learning when they understand its rationale, that electives and off-campus programs are of particular value, that the medical faculty and students were less supportive of the effort than other participating schools, and most important perhaps, that the problem-solving modality seemed to be the most effective type of learning experience.

An account of the mechanics of introducing an interprofessional course (Yeaworth & Mims, 1973) is detailed in a description of the effort of an interdisciplinary committee to establish an offering on sex education. Viewing the introduction of a program as an "influence system," the authors maintain that the success of the venture depends on "who is willing to expend influence on interdisciplinary education under what circumstances [p. 696]." In this example, the final form of the course was dictated by a number of political trade-offs; the medical school committee was willing to include nurses and social workers to provide a better ratio of men to women, but since there was no incentive to include pharmacy students they were excluded. The authors also cite the numerous practical impediments to planning even one interdisciplinary course, including appointment of faculty, decision

of the level of course material, and obtaining permissions for students to be released from other obligations for attendance.

While interprofessional education is increasingly thought to be valuable and economical, it is also recognized as a threat to the disciplines involved. Leininger (1971), a strong advocate of interprofessional training, acknowledges that changing the undisciplinary values underlying the different curricula would be difficult. Yet she considers that the "linear-isolate" model of education in the health professions is expensive and perpetuates a status-bound delivery system.

Also commenting on the health field, an interdisciplinary task force (Continuing Education, 1966) concluded that interprofessional continuing education is crucial and yet, unlikely to succeed until faculties of professional schools begin forging professional ties. The threatening nature of the subject is illustrated by the report of a conference on collaboration of education and social work (Beck, 1965). When it was proposed that social workers and teachers might learn of each other by exchanging roles for a short time with teachers making home visits and social workers conducting classes, the conferees rejected this role-assumption with dismay. The suggestion was seen as a denial of the need for professional training.

Chapter III

OBJECTIVES FOR COMPETENCE IN INTERPROFESSIONAL TEAMWORK

Indisputably social workers should be prepared for interprofessional team practice, but specifying the nature of that preparation is difficult and controversial. A curriculum design for social work students can only be made across a bridge of objectives. The objectives, expressed as far as possible in behavioral terms, must delineate the knowledge, skills, and attitudes necessary for the effective team practitioner. Once terminal behaviors are identified, learning experiences suggest themselves readily and are only limited by the instructor's imagination (Kane, Woolley, & Kane, 1973).

Several organizing ideas underlie all the objectives suggested in this chapter. First is the conviction that competence for teamwork can be approached generically in a school of social work and need not be linked to a particular field of practice. It is apparent from an examination of practice that social workers are employed on teams in a wide variety of settings; it is also true that the fields of practice are blurring and becoming less distinct. Moreover, given all the possible collaborators any social worker might enjoy during his career and the enormous number of combinations of professionals who compose teams, it would be highly impractical to educate the social worker solely for a specialized practice setting or field. These objectives, then, are aimed at a general competence in team practice which is transferable from field to field.

A second organizing principle is that the objectives address preparing social work students to cooperate effectively with those of other disciplines, but not to perform their tasks. It is appropriate for a social work student to seek another professional degree either simultaneously with or following his social work education; such a student will be attempting to acquire more than one set of professional competencies. But the responsibility within the social work program is to prepare the student to function effectively as a social work practitioner on an interprofessional team.

An effort is made also to link the objectives to what social workers are required to do on the team. Social workers participate as team members and, less frequently, as team leaders. They should be prepared to understand both roles. Since social workers so often are involved in screening and referral procedures they should develop a particular expertise in these areas, breaking down the activities into the components of knowledge and skill required. And since evaluation of the interprofessional team is so necessary to the continued development of the

modality, social workers should be able to meet at least the knowledge and attitudinal objectives around team assessment, although perhaps the specialized skills are not necessary for all social workers.

Finally, the objectives suggested here do not presuppose that there is one formula for team organization and process that the student should master. Rather it is assumed that different team structures and patterns are effective for accomplishing different goals and that the student must learn to make reasoned judgments about appropriate team processes in given instances rather than simply to compare reality to a learned ideal model.

Perhaps, in the past, a comfortable assurance has existed that teamwork skills are learned by the student during the course of his field work assignments. Such an assertion is as hard to prove as it is to disprove. Certainly the practicum is the part of the curriculum where experiences are least consistent from student to student. Depending on the setting and the field instructor, the student may learn a great deal about interprofessional teamwork as part of his field work, although the focus will probably center around the particular professions employed in the agency. In other settings, the students may be exposed to poor teamwork models or no models at all. This chapter does not deal with the field work dimension of education for teamwork, but limits the discussion to the provision of a base for all students through classwork curriculum. The various field settings could then build upon this base in whatever specialized direction was appropriate.

With these general provisos, some educational objectives for competent social work practice on teams are suggested below. In most instances, they have a familiar ring and are already part of the social work curriculum in other contexts; this should make their integration all the easier.

Knowledge Objectives

Knowledge of Group Process

The student should understand the way group process can be utilized towards the achievement of group goals. He should have a grasp of the issues of small group process (see Kane, 1975) including individual behavior in the group, group norms, decision-making and

conflict resolution in groups, leadership, communication, and group harmony in relationship to productivity. He should understand the stages of group development, an insight which is part of the social group work curriculum.

Problem-Solving Processes

An approach to problem-solving is also frequently built into the social work education. In terms of teamwork, the student should know how to formulate a problem, set goals and priorities, implement tasks, and evaluate the achievement of the goals.

Evaluation

In terms of evaluation, the social worker may not need to understand all the nuances of research design, but he should know enough about the subject to understand the principles of measurement of effectiveness in comparison with a control group. He should be able to recognize the way results can be biased and have some knowledge of when one can draw conclusions from evidence. This knowledge is especially necessary because the social worker must be able to document the effectiveness of his profession's contribution to the team as well as contribute to the overall evaluation of the interprofessional venture.

Social Work Knowledge

It is assumed that the student who is competent to practice in an interprofessional team has mastered the knowledge objectives required of the social work student, so that he is capable of performing his own functions effectively. He should be able to articulate the contribution that social work can make to a given problem and to understand when social work has no appropriate solutions.

More specifically, since social workers are often at the doorway of the team, ushering clients in and arranging discharge or referral (Kane, 1975), the social worker should understand these processes. Both call for marshalling relevant data and making conclusions based on evidence. Both call for knowing how to engage other persons on behalf of the client and for knowing what other professional skills are needed as well as what resources are available in the community to support the team.

Characteristics of Professional Groups

The social worker should understand the nature of professions and of evolving professions; he should recognize concerns and needs which might arise which are peripheral to the team's function. These include concepts of status, power, role clarity and role-gratification. The social worker should recognize that incongruities between role expectations exist on interprofessional teams, and should know what some of these incongruencies tend to be in regard to the social work profession.

The social worker needs some knowledge of the attributes and skills of the collaborating disciplines on the team. Rather than approaching this knowledge in a rote-fashion through memorizing lists of attributes, the student should know how to acquire the information he might need about any given profession with whom he might have occasion to work on a team.

Organizational Structure

The student should understand how the administrative organization of the team affects the team processes. He will require some knowledge of basic administrative concepts such as line and staff authority and delegation of responsibility.

The student should also understand the levels of practice within his own profession and the functions and skills of paraprofessionals. Increasingly paraprofessionals of different disciplines serve along with the professional on the interprofessional team and the social worker should be prepared to suggest the tasks of each.

Knowledge of Teamwork

A growing literature on team processes themselves is available. The student should have enough familiarity with this body of knowledge to know that various team models do exist and the rationale for their use. For example, the student should probably be able to know the difference between a coordinate and integrative team (Horwitz, 1972). It is not suggested that the student approach any one writer on teamwork as an authority or a textbook, but that an exposure to the team literature be provided. Some of the theoretical writings on teamwork have been included in the annotated bibliography appended to this monograph.

Skill Objectives

Separation of knowledge and skill objectives is rather difficult; for each properly acquired segment of knowledge, a corresponding skill should develop. It is assumed, moreover, that the social work student will master the skills required of the graduating social worker. With these abilities to communicate, to interview, to empathize, and to analyze, the social worker should have in his repertoire ample skills for facilitation of the team process. Some skills particularly pertinent to effective teamwork are isolated below.

Group Process Skills

The student should be able to utilize group process effectively to help the team move toward its goals and to help achieve his own goals within the team. He should be able to facilitate the participation of others, recognizing when members are withdrawing from the group or dominating it. He should be able to articulate his own goals and help others articulate theirs. When serving as a leader he should be able to bring out skills of others and help the group reach consensus when possible or resolve conflict openly when agreement is not possible.

Communication Skills

As an important part of becoming a facilitator on the team, the social worker must be able to communicate clearly and accurately. He must be able to present information to a group, express feelings, listen accurately, give and receive feedback. He should be able to communicate without jargon, moreover, so that he can be understood by those of all disciplines.

Written communication is almost as important as verbal communication. He should be able to express himself clearly and succinctly in writing and have sufficient grasp of record-keeping skills that he can contribute to the team deliberations about appropriate shared recording.

Attitudinal Objectives

Self-Confidence and Self-Respect

The student should feel confident in his own ability as a professional and a person. He should believe that he has a contribution to make to the team. Without this security, he is unlikely to be an effective contributor to an interprofessional team.

Respect for and Confidence in Others

As well as respecting his own ability, the student should respect the abilities of the other professionals with whom he works. He should recognize that others with a different training and different approaches to problems are similarly motivated to serve the clients. He must be sensitive to and accepting of the fact that different professionals solve problems in different ways and accept the need of others for recognition and self-esteem.

Willingness to Share and to Trust

The effective teamworker must be willing to share a task. He must also be able to trust his professional colleagues. It is expected that the social worker on the team will accept and represent social work values and ethics. At the same time, he must be able to interpret values such as confidentiality in such a way that he does not belittle and distrust his teammates with information about the client or the problem.

Tolerance of Disagreement

The teamworker must accept the inevitable conflicts inherent in interprofessional teamwork and be able to work towards their resolution without undue anxiety, frustration, or anger.

Flexibility

The interprofessional teamworker needs to be able to tolerate a situation with a certain amount of ambiguity and change. The

team situation is not controlled by a single profession, and teams are created to evolve new solutions to difficult problems. The social worker on the team cannot be inflexible about his professional role or about adhering to a particular routine.

Research-Mindedness

The social worker should accept the desirability of testing different interprofessional arrangements in terms of their effectiveness. He should welcome research and participate in it rather than regard it as a threat to his team position.

Favorable Attitude Towards Intake and Referral Functions

At times social workers have regarded intake and referral functions as perfunctory and not involving a great deal of skill. An example is discharge planning and nursing home placement, often the first function to be delegated to a social work paraprofessional. In order to perform these tasks creatively and well, the social worker should recognize their great importance in terms of the life of the client and appreciate the degree of skill and judgment which are involved in helping clients make wise decisions. The social worker should view these services as important, skilled, and worthy of the professional social worker.

Learning Experiences

The above objectives are compatible with social work objectives in general and the content can be very easily integrated into the curriculum. Interprofessional experiences with other professional students from other disciplines are important and should be encouraged, yet are probably more useful after an understanding of interprofessional teamwork from the perspective of one's own profession has been achieved. This contention is supported by the experience of a nursing school which arranged team experiences for medical and nursing students (Rosenaur & Fuller, 1973); the authors discovered that it was necessary to introduce special training for the nursing students alone so that they would know how to function competently and confidently in joint enterprises with the medical students. With some introduction to team concepts and the social work contribution, the social work student will be able to make better use of team experiences which may occur during his field work education.

Szasz' (1970) observation that students learned about teamwork best through problem-solving does seem pertinent. It would be possible to arrange many learning experiences for students which involved a problem-solving dimension. It would also seem desirable to adhere to Bruner's (1960) emphasis on discovery and to arrange educational experiences which permit the students to discover for themselves the ingredients of effective teamwork.

The desired terminal objectives suggest the learning experience. To meet the goal of helping practitioners acquire the necessary knowledge of the attributes of other professions, a task might be designed in which students drew the name of a profession and proceeded to discover what they needed to know to cooperate with its representative. This could be achieved by interviewing graduates of that profession, scanning the professional journals, and becoming aware of any role or status considerations that have been historically important to the profession. The value stance of the profession could be examined as well as the characteristic approach to human problems.

To assist a student in achieving the goal of clear, jargon-free communication, he could be asked to translate social work materials into readily understood language. Oblique ways of interprofessional communication have been described (Stein, 1967); these could be examined for their effectiveness and alternative modes suggested.

Students could be asked to analyze reports of interprofessional practice in order to assess the communication process, the leadership patterns, the extent the task focus was shared, and the mechanism to evaluate effectiveness. A number of accounts of team practice are described briefly in the appendix. Students could utilize the materials to critique both team process and also social work role.

The accounts of teamwork in action, annotated in the appendix, were not generally written with the primary purpose of explicating teamwork. They therefore offer the student an unobtrusive glimpse into the mechanics of team practice. Examples are included which give substance to many theoretical issues. Should the client be a member of the interprofessional team? Should an organization based on teamwork retain professional departments? Were paraprofessionals utilized effectively on the team? Is an interprofessional management team effective in monitoring teams in the field? Similarly, the student can ask whether the social worker was applying social work knowledge, skills and values appropriately.

Was he making a unique contribution to the team? Could the social worker have suggested a different role for himself or different team processes?

Role-playing is a ready technique to dramatize teamwork situations and incidents in the classroom. Through role-playing, students can practice entering empathically into the experience of a member of another profession. Problem-solving skills for the inter-professional team can also be introduced through experiential exercises. A class might approach the problem of reformulating team goals and activities to meet new circumstances by forming mock teams and generating appropriate new solutions. One objective is to help students acquire a flexible attitude towards their professional role while retaining a firm grasp on the essentials in their profession; this can be approached through enactment of situations which call for an innovative social work role definition. Similarly, ethical dilemmas can be posed, allowing the student to discuss the application of their professional ethics and values in the interprofessional team context. Again the annotated bibliography in the appendix offers examples which could be adapted for these purposes.

The difficulties in uniting practitioners with different approaches and different skills is illustrated by the methods of social work itself. Although social workers share a frame-of-reference and a value base, sufficient differences exist between social workers in direct service and in community organization that conflicts inevitably arise in their collaboration; at the same time social work agencies are increasingly finding wisdom in utilizing "teams" of two or more social work subspecialists (Bateman, 1970; Lowry, 1970; Shubin, 1970). Social work students are in an excellent position to perceive and explore the pitfalls of teamwork with their own social work peers (Brieland, Briggs, Leuenberger, 1973), and these insights can then be extrapolated to the interprofessional context.

The social work student usually has first hand experiences with task groups, through participation in a field unit, a group presentation, a research group, or as a student representative to a faculty committee. In such settings, he can observe the way in which the group process and the organizational structure facilitates or hinders goal achievement. This learning is especially feasible if some seminar mechanism is planned to ensure that the student makes the appropriate generalizations.

The learning experiences suggested here are only a sampling of the possibilities which might be utilized to help the student recognize the essential aspects of team functioning and to acquire the desired end behaviors. Since the state of understanding of interprofessional

teamwork is still embryonic, the student may well assist in developing knowledge for the use of the profession. He certainly would be more than a passive recipient. The organizing focus of behavioral objectives is crucial, even though these objectives are necessarily tentative and subject to change.

Although courses in interprofessional teamwork are desirable, the concepts are familiar ones which appear in other parts of the curriculum; connections could be made quite readily and a theme of interprofessional teamwork might run through the entire course offering. In the behavior classes, for instance, the student is usually exposed to role theory, and these concepts, usually applied to marital and family roles, are relevant to professional roles. The student is expected to understand something about human motivation and the way that internal and environmental forces combine to shape behavior. Currently the student utilizes a "systems approach" to analysis of behavior; such a stance is useful for understanding the team-profession-agency-client-community configuration as an open system.

The administration courses introduce concepts of efficiency and effectiveness, program evaluation, objective-setting, planning to reach goals, communication, and organizational structure; all these ideas are important for the team practitioner. Research courses offer the rudiments of design, and lately, have highlighted evaluation research as an important concern for the practitioner. Social work methods courses usually emphasize communication skills, another important ingredient of effective teamwork.

The relevance of group work content to interprofessional team practice is evident. The team practitioner needs to understand about group formation and recognize the ways in which group norms can affect individual behavior. The group work literature has particularly developed materials around stages of group development (Bernstein, 1965; Vinter, 1965) which have great pertinence to the interprofession team. In general, the group work courses should be rich in content relevant to effective team leadership and team participation. The group worker who applies his knowledge of group dynamics should, in fact, be particularly capable of filling the leadership vacuum that often exists on the team.

The material related to effective teamwork, then, is not an exotic, foreign fabric; the principles are already woven into the social work curriculum and applied to client and community

contexts. Yet, despite the homespun familiarity of the ideas, the subject of teamwork cannot be ignored; students will not automatically transfer principles of organization, communication and group management to the interprofessional team. The educational systems of the various professions must reinforce the importance of working at teamwork by affording the topic some curricular importance.

The matter of reinforcing behavior through curricular emphasis is not a trivial consideration. When professional students, whatever the discipline, find their teachers emphasizing the need for teamwork skills and giving attention to the process of practicing effectively in a teamwork context, they will also attach significance to the subject. If teamwork is ignored in the formal curriculum, at the very least students will receive reinforcement for the opinion that there are no particular challenges to working on the interprofessional team. If he has given no prior consideration to teamwork as a difficult and skilled process, the new practitioner is likely to blame conflicts and miscommunications on his teammates. The professional student needs to be taught the importance of examining teamwork as a process and understanding his own contributions to its success or failure. It is, therefore, preferable to introduce the subject with all its uncertainties and unanswered issues than to allow students to enter the professional world without even realizing that there are questions to be asked about interprofessional teamwork.

REFERENCES

- Andrew, G. Forecasting social work practice as a base for curriculum development. Journal of Education for Social Work, 1974, 10 3-8.
- Arbuckle, D. Counselor, social worker, psychologist: Let's ecumenicalize. Personnel and Guidance Journal, 1967, 45, 532-538.
- Baktenica, N. A multidisciplinary training team in the public schools. Journal of School Psychology, 1970, 8, 220-225.
- Bandler, B. Interprofessional collaboration in training in mental health. American Journal of Orthopsychiatry, 1973, 31, 99-107.
- Bateman, R. A team approach to parish and community development. Catholic Charities Review, 1970, 54, 3-4.
- Beck, R. H. (Ed.) Society and the schools: Communication Challenges to Education and Social Work. New York: National Association of Social Workers, 1965.
- Bernstein, S. Exploration in Group Work. Boston: Boston University School of Social Work, 1965.
- Blanchard, M. & Felsenburg, R. Social work education for community mental health center functioning. Social Work Education Reporter, 1972, 20, 51-55.
- Boehm, W. Common and specific learnings for a graduate school of social work. Journal of Education for Social Work, 1968, 15-26.
- Brieland, D., Briggs, T. & Leuenberger, P. The Team Model of Social Work Practice. Syracuse: Syracuse University School of Social Work, 1973, Manpower Monograph Number Five.
- Briggs, T. & Van Voorst, E. Teaching and learning about inter-professional teamwork. Paper presented at the 17th International Congress of Schools of Social Work, Addis Ababa, Ethiopia, June 1974.
- Bruner, J. The Process of Education, New York: Vintage Books, 1960.

- Carlaw, R. & Callan, L. Team training. Health Services Reports, 1973, 88, 328-336.
- Curran, W. Cross-professional education in law and medicine. The promise and the conflict. Journal of Legal Education, 1971, 24, 42-72.
- Damman, G. Interprofessional aspects of nursing and social work curricula. Nursing Research, 1972, 21 160-163.
- Dana, B. & Sheps, C. Trends and issues in interprofessional education. Journal of Education for Social Work, 1968, 4, 35-41.
- David, H. Education for the professions. Journal of Education for Social Work, 1967, 3, 5-12.
- Duce, L. A. Changes in higher education. Journal of Education for Social Work, 1965, 1, 11-18.
- Eichenberger, R. & Gloor, R. A team approach to learning community health, Journal of Medical Education, 1969, 44, 655-662.
- Eichhorn, S. F. Becoming: The Actualization of Individual Differences in Five Student Health Teams. The Bronx, N.Y.: Institute for Health Team Development, 1973.
- Greenberg, L. & Denham, E. Interdisciplinary collaboration conference. Paper presented at Annual Meeting, American Association of Psychiatric Clinics for Children, New York, November 9, 1968.
- Haggerty, R. J. Education for the health professions. In Health and Disability Concepts in Social Work Education. Proceedings of a workshop sponsored by University of Minnesota, School of Social Work, Minneapolis, April, 1964.
- Horwitz, J. Education for Social Work in the Rehabilitation of the Handicapped. New York: Council on Social Work Education, 1959.
- Horwitz, J. Team Practice and the Specialist. Springfield, Ill.: Charles C. Thomas, 1970.
- Johnson, A. (Ed.) School Social Work: Its Contribution to Professional Education. New York: National Association of Social Workers, 1962.
- Kane, R. A. Interprofessional Teamwork, Syracuse: Syracuse University School of Social Work, 1975. Manpower Monograph Number Eight.

- Kane, R. L., Woolley, F. R. & Kane, R. A. Towards defining the end product of social work education. Journal of Medical Education, 1973, 48, 615-624.
- Kendall, K. Choices to be made in social work education. In Social Work Practice, 1966. New York: Columbia University Press, 1966.
- Konopka, G. Team relationships and operations in social group work. In M. Murphy (Ed.) The Social Group Work Method in Social Work Education. New York: Council on Social Work Education, 1959.
- Linn, M. W., Stein, S. & Carter, J. S. The C.A.R.E. Project: Interdisciplinary and community-oriented approach to training social work students. Journal of Education for Social Work, 1974, 10, 47-50.
- Lowry, E. Organizing the inner-city parish community. Catholic Charities Review, 1970, 54, 9-12.
- Lowy, L. Whither social work education amid social change. Journal of Education for Social Work, 1968, 4, 31-36.
- Murphy, M. The social Group Work Method in Social Work Education. New York: Council on Social Work Education, 1959.
- Phillips, B., McCulloch, J. W., Brown, M. J. & Hambro, N. Social work and medical practice. Hospitals, 1971, 45, 76-79.
- Public Health Concepts in Social Work Education. (Proceedings of seminar at Princeton University, March, 1962). New York: Council on Social Work Education, 1962.
- Reece, S. A. Social work participation in psychiatric training related to intake work. American Journal of Psychiatry, 1965, 121, 1183-1189.
- Rehr, H. (Ed.) Medicine and Social Work, New York: PRODIST, 1974.
- Rosenauro, J. A. & Fuller, D. J. Teaching strategies for interdisciplinary education. Nursing Outlook, 1973, 21, 159-162.
- Shubin, S. The team and its approach. Catholic Charities Review, 1970, 54, 5-8.

- Smith, J. R. Study seeks to help form future of rural towns. Lutheran Social Welfare Quarterly, 1971, 11, 54-57.
- Smith, N. F. Interprofessional training for community mental health. Journal of Education for Social Work, 1974, 10, 106-113.
- Spencer, S. The Administration Method in Social Work Education. New York: Council on Social Work Education, 1959.
- Stein, L. The doctor-nurse game. Archives of General Psychiatry. 1967, 699-703.
- Studd, E. Education for Social Workers in the Correctional Field. New York: Council on Social Work Education, 1959.
- Szasz, G. Education for the health team. Canadian Journal of Public Health, 1970, 61, 386-390.
- Tanner, L. & Carmichael, L. P. The role of the social worker in family medicine training. Journal of Medical Education, 1970, 45, 850-865.
- Tanner, L. & Soular, E. Interprofessional student health teams. Nursing Outlook, 1972, 20, 111-114.
- Towle, C. The Learner in Education for the Professions. Chicago: University of Chicago Press, 1964.
- Vigilante, J. Education matures to the undergraduate level. Social Work, 1974, 19, 638-646.
- Vinter, R. (Ed.) Readings in Group Work Practice. Ann Arbor, Michigan: Campus Publications, 1965.
- White, G. Preparation of social workers for interprofessional and interagency collaboration. Education for Social Work, 1960, Proceedings, New York: Council on Social Work Education, 1960.
- Yeaworth, R. & Mims, F. Interdisciplinary education as an influence system. Nursing Outlook, 1973, 21, 696-699.

APPENDIX

AN ANNOTATED BIBLIOGRAPHY OF
TEACHING MATERIALS

Most of the references annotated here were drawn from periodical literature describing teams at work. The criteria for selection include illustration of some points of team organization or process and representativeness of the wide number of fields in which teamwork is practiced as well as the trends apparent in team practice today. An effort was made to select articles that might raise questions and stimulate discussion among students, or show social work students performing unusual or unfamiliar roles.

The references are listed alphabetically. At the end of the citations, a key is provided to indicate the particular team theme(s) illustrated within the article and the field of practice from which it is drawn. The key is interpreted as follows:

GP = group process	h = health
SW = social work role	m = mental health
PR = professional roles in general	c = corrections
OR = organization of team	e = education
EV = evaluation	w = welfare

A few works are included which do not describe a team but rather attempt a theoretical formulation about interprofessional teamwork. These are indicated by an asterisk.

Abrams, G. Defining milieu therapy. Archives of General Psychiatry, 1969, 21, 553-560. GP, m

In the author's conception of milieu therapy there is a belief that patients have more contact with other patients than do staff members and, therefore, should help dispense treatment. The author indicates the number and type of staff meetings he considers essential. These include (1) a daily community meeting with all staff and all patients, (2) a weekly team meeting including the psychiatric resident, his supervisor, the social worker, the nurses, an occupational therapist and 6-8 patients, (3) a weekly team planning meeting without the patients, (4) weekly sensitivity sessions for the staff, and (5) a weekly policy committee meeting. The latter group includes the ward director and representatives of each of the occupational groups. As a process-oriented account of teamwork, this article is very useful.

Abrams, H. The role of the social worker in relocation for employment. Social Casework, 1968, 49, 475-480. SW

An interprofessional team consisting of social worker, psychologist, and rehabilitation counselor is described with rather clear discussion of the division of roles between the social worker and the counselor. The purpose of the team was to assist hard-core unemployed individuals to relocate to urban areas and hold jobs there. Data were collected to show what kinds of clients were successfully relocated after a one-year follow-up.

Adamson, J. A modified team approach for the evaluation of children with moderate or greater mental retardation. Community Mental Health Journal, 1969, 5, 476-481, SW, EV, m.

Describes a diagnostic team approach to evaluation of children in terms of possible placement in one of the state facilities. Because of the relative availability of psychologists compared to social workers, the modified team used psychologists and pediatricians in roles traditionally reserved for social workers and psychiatrists. The social worker served as a consultant and engaged in direct activities around child placement. The staff made inroads into the waiting list, finding that only 5% of patients required a full evaluation after work-up by the partial team. The article also demonstrates an effort to forge criteria to determine for which patients this less conventional approach was appropriate.

Albini, J. The role of the social worker in an experimental community mental health clinic. Community Mental Health Journal, 1968, 4, 111-119, SW, m.

Describes a novel role for a social worker as part of a demonstration project team. The social work skills are used for the unfamiliar purpose of recruiting and maintaining a sample in order to test whether schizophrenic patients can be maintained in the

community with public health nurse visits and, in some cases, drugs. After patients were hospitalized, the social worker persuaded the families of those randomly selected for the experimental group to take the patients back into the home under team care.

Ashley, C., Fisher, C. & Hanson, P. A maternal and infant care project. Lutheran Social Welfare Quarterly, 1970, 10, 24-33, EV,h

In an area with high prematurity and low acceptance of pre-natal care, a team effort was made to reduce premature births. Evaluation indicates that prematurity rate and incidence of hypoglycemia did decrease. Consumer satisfaction is evidenced by dramatic changes in number seeking care earlier in the pregnancy. Dental care was introduced to a previously dentist-resistant population through careful teamwork.

Baktenica, N. A multidisciplinary training team in the public schools. Journal of School Psychology, 1970, 8, 220-225, GP,e

A team of students from psychology, psychiatry, special education, educational administration, social work, early child development and counseling, along with their preceptors, attempt to establish mental health services in a school. One student becomes team coordinator and an effort is made to establish the team as a reference group. Training objectives and service objectives are distinguished. Students are discouraged from performing tasks associated with their own discipline but instead try to understand the school and the community as a system. Author suggests that this kind of training team might evolve into an appropriate model for establishing positive mental health services in a school setting.

Banta, H. D. & Fox, R. C. Role strains of a health care team in a poverty community. Social Science and Medicine, 1972, 6, 697-722. PR, h.

Interprofessional teams of physicians, nurse and social worker were based in a housing project in a black neighborhood. The attitudes of the team members were carefully assessed, revealing considerable role strain. The conflict was most overt between the public health nurses and the social workers. The extra-team supervision of the social workers was cited as a barrier to teamwork by the nurses, but more important, the nurses and social workers were critical of each other's basic approach to the client.

Beloff, J. & Karper, M. The health team model and medical care utilization. Journal of the American Medical Association, 1972, 219, 359-366. EV, h.

The purpose of this team was to demonstrate that the organization of health services influences patient behavior. The team included physician, social worker, nurse, dietician and health aide. The article presents data recording the number and kinds of contacts which each team member maintained with the patients so that differential use of personnel is documented. Eventually the number of contacts initiated by the physician dropped.

Blum, H., Wahl, F., Lemon, G., Jornlin, R. & Kent, G. The multipurpose worker and the neighborhood multipurpose center. American Journal of Public Health, 1968, 58, 458-468. PR, w.

"Health and well-being services" formerly delivered by the county health department, the welfare department and the probation department are provided by a single agency with plans for absorbing rehabilitation counseling, mental health and school guidance also. The authors take the position that the ideal worker is a generalist. Called "primary counselors," they may be of any background with social work and nursing frequently represented. The primary counselors coordinate services for the client, but never relinquish a case to another worker. Although team members pick up skills from each other, essentially this is an antiprofession, anti-team approach and the article offers a rationale for such a system.

Brody, E., Cole, C. & Moss, M. Individualizing therapy for the mentally impaired adult. Social Casework, 1973, 54, 453-461, GP, EV, m.

A team effort to demonstrate that brain-damaged elderly patients can make behavioral gains. The multidiscipline effort is coordinated by a social worker with all professions participating in taking baseline measurements and determining the degree of "excess disability" over and above physical damage which existed for each patient. Through assignment of the excess disabilities to various professions and a coordinated approach, gains were made, particularly with aggressive patients who were hard to manage. After the experiment ended, the patients regressed to their former level of functioning.

Brunetto, E. & Birk, P. The primary care nurse--the generalist in a structured health care team. American Journal of Public Health, 1972, 62, 785-793, OR, EV, h.

A primary care nurse is the leader and pivotal person in a health care team. Diagrammatically, the nurse is shown in the center with the social work and nutritionist consultants on one side serving directly and indirectly and the physician consultants

on the other side doing the same. Two kinds of paraprofessionals serve on the team; one set assists the social personnel and the nurse in the community and the other assist the physician and the nurse in the clinics. The teams are shown to have capacity to treat more patients than a physician working alone. The authors extrapolate the model to the whole of the United States to determine the additional personnel needed to muster this team approach as compared to the additional physician personnel needed to serve the same number of patients on the basis of an average four patients visits per year.

Chess, S. & Lyman, M. A psychiatric unit in a general hospital pediatric clinic. American Journal of Orthopsychiatry, 1969, 39, 77-85. SW, PR, m.

A complete restructuring of roles of the traditional child guidance team is described. Purpose of team is to provide psychiatric coverage for the pediatric clinics of Bellevue Hospital in New York. Team managed to meet referrals in minutes and make quick dispositions. Roles were blurred so that all members did intake and therapy and the social worker was no longer the only team member to communicate with outside agencies.

Cokin, M., Calligan, E. & Ferrer, R. Helping parents in a pediatric clinic. Child Welfare, 1971, 50, 504-511. SW, h.

A pediatrician and social worker have developed a "medical-social clinic" for patients with no apparent organic problem. Reversing the usual roles in a medical setting, the social worker leads out in the team, makes the first contacts, introduced the patient and parents to the physician and remains present during the physical examination. Acceptance of this process among patients is high and data indicate that parents accept the recommendations and some children respond dramatically with symptom alleviation. Initial contact with social worker instead of physician was accepted by the parents.

Cortazzo, L., Bradtke, L., Kirkpatrick, J. & Rosenblatt, K. Innovations to improve care in an institution for the mentally retarded. Children, 1971, 18, 149-154. OR, m.

Teams operated with the premise that no child was too retarded to improve in functioning. Administrative structure in the hospital was changed to become child-centered rather than department-centered or profession-centered. Former department heads become an advisory interprofessional committee as a resource to four treatment teams, which included teacher, social worker, nurse, recreationist, psychologist and various cottage supervisory personnel. Previously unsuccessful staff members were retrained to work with the severely retarded "custodial" cases. Children formerly considered hopeless improved to the point of enrollment in the regular school program.

Cowan, D. & Sharbaro, J. Family-centered health care. Medical Care, 1972, 10, 164-172. SW, GP, h.

In an effort to offer family-centered, comprehensive health care, teams tried different leadership patterns, public health nurses were ineffective as leaders and finally leadership was invested in a neighborhood aide under social work supervision. A team approach was not always considered necessary, nor was it always acceptable to the patient, but in about 40% of the cases, a team approach was deemed essential. The social worker was responsible for forming a flexible team to meet the needs of the particular patient.

This article also contains a fine review of efforts at team delivery of primary health care.

Cowin, R. Some new dimensions of social work practice in a health setting. American Journal of Public Health, 1970, 60, 860-869. SW, OR, h.

The role of social workers in a health center for child-bearing women and their children is described. Professionals and paraprofessional are present in the social work department and the use of the latter is discussed. Social workers are assigned to teams and function as generalists using all social work methods. Article includes an Appendix which supplies guidelines to other team members about when a referral to social work is appropriate.

Dahl, G. Behavior modification and the team approach. The Social Worker, 1973, 41, 144-153. SW, m.

A team approach in a psychiatric hospital developed for patients with immature personalities. Team members, namely psychiatrist, psychologist, nurse, social worker, and occupational therapists, strive to give consistent messages to the patient in implementing an operant conditioning plan. The social worker supports the team's plan, reinforcing the desired behaviors, and performs special tasks concerning diagnosis, family work and discharge plans. It is emphasized that the usual social work technique of forming a therapeutic or supportive relationship with the patient is minimized and not utilized at all in the early part of the regimen.

DeYoung, C. Nursing's contribution in family crisis treatment. Nursing Outlook, 1968, 16, 60-62, PR, M.

A psychiatric nurse delineates her role on a crisis-intervention team. As part of the nurse's special contribution she includes (1) a community orientation, (2) a family-centered focus, (3) skill in home visits, (4) pharmacology knowledge, and (5) knowledge of public health services and agencies; the first three are often considered social work attributes. The author also describes an effort to maintain affiliations with her own profession through

nursing schools and organizations. As the only woman on the team, she queries whether her role is as much due to her sex as her professional affiliation.

Doeltz, D. & Adamson, D. Collaboration of chaplain and social worker in hospital care. Social Casework, 1968, 49, 410-417. PR, h.

Advocates clear allocation of activities and coordination between social workers and chaplains in hospitals. Chaplain deals with churches in the community and social worker with agencies. The former mobilizes faith and the latter mobilizes resources.

Dunforth, J., Miller, D., Day, A. & Steiner, G. Group services for unmarried mothers: An interdisciplinary approach. Children, 1971, 18, 59-64. GP, w.

An example of teamwork between public health nursing and social group work in a group approach to unmarried mothers. Responsibilities for leadership were shared with each professional occupying primary leadership for part of the meeting and assuming a supportive role for the other part. Sessions were taped so leaders could review them. Objective consultation was also sought from other mental health professionals around the interaction of the two leaders.

Ebra, G. & Toth, J. Chronic hemodialysis. Rehabilitation Literature. 1972, 33, 2-10. PR, h.

The team's purpose is total rehabilitation, including vocational of the dialysis patient and its membership includes physicians, psychologist, nurse, and rehabilitation counselor. It is interesting that the psychologist and rehabilitation counselor together fulfill a social work function with the former doing psychotherapy and the latter doing counseling in the home.

*Eichhorn, S. F. Becoming: The actualization of individual differences in five student health teams. The Bronx, NY: Institute for Health Team Development, 1973.

The author describes in detail the interaction of five inter-professional student teams which were asked to forge out their own purpose and process in summer experiences in Appalachia. She advances a model for conflict resolution on the interprofessional team which she believes permits individual differences and strengths of the team members to emerge.

Elliott, A. A group treatment program for mentally ill offenders. Crime and Delinquency, 1966, 12, 29-37. GP, c.

Description of a role-blurring team for mentally ill offenders. The team is committed to the therapeutic milieu and prefers group modalities to individual therapy. Team goal-setting is employed as an effective way of preventing miscommunication and ensuring that the offender cannot manipulate the team.

Ellwood, P. M. Medical rehabilitation--cliche or reality? Public Welfare, 1965, 23, 47-52, PR, h.

Articulating a rehabilitation philosophy aimed at the whole man, the author, a physician, advocates an interprofessional approach with clear leadership exercised by a single person. As he puts it, "Shared decisions may be psychodynamically satisfying for the team but they may be therapeutically disastrous for the patient."

Gerard, R. Institutional innovation in corrections. Federal Probation, 1970, 34, 37-44. OR, EV, c.

At the federal Kennedy Youth Center in Morgantown, West Virginia, a team approach is employed, with all members belonging to a single Case Management Department. Staff have developed a typology of delinquent behavior to guide their work. Team leader is a social worker and the youth is a member of his own treatment team. Preliminary findings indicate that 81% of students find the program helpful. Data are being collected on (1) post-release adjustment, (2) program costs, (3) custody and control, and (4) quality of life. The program will be compared with other federal youth centers which do not utilize this team approach.

Grass, C. & Umansky, R. Problems in promoting the growth of multi-disciplinary diagnostic and counseling clinics for mentally retarded children in non-urban areas. American Journal of Public Health, 1971, 61, 698-710. EV, h.

An effort to establish local teams to diagnose and treat retarded children. Each team had physician, nurse, social worker and psychologist as a nucleus. The article evaluates the first four of these teams, comparing them as to make-up, interaction and effectiveness. The individual professional members were rated on their ability to work in teams.

Gray, J. Hospital-based battered child team. Hospitals, 1973, 47, 50-52, OR, h.

Careful planning is needed so hospital personnel can respond appropriately in suspected abuse situations. Each team member needs to know his role in advance and hospital administration and legal personnel should be consulted. Clear communication to community agencies must be established in advance of a crisis by face-to-face planning in which key persons develop procedures for functioning as a team. A process for admission of children without parental consent was designed by pediatrician, welfare worker, welfare lawyer and judge in this kind of personal process.

Gregg, R. Rehabilitation teamwork in an acute hospital environment. Journal of Rehabilitation, 1966, 32, 14-17, OR, h.

A team approach to facilitate rehabilitation of patients who will return to rural areas. Team of physician, social worker,

nurse, physical therapist, occupational therapist, dietician, and vocational counselor respond each week to a referral presented by various hospital services. Administrative arrangements hamper the work of the team. Team reports back to referral source a week later, often after patient is discharged. Team's work is fragmented, its impact diffused. The services involved--medicine, surgery, orthopedics, urology, plastic surgery and neurosurgery--never developed interest or perceived the benefits of the rehabilitation team.

Gritzka, K., Berfelz, K., & Geissmar, R. An interdisciplinary approach in day treatment of emotionally disturbed children. Child Welfare, 1970, 49, 468-477, OR, m.

In a Day Care Center for disturbed children, each child has a team of nurse, therapist, teacher and occupational therapist--the therapist on the team may interchangeably be a psychiatrist, social worker, or psychologist. In addition, a larger group including a psychiatrist, psychologist, and social worker meets regularly with the treatment team. The child's parents often are included in team meetings. Article shows how procedures for teamwork evolved and changed over time.

Grynbaum, B. & Speare, E. Quality control in an urban amputee program. American Journal of Public Health, 1966, 56, 1199-1204. OR, h.

An interprofessional advisory committee developing standards for an amputee service program in New York City is example for discussion of problems of quality control. Ideal guidelines drawn up call for an inter-professional team with physician, nurse, occupational and physical therapist, social worker, vocational counselor, and prosthetist; regular team conferences and shared records were required. Hospitals could not meet ideal standards, but fifteen hospitals were improved and ten prosthetic vendors identified. This led to corrections of obvious abuses such as time-lags between the prescription and delivery of the prosthetic limb. The authors point out the difficulty in judging whether 15 centers are too many or too few or the right number since no data are available on the extent of the amputee problem among indigent New Yorkers. This is a good example of an interprofessional approach to planning and standard setting.

Hart, R. & Hippchen, L. Team treatment of Air Force offenders. American Journal of Corrections, 1966, 28, 40-45, OR, C.

The goal of the team was to return offenders to duty or civilian life. The professional team included social worker as leader, psychologist, vocational counselor, educator, and several non-commissioned officers. The client "retrainee" was involved as a team member at all stages. Statistics of return to duty are presented which compare this system favorably to a former non-team system.

Hogan, C. & Campbell, C. Team classification in federal institutions. Federal Probation, 1968, 32, 30-35, OR, c.

The centralized interdisciplinary classification committee is replaced by a decentralized team responsible for coordinating rehabilitation plans for a group of inmates. Managerial personnel in departments such as food services and business have been utilized as leaders to manage the process of the teams.

Hogarty, G., Goldberg, S. & the Collaborative Research Group. Drug and sociotherapy in the aftercare of schizophrenic patients. Archives of General Psychiatry, 1973, 28, 54-64, EV, m.

Study determines effectiveness of a sociotherapy known as Major Role Therapy (MRT) singly and combined with drugs. MRT is offered through social caseworkers and rehabilitation counselors. Patients were randomly assigned to four groups; MRT and drug, MRT and placebo, drug alone, placebo alone. The effectiveness of the drug was remarkable but the MRT also had positive effect in lowering relapse and rehospitalization rates if the therapy continued for at least six months.

*Horwitz, J. Interprofessional teamwork. The Social Worker, 1970, 38, 5-10.

This is an extremely helpful introduction to the study of interprofessional teamwork. The author attempts to identify the variables which are important to interprofessional teamwork, including individual personality variables, team processes and structure of the organization. He makes a useful distinction between "integrative" and "coordinate" teams. The issue of maintaining identification with the primary profession as well as the team is discussed here.

Jivoff, L. Strokemobile. Hospitals, 1971, 45, 50-54, EV, h.

Describes a team headed by social worker and including physical and occupational therapists, speech therapist, and orthotist. Purpose of team was expert evaluation of the stroke patient and stimulation of local interest and resources for stroke treatment. Over the period of the project, the traveling team changed its approach several times. Figures are supplied to document the exposure of the communities, health personnel and patients to the team, and some positive and negative reactions are listed. This short paper illustrates the difficulties in evaluating the effectiveness of this kind of detached team which has both a direct service function and an indirect educative one.

Johannessen, J. & Fey, A. Team effort in the rehabilitation of laryngectomy patients. Journal of the American Geriatrics Society, 1964, 12, 1073-1076, PR, h.

An example of a coordinate team, led by a physician, in which each professional has a particular role in relationship to the laryngectomy patient. The professions tend to be involved sequentially; the speech therapist has a continuous role, the occupational therapist teaches any illiterate patients how to write immediately before surgery, the dietician is involved right after surgery, and the social worker tends to be active later in the recuperative period.

Johnson, M. The social worker and the chaplain in the general hospital. Lutheran Social Welfare Quarterly, 1968, 8, 36-43, PR, h.

Article focuses on the relationship between chaplain and social worker, emphasizing the need for trust between the two professions. The chaplain is seen having a function around guilt (i.e., real guilt), grief, and confusion about God's purpose. Teamwork is not automatic since clergy are educated to work independently and social work education does not emphasize collaboration with religious leaders.

Kahn, R. Stroke rehabilitation in general hospitals. Hospitals, 1971, 45, 47-50, OR, PR, h.

The Chicago Heart Association sponsored stroke teams in general hospitals. Teams consisted of physician, nurse and social worker, each of whom functioned in an unusual role for the professions. A central consultation team assisted the hospitals in establishing their teams and monitored their progress, withdrawing gradually as the teams became effective units on their own.

*Kane, R. A. Interprofessional Teamwork, Syracuse: Syracuse University School of Social Work, 1975. Manpower Monograph Number Eight.

Interprofessional teamwork in social work is reviewed historically. Teamwork is discussed in terms of role relationships, small group process, and evaluation of the effectiveness of the interprofessional team. A review of accounts of 229 teams located in the periodical literature was undertaken in order to describe interprofessional teamwork as it currently exists in a number of fields.

Keil, E. C. & Berry, K. L. The vocational rehabilitation counselor on mental patient treatment teams. Personnel and Guidance Journal, 1969, 47, 531-535, PR, m.

The addition of a rehabilitation counselor to the team allowed a possibility of evaluating the impact of this newest

member. It was found that other professions expected more vocational counseling of severely ill patients than the rehabilitation counselor desired but approved less psychotherapy and job-related counseling of less ill patients than the rehabilitation counselors wished.

Kemp, C. J. Family treatment within the milieu of a residential treatment center. Child Welfare, 1971, 50, 229-235, GP, m.

A highly integrative team in a residential treatment center context, consisting of a therapist (either social worker, psychologist or psychiatrist), a teacher, an occupational therapist, and a child care worker (either nurse or institutional aide). The entire team makes a home visit prior to admission during which the teacher and o.t. visit the school and the others concentrate on family. The team makes consensual decisions and supports the total plan. Good results are reported under this system.

Kovner, A. & Seacat, M. Continuity of care maintained in family-centered outpatient unit. Hospitals, 1969, 43, 89-94, OR, h.

In this comprehensive health program weekly team meetings are attended by paraprofessionals and clerical staff as well as professional and roles are continuously clarified. Professional affiliations are also maintained through a professional department structure. The effort was to develop a team unit small enough to permit personal working relationships to form and large enough to permit flexibility in providing continuous care.

Kumabe, K. A prenatal clinic in a rural area. Children, 1964, 11, 214-218, GP, h.

All team members in this rural Hawaiian prenatal clinic show warm individualized attention to the patients. The atmosphere is deliberately informal to counteract the population's mistrust of clinics. Team members work at becoming a team--holding meetings after each clinic. Data are presented to show that under this system the patients tended to keep appointments, seek care early in the pregnancies and follow their regimens faithfully.

Landreth, G., Jacquot, W. & Allen, L. A team approach to learning disabilities. Journal of Learning Disabilities, 1969, 2, 79-87. GP, e.

Three distinct disciplines, namely speech and hearing therapists, reading teachers, and counselors cooperate in a clinic for learning disabilities. Authors attribute the success of the effort to a shared ideology, commitment to meeting and planning, acceptance to each other's competence, and unwillingness to let team process break down after a diagnosis is reached. This team attempts to involve all disciplines in the treatment phase and prevent any one from predominating.

Levinson, R. & Gerard, R. Functional units: A different correctional approach. Federal Probation, 1971, 37, 8-16, OR, c.

A prison reorganization left responsibility for planning and implementing rehabilitation programs for a unit of 50-100 prisoners to decentralized teams. Each team had a manager-- a generalist who may be a social worker, an educator, a mental health specialist or a correctional officer. Departments which formerly held line authority became a resource to the decision-making teams. The authors believe that this change led to higher morale among staff members but lower morale at least temporarily among the higher echelon employees who lost their authority in the chain of command.

Lief, V. & Brotman, R. The psychiatrist and community mental health practice. Community Mental Health Journal, 1968, 4, 134-143, OR, m.

Describes a team with deliberate role-blurring; the psychiatrist, social worker, psychologist and nurse are all considered "community mental health workers." After the team reviews the case initially, a team manager is selected for the particular patient.

Livingstone, J., Portnoi, T., Sherry, N., Rosenheim, E., & Onesti, S. Comprehensive child psychiatry through a team approach. Children, 1969, 16, 181-186, PR, m.

A highly process-oriented discussion of a child psychiatry team which compressed the diagnosis and recommendations into a 3-hour series of sessions, observations, and conferences with and about a given family. An effort is made to preserve the skills associated with the original child guidance professional roles, and the psychiatrist assumes responsibility for synthesizing the diagnostic information into a meaningful whole.

Luckens, M. Developing total services capabilities in poison information centers. American Journal of Public Health, 1972, 62, 407-410, PR, h.

A poison information center must attract a highly skilled interprofessional team most of whom serve in a voluntary capacity. To engage personnel in such an effort they must be convinced of the value of their role. The author discusses roles of nurse, social worker, librarian, and others. The social worker, it is suggested, should conduct research into psychosocial aspects of poisoning.

*Luszki, M. Interdisciplinary team research. New York: National Training Laboratories, 1958.

A classical work on the interdisciplinary research team which grew out of a NTL symposium. Luszki raises provocatively many of the practical problems which occur because of different frames of reference held by the different professions. Although the work is directed specifically to interprofessional research, many of her points about team process and roles are applicable to interprofessional practice.

Mendlovitz, A. & Cohen, S. Bringing about changes in staff knowledge, attitudes and service in a home for the aged. Journal of Jewish Communal Service, 1968, 44, 246-259, OR, h.

A social group work consultant reorganized two wards of a home for the aged into a team approach with the charge nurse of the ward designated as leader. All personnel including aides, waitresses, and housekeepers were included in the team. The teams crossed functional lines since the supervisors of social work, occupational therapy and dietetics attended the team meetings but the charge nurse, with the help of the group work consultant, retained leadership.

Miller, R. & Kenney, E. The hospitalized adolescent: It is necessary to segregate him from adults. Crime and Delinquency, 1968, 14, 245-254, EV.

A team approach to providing day care treatment for disturbed adolescents through partial integration with adult programs. The evaluation procedure is especially impressive. Prior to establishing the team, 100 patients were studied and then compared to 100 patients in a new program. Experimental group accepted more recommendations on discharge, were less often lost to follow-up, and their families were more often involved in the program. Damage of day care facilities was less when adolescents mingled with adults. Finally, the program was efficient in terms of maximizing professional time.

Morrill, R. A new mental health services model for the comprehensive neighborhood health center. American Journal of Public Health, 1972, 62, 1108-1111, OR, h, m.

Article makes a persuasive case for integration of health and mental health personnel into a "primary health care team." One such effort is described in which mental health personnel become integrated into a neighborhood health center rather than serving as consultants to it. Authors believe that the mental health personnel can treat on the basis of more accurate information, that the patient does not feel the stigma of mental illness, and that they are better accepted by health personnel.

Morse, J. The goal of life-enhancement for a fatally-ill child. Children, 1970, 17, 63-68, GP, h.

Describes team activity during three years of care for one terminally ill child. The need for leadership to be firmly invested in the physician is asserted and roles of social worker, nurse, physical therapist and occupational therapist are outlined. Goals were to enrich life of dying child, assist parents with coping, and help other children in hospital deal with the patient's death. The collaborative approach helped team members handle their own difficulty in facing the patient's death.

New, P. K. An analysis of the concept of teamwork. Community Mental Health Journal, 1968, 4, 326-333.

A sociologist's analysis of some of the dissonant features of the team ideal as compared to team practice. New identifies six assumptions about teamwork which have within them the difficulties which give rise to cognitive dissonance among practitioners.

Philippus, M. Successful and unsuccessful approaches to mental health services for an urban Hispano population. American Journal of Public Health, 1971, 61, 820-830, GP, m.

An example of an attempt to level professionalism; all staff members on this role-blurring team were on a first name basis and the term "senior staff member" was used to distinguish the professional from the paraprofessional on the team.

Plutchik, R., McCarthy, M., Hall, B., & Silvenberg, S. Evaluation of a comprehensive psychiatric and health care program for elderly welfare tenants in a single-room occupancy hotel. Journal of the American Geriatrics Society, 1973, 21, 452-459, OR, EV, w.

An example of a multi-agency, multiprofessional team established cooperatively by a welfare department, a mental health center and various professional schools to offer comprehensive services in a large single-room occupancy hotel. An interesting discussion of the difficulty in evaluating the program is included; because control groups could not be found, researchers adopted the strategy of making repeated measures of the system over time.

Radzinski, S. F., et al., Care and rehabilitation of the geriatrics patients. Journal of the American Geriatrics Society, 1969, 17, 1134-1158, PR, m.

The team approach employed in a Veterans Administration hospital is described through brief articles by members of eleven disciplines, namely physician, psychiatrist, social worker,

nurse, psychologist, occupational therapist, physical therapist, industrial therapist, recreation therapist, corrective therapist, and director of volunteers. Each describes his/her role in a way that its distinctive features are apparent yet the interdependence of the professions also is highlighted. Each team member attempts to provide figures on how their skill is utilized. Team morale in this setting is claimed to be high.

*Rehr, H. (Ed.) Medicine and social work, New York: PRODIST, 1974.

A report of a symposium on medicine and social work which raises many issues about team practice in health settings. Includes discussion on education of medical and social work students for collaboration.

Richards, H. & Daniels, M. Innovative treatment roles and approaches. American Journal of Orthopsychiatry, 1969, 39, 662-676, OR, m.

A fascinating discussion of the relationship between professionals and paraprofessionals on a team in which the paraprofessionals serve the clients directly and the professional members facilitate the work of the nonprofessional.

Rogers, K., Mally, M. & Marcus, F. A general practice using non-physician personnel. Journal of the American Medical Association, 1968, 206, 1753-1757, SW, EV, h.

A general practitioner's services in a housing project were augmented by an office nurse, a public health nurse, a social worker, and a technician. Despite the unusual presence of the social worker and the public health nurse, the population was served at about the same cost as the doctor with regular personnel. Tables display the breakdown of staff activities showing which cases are under primary responsibility of which personnel. Social workers took leadership only in cases with a psychiatric problem. It is pointed out that the social worker's services, especially counseling, tend to be time-consuming and costly compared to services of other team members.

Schwartz, R. Integration of medical and counseling services. Personnel and Guidance Journal, 1973, 51, 347-349, GP, m, h.

The counselor explains the rationale for placing his office along with that of medical and nursing staff in a university health center.

Sloss, J., Young, W., & Weinerman, R. Health maintenance in a prepaid practice. Medical Care, 1968, 6, 213-230, EV, h.

Article examines the cost of preventive services in relationship to their effectiveness in describing an experiment of a prepaid group practice. Team services including a public health nurse,

social worker and health educator were added for some patients and this group was compared to a control group from the practice matched for seriousness of disease. Attempt was to determine whether the addition of these services to the pre-paid practice would prevent serious illness and prove economically feasible.

Smith, E., Duncan, A., Shouse, J. and Brown, R. Adolescent maternity services: A team approach. Children, 1971, 18, 208-213. GP, w.

A core team considered essential to meet needs of teenage mothers includes nurse, social worker, and teacher. Each client has such a team which meets twice weekly and communicates daily, adding other personnel such as dietician, vocational counselor, or occupational therapist as it seems indicated. The client may select the way she wishes to use her 3-person team, sometimes working with one member extensively and sometimes utilizing the team members sequentially. Team members strive to be flexible in their roles and adapt to client's needs.

Smith, J. R. Study seeks to help form future of rural towns. Lutheran Social Welfare Quarterly, 1971, 11, 54-57, PR, EV, w.

An interdisciplinary project involving students and professors from ten college departments, namely psychology, social work, nursing, education, religion, recreation, political science and economics, business, and geography. The team's effort was to prevent the decline of a rural South Dakota community through conducting studies and acting as a resource to a particular town. Team also had an educational purpose for its members. Both purposes were met since the students became enthusiastic about their cooperative work and the town developed a number of programs in health, recreation and community planning as a result of student programs, surveys and suggestions. This excellent article illustrates well how the knowledge and techniques of each of these disciplines complement each other in an indirect, planning team.

Steele, S. Who knows Suzie? Nursing Outlook, 1966, 14, 64-65, GP, h.

In a complete program for children with cerebral palsy, the entire interprofessional team felt that Suzie's capacities were limited and that parents were denying her disability by insisting the child could move and speak better at home. A home visit by a team member verified the parents' observations and indicated that the child was less retarded than the team, over the course of several years, had believed. New plans were made on the basis of inclusion of parents on the team. This

very brief article illustrates that an interprofessional team may become insular and fail to profit by insights that parents and others outside the group may possess.

Stone, N. Effecting interdisciplinary coordination in clinical services to the mentally retarded. American Journal of Orthopsychiatry, 1970, 40, 835-840, GP, m.

An excellent description of a team approach which combines distinct professional skills with a cohesive, flexible team group. Leadership is rotated among team members and decisions are made by the team. Communication is emphasized, however, rather than equality.

Streeter, N. & Owens, W. E. Partners in ministering--a psychiatrist and a pastor. Community Mental Health Journal, 1970, 6, 292-299, PR, GP.

A psychiatrist and a clergyman who often had occasion to work as a team detail the laborious process through which they became effective collaborators. Attention is paid to theoretical similarities and differences between the two professionals, personality factors relevant to the two individuals, and the value stance of the professions. The necessary ingredients of their collaboration are listed under the headings: Process, personality and philosophy.

Vavra, C., Urbain, L., & Shaw, A. Meeting the challenge of educational care in heart disease. American Journal of Public Health, 1966, 56, 1507-1511, PR, h.

A team approach to counseling families of cardiac patients and reinforcing a physician's recommendation. Although prohibited from working directly with the patient, the team, led by a health educator and including a social worker and dietician, accept referrals to work individually and in groups with relatives. Most of the referrals are initiated around food management and then the focus expands to include psychosocial problems.

Vaughan, M. Everyone gets into the act. American Journal of Corrections, 1970, 32, 6-12, PR, e, c.

A novel approach to delinquency deterrence utilizes teams in eight high schools in a community. Personnel on the teams include the principal and assistant principal, social worker, nurse, psychologist, a representative of Big Brothers, and a liaison detective. Presence of a plainclothes detective in a school is discussed and assertion is made that the detective is well-accepted by students who sometimes prefer to confide in him because he is less "shockable" than other team members.

Vorzimer, J. & Katz, G. Towards comprehensive ambulator care. Medical Care, 1970, 76-81, OR, EV, h.

Primary health teams were established to address the problem that patients in a congested urban area tended to avoid out-patient clinics and use emergency room instead. A seven-person team, including two physicians, two nurses, a social worker, a nurses' aide and a medical secretary showed they could provide continuous care to 5000 outpatients. Team members contributed to the same record which was generally typed to enhance communication. Inappropriate use of emergency room dropped off after this reorganization.

Wang, V. & Bricker, A. J. A team approach to teaching blind homemakers; A home economist as member of the health team. American Journal of Public Health, 1970, 60, 1910-1915, PR, h.

Article highlights role of home economists which is broad and bears similarities to that of a social worker. Her expertise is defined as "management of human and material resources within the context of the family. These include foods and nutrition, textiles and clothing, housing and household furnishings, family economics, child development and family relationships."

Watanabe, S. The developing role of occupational therapy in psychiatric home service. American Journal of Occupational Therapy, 1967, 21, 353-356, PR, GP, m.

The occupational therapist's role is highlighted and shows similarity to that of social worker. For example, the o.t. indicates that knowledge and use of community agencies is part of her expertise.

Team process involves a home visit by social worker and psychiatrist, followed by one from o.t. After team conference, a primary therapist, either a social worker, nurse, or o.t. is assigned full treatment responsibility, using others as consultants. The kind of patients generally assigned to the o.t. are very depressed individuals or highly delusional schizophrenics.

Watts, S. The modified lateral team in a psychiatric setting. The Social Worker, 1973, 41, 136-143, PR, GP, m.

Author discusses lateral treatment teams which are consensual and emphasize the group process. A policy team consisting of the senior department heads of each profession serves to integrate the operations of the treatment teams into the hospital structure. The role of each profession is discussed in context of the values that profession brings to the team. The social work role is handled in detail with a review of the characteristics of the professions which militate for and against effective teamwork.

Wedl, K. A therapeutic confrontation approach to treating patients with fictitious illness. Social Work, 1971, 16, 69-73, SW, h.

A team approach to treating fictitious illness through confrontation followed by support and therapy. The team of physician, psychiatrist, social worker, and nurse acts in concert. The social worker's role is narrow and distinct and consists of offering support to the patient during the time that his fictitious illness is exposed and he is urged to accept therapy from a psychiatrist.

Weinstein, B. The parent counseling conference. Rehabilitation Literature, 1968, 29, 233-236, GP, h.

The team, including physician, psychologist, social worker, physical, occupational and speech therapists and teacher, diagnose and treat disabled children. A process has developed whereby the team meets as a total group with the parents to convey its findings. Prior to the parent conference the team has a "pre-conference meeting" to discuss its strategy.

Weisman, G., Feinstein, A. & Claudewell, T. Three-day hospitalization--a model for intensive intervention. Archives of General Psychiatry, 1969, 21, 620-629, GP, m.

The team attempts to offer an intensive three-day hospitalization followed by one month of out-patient help. A highly integrative approach is used with sensitivity training for staff and a high staff: patient ratio. The psychiatrist leads the daily team meeting but each team member including the aides leads treatment teams for particular patients. A deliberate effort was made to have the team represent a range of social, educational, and racial backgrounds and therapeutic styles so that, in the course of the barrage of multiple interviews that characterize the method, the patient might find a person to whom he could readily relate.

Williams, J., Dudley, H. & Guinn, T. Use of day treatment center concepts with state hospital inpatients. American Journal of Orthopsychiatry, 1969, 39, 748-752, EV, m.

Team espoused a "reintegrative approach" to mental illness through educational, recreational, occupational and psychotherapies. The evaluation procedure is of particular interest. A random stratified sample (matched on three variables) was assigned to the special Day Care Center program with the control group assigned to the regular ward. Outcome measurements included length of hospitalization, duration of post-discharge maintenance in the community and scores of various tests.

Williams, T. F., Hill, J., Fairbank, M. & Knox, K. Appropriate placement of chronically ill and aged. Journal of the American Medical Association, 1973, 226, 332-335, EV, h.

A team was introduced to demonstrate comprehensive evaluation of elderly patients for appropriate placement at the correct level of chronic care. Prior to formation of this Evaluation-Placement unit (E-P unit), a nurse and physician team with a high degree of inter-rater reliability, had shown a large number of inappropriate placements were being made. The effectiveness of the E-P unit was evaluated by an assessment team which reviewed its placements in comparison to another placement to the same home. The evaluation unit was blinded to which placement was made by the E-P unit. The placements of the Unit, consisting of a team of physician, psychiatrist, social worker, nurse, and rehabilitation counselor, were shown to surpass the control group and the results of the previous study.

*Wise, H., Beckhard, R., Rubin, I. & Kyte, A. Making health teams work. Cambridge, Mass.: Ballinger Publishing Co., 1974.

A theoretical treatment of teamwork which grew out of the efforts of the Martin Luther King Neighborhood Health Center in New York to force effective interdisciplinary units. Two of the authors are among the management consultants who helped the organization achieve its goal. A strong argument is advanced for the concept of team manager who is responsible for advancing the team process. Professional departments are considered dysfunctional, and the team managers envisaged as having a line relationship to the director of the organization. The authors are also committed to training a team as a unit to function together.

Yedwab, D. & Schmidt, E. Patient identification with I-SPY health program. Medical Care, 1973, 11, 52-58, OR, EV, h.

Basic team for delivering pediatric services included the physician, social worker, nurse and family health worker, with other specialists utilized as needed. Team met at end of each day to review patients seen. The evaluation focused on consumer satisfaction through bilingual interviews in patients' homes. Finding that 70% of group sampled named I-SPY as their main source of primary care and most could recall their doctor's name but could not recall the name of doctors in other programs, the authors concluded that team was meeting its goal of providing continuous, personalized health care in this low-income area.

Faint, illegible text at the top of the page, possibly a header or introductory paragraph.

Second block of faint, illegible text in the middle of the page.

Third block of faint, illegible text at the bottom of the page, possibly a signature or footer.

SYRACUSE UNIVERSITY
SCHOOL OF SOCIAL WORK

MANPOWER MONOGRAPH SERIES

1. *Using Teams to Deliver Social Services* by Robert Barker and Thomas Briggs, 44 pp. (1969)
2. *Social Work Manpower in Mental Health Programs*, edited by Thomas Carlsen, forward by Mrs. Ruth Knee and Dr. Allen Miller. Contributors: Walter Beattie Jr., Robert Barker, Thomas Briggs, Thomas Carlsen, Lester Glick, Margaret Hoffman, Milton Wittman, 41 pp. (1969)
3. *Educating the Undergraduate for Professional Social Work Roles* by Robert Barker, Thomas Briggs and Dorothy Bird Daly, 11 pp. (1971)
4. *Research on the Complexity Responsibility Scale: An Approach to Differential Use of Hospital Social Work Staff in the New York State Department of Mental Hygiene* by Thomas Briggs, Donald Johnson and Ellen Lebowitz, 77 pp. (1971)
5. *The Team Model of Social Work Practice*, by Donald Brieland, Thomas Briggs and Paul Leuenberger, 55 pp. (1973)
6. *Social Work Departments in University Hospitals: Some issues in Manpower Utilization* by Jules Schrager, 30 pp. (1974)
7. *Innovative Projects in School Social Work Practice*, Volume I, edited by Neal Bellos, Gerald Gross and Joseph Steiner, 164 pp. (1974)
8. *Interprofessional Teamwork* by Rosalie A. Kane, forward by Milton Wittman, 86 pp. (1975)
9. *Training for Teamwork: With an Annotated Bibliography of Teaching Materials* by Rosalie A. Kane (Scheduled for Publication in 1975)
10. *Innovative Projects in School Social Work Practice*, Volume II, edited by Neal Bellos, Gerald Gross and Joseph Steiner (Scheduled for Publication in 1976)

SPECIAL PUBLICATIONS

The following two volumes are the final reports of a national curriculum building project conducted under contract with the U.S. Veterans Administration.

Undergraduate Social Work Education for Practice: Volume I A Report on Curriculum Content and Issues edited by Lester Glick. Contributors: Herbert Bisno, Cordelia Cox, Kay L. Dea, James R. Dumpson, Donald Feldstein, Lester Glick, Gerald Gross, Claire R. Lustman, Benjamin H. Lyndon, Margaret B. Matson, Mereb E. Mossman, Marguerite V. Pohek, John M. Romanyszyn, Zelda Samoff, Simon Slavin, Richard Steinman, Joseph L. Vigilante, Thomas H. Walz, Ernest Witte, 308 pp. (1972).

Volume II Manpower Research on the Utilization of Baccalaureate Social Workers: Implications for Education edited by Robert Barker and Thomas Briggs. Contributors: Claire M. Anderson, Mary R. Baker, Robert Barker, Thomas Briggs, Thomas Carlsen, Dorothy Bird Daly, Margaret Daniel, Michael Herrera, Margaret Hoffman, Donald E. Johnson, Virginia Karl, Ellen P. Lebowitz, Leonore Rivesman, Fred Wight, 109 pp. (1971)

