AN EXPLORATORY STUDY OF ROLE BEHAVIOR WITHIN INTERDISCIPLINARY TEAMS IN A RESIDENTIAL FACILITY FOR THE MENTALLY RETARDED

by

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CHAPTER 1

INTRODUCTION

Today there are 282 public residential facilities (PRFs) in the United States providing services for 125,799 residents (Sheerenberger, 1982). PRFs continue to serve as a major resource for meeting the needs of mentally retarded persons in this country (Sluyter, Cleland, and Walker, 1982).

In a recent survey of PRFs in the United States, Scheerenberger (1982) reported a significant decrease in levels of resident adaptive behavior and an increase in the frequency of multiple handicapping conditions of physical origin and the number of residents with emotional disturbance. As expected, Scheerenberger's (1982) survey data revealed that a higher percentage of the residents living in PRFs were severely and profoundly retarded than mildly and moderately retarded. Corresponding to this increase in the severity of mental retardation, Scheerenberger (1982) reported an increase in the degree of programmatic deficiencies in PRFs. The primary areas of deficiencies included speech, occupational and physical therapies.

Due to reduced budgets and/or reduced census, staffing levels have declined and additional cuts are anticipated by PRFs (Scheerenberger, 1982). In a survey of superintendents of PRFs, Sluyter, Cleland, and Walker (1982) reported budgetary problems and a corresponding lack of resources as

major problems facing PRFs. Meeting the needs of the severely and profoundly handicapped with multiple medical, social and developmental problems within current budgetary and staff constraints poses a definite challenge for the nation's PRFs.

In recent years administrators have sought to meet the complex needs of residents living in PRFs by shifting to a decentralized model of service delivery. This process of breaking large, complex organizations into smaller, manageable and programmatically effective units is referred to as unitization or the unit system (Perry, 1971; Granger, 1972; Sluyter, 1976). The unit system provides an organizational structure that fosters the optimum development of each resident because decisions are made by those staff working directly with the resident (Zubowicz, 1967; White, 1976).

Sluyter (1976) noted that the unit system establishes a natural framework for the development and maintenance of interdisciplinary (ID) teams. Teams rather than specialized departments are responsible for groups of residents. As teams are composed of staff working with the residents, they have the expectation that their ideas, suggestions and recommendations will impact upon the decision making process (Sheerenberger, 1975).

As increased numbers of PRFs have adopted a

decentralized model of organization, the ID team model has become the recognized and accepted approach to program planning in residential facilities for the developmentally disabled. The Standards for Services for Developmentally Disabled Individuals ". . . mandate that a unified and integrated evaluation and individual program plan be developed by an appropriately constituted team for each individual served (Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons, 1979, p. 2). Today the ID team approach is the most widely used model for treating and evaluating the multiple impairments of handicapped individuals (Magrab, 1979).

ACMRDD Standards (1979) mandate that the ID team review each resident's individual program plan at intervals determined by the team, but at least annually. According to the ACMRDD Standards (1979, p. 13), the review:

1. Assesses the individual's response to activities designed to achieve the objectives stated in the program plan;
2. Modifies the activities and/or the objectives as necessary;
3. Determines the services that are needed; and
4. Includes consideration of the advisability of continued enrollment and/or alternative placements.

To comply with these standards, ID teams in PRFs must at least annually address the following areas of the resident's program plan: (1) Assessment; (2) Program Planning; (3) Program Implementation; and (4) Placement Alternatives.

Golin (1981, p. 2) defined an ID team as a ". . . functioning unit composed of individuals with varied and specialized training who coordinate their activities to provide services to children." Team members continue to perform many of their typical tasks. Teachers continue to teach while psychologists provide diagnostic information. What differentiates the team concept is the degree of coordination among members of the team in contrast to the more semi-independent stance of the more traditional professional roles (Golin, 1981). Coordination activities such as the sharing of information and implementation of program plans are crucial to effective team functioning (Golin, 1981).

The problems associated with developmental disabilities do not fall within the purview of any one discipline (ACMRDD, 1979). By using the ID team approach, participants can share information and jointly develop a program plan to meet the many needs of the developmentally disabled individual. The thrust of this interdisciplinary approach is to control potential fragmentation of findings by fully

utilizing the skills, competencies and expertise of a group of individuals with specialized training and knowledge (Hart, 1977).

ID teams in PRFs consist of those staff members who are responsible for program planning and service delivery, particularly those persons drawn from relevant professions, interests and service areas, including the resident, family, guardian, and advocate (Minnesota Developmental Programming System, 1976). However, unless members share and discuss information and together develop an integrated plan, the effort will result in a multidisciplinary process (Gardner, 1980).

The degree to which the staff engage in an interdisciplinary effort will be affected by the manner in which the team members perceive their own roles and the roles of other members (Bales and Slater, 1955; Sarbin and Allen, 1968; Fenton, 1979). Gilliam (1981) found that members of an Individual Education Plan (IEP) Committee in public schools attributed high status by others before a meeting were not necessarily considered influential after the meeting. Goldstein, Strickland, Turnbull, and Curry (1980) suggested that the roles and responsibilities of some IEP Committee members were not clearly defined, and that further training in those roles was needed. Many of the conflicts between team members arise not out of personality

problems but out of lack of role definition that is understood and accepted by all members (Brill, 1976). The goals of the team are more likely to be fulfilled if members clearly understand their responsibilities. Insufficient information and lack of agreement between team members in a given role may lead to tension, dissatisfaction, a sense of futility and lack of self-confidence among team members (Fenton, no date).

Statement of the Problem

The ID team approach has proliferated in residential facilities as a replacement for the traditional medical model of service delivery. The residents who currently live in PRFs are severely and profoundly handicapped with accompanying medical, physical and social problems. Thus, the effectiveness of the ID team depends upon the ability of the members to make complex decisions and coordinate their efforts to develop integrated program plans for multiply handicapped persons.

Additional research is needed to examine the complicated nature of teamwork. Golin (1981, p. 1) addresses this need in the following statement:

> Although the team approach has been widely heralded as a promising innovation in the delivery of services to exceptional persons, the concept seems to have generated more rhetoric that formal research, and to date an adequate theory of the team approach has not been formulated. Before an appropriate conceptual base for the team approach can be fully developed, there is a clear need for

> additional research on the use and effectiveness of the interdisciplinary team in working with exceptional children.

It appears that a major problem is the lack of empirical data stemming from the systematic observation of team interaction. Most of the descriptive information presently available consists of self reports given by individual team members (Golin, 1981). If the major parameters of ID team functioning in PRFs are to be identified, additional research using the systematic observation of team interaction is necessary.

Purpose of the Study

The purpose of the study is to obtain descriptive data on the way in which ID teams function in a residential facility for the mentally retarded. Teams will be observed in a PRF that serves a diverse group of residents of varying ages, degrees of mental retardation, and handicapping conditions.

The contributions made by individual team members in accomplishing the tasks of the team will be examined. Additionally, factors that influence the operation of the team will be considered. As ID teams are the catalysts for all services provided to residents in PRFs, it is critical that the driving and restraining forces associated with the functions of the ID team be closely examined.

From these considerations, two major research questions emerge:

1. What are the members' relative contributions to the task activities dimension of the ID team as defined by ACMRDD Standards?

2. What are the group process dimensions (relative to the task functions) which occur among members of ID teams?

Limitations of the Study

A qualitative research approach employing observation of ID teams in a residential facility for the mentally retarded will be utilized in this study. This approach is appropriate for this research endeavor because it allows the researcher to derive concepts from emerging data rather than from preconceived operational definitions (Filstead, 1977). While this technique provides the researcher with an open-ended, flexible design, it also is subject to limitation.

The generalizability of this study will depend upon the extent to which the teams observed are representative of teams in other residential facilities for the mentally retarded.

While conducting observations of teams, the researcher can never completely eliminate what Denzin (1970, p. 203) refers to as the "reactive effects of observation." The very presence of an observer introduces a degree of reactivity into the field setting (Denzin, 1970). Furthermore, the observers, while recording ID team behavior, may

allow their own personal feelings and interpretations to bias the manner in which they define the situation.

Recording and coding of human behavior is subject to recording error. To minimize the risk of error, observers must be carefully trained and allowed to develop their skills in trial observations. By recording the meeting, using a video-or audio-tape recorder, the verbal interaction among members during the meeting can be preserved for future reference. However, the presence of a recording device may unduly inhibit or prompt members to speak during ID team meetings. Despite these limitations, qualitative research appears to offer the most appropriate methodology for this exploratory investigation.

Significance of the Study

Currently, ID teams serve as the focal point for service delivery for residents living in institutions. Virtually every aspect of a resident's life is impacted upon by decisions made by the ID team. This study will explore the manner in which ID teams conduct annual review meetings of resident program plans in a state operated institution. All staff responsible for implementing the program plan are expected to attend and contribute to the review meeting. Although it is assumed that member participation in the review meeting is important because of the members' roles in carrying out the program plan,

research has not documented the actual nature and quality of participation by staff members serving on ID teams.

The results of this observational study will provide data regarding the manner in which team members actually participate in program review meetings. This information will be useful in evaluating the implementation of the interdisciplinary service delivery model in public residential facilities.

Definitions

Assessment - The assessment of the individual includes attention to the following areas: physical development and health, sensorimotor development, communicative development, social development, affective development, cognitive development, and adaptive behavior or independent living skills. The assessment process: identifies the presenting problems and disabilities and, where possible, their causes; identifies the individual and specific developmental strengths and needs; identifies the individual's need for services, without regard to the actual availability of the services needed; identifies available alternatives for the selection of needed services; and documents a locus of responsibility for identified needed services. The assessment process includes physical examination and health assessment; dental evaluation; medication history; evaluation of nutritional status; visual screening; auditory screening; speech

and language screening; social assessment; and educational, vocational, psychological, or developmental assessments (ACMRDD Standards, 1979).

Interdisciplinary Team Process - An approach to diagnosis, evaluation, and individual program planning and implementation in which professional and other personnel, including the individual being served, and when appropriate, the individual's family participate as a team. Each participant, utilizing the skills, competencies, insights and perspectives his or her training and experience provide, focuses on identifying the developmental needs of the individual and devising ways to meet them, without the constraints imposed by assigning particular domains of behavior or development to particular disciplines only. Participants share all information and recommendations, and develop, as a team, a single, integrated individual program plan to meet the individual's identified needs (ACMRDD, 1979).

Placement Alternatives - Consideration by the ID team of the advisability of continued enrollment in the resident's current placement and/or enrollment in alternative placements.

Program Implementation - Factors related to the implementation or provision of services in accordance with the individual program plan; includes persons responsible for the program; services residents need; the training environment; and training materials.

Program Planning - The process of developing a

written plan of intervention and action that is based on assessment results and modified at frequent intervals, with the participation of all concerned. This process includes the development, addition, deletion, modification or deferment of goals, objectives, plans and activities for individual residents.

Residential Care Facility - An organizational entity that has physical identity and administrative integrity and conducts a program of services directed primarily to enhancing the health, welfare, and development of individuals classified as mentally retarded. The primary purpose of a residential facility is to protect and nurture the dignity, health, and development of each individual requiring twenty-four hour programming services (Joint Commission on Accreditation of Hospitals, 1971, p. xiii).

CHAPTER 2

REVIEW OF RELEVANT LITERATURE

Three broad areas were selected for the literature review. They are: (1) descriptive data about ID teams; (2) role behavior within ID teams; and (3) methodology for studying ID teams. Due to the descriptive and exploratory nature of this study, it appears that a review of these three areas would provide an adequate foundation for the research investigation.

Descriptive Data about ID Teams

In recent years, the ID team approach has become widely adopted, and even mandated in many settings throughout the United States, as a service delivery model for handicapped individuals. However, as Wendland and Crawford (in Golin, 1981, p. 2) note "Individuals trained in differing disciplines do not become a team by the mere process of calling themselves one, nor do they manage treatments by simply doing them. . ."

Generally speaking, what characteristics are descriptive of groups of people working together as ID teams? More specifically, how are ID teams in residential facilities for the mentally retarded characterized? In the following section, these questions will be addressed by reviewing some of the definitions and descriptions of ID teams written by

professionals in the field.

Definitions of ID Teams

A review of the literature reveals numerous descriptive definitions of interdisciplinary teamwork (Luszki, 1958; Krakow, 1969; Powers, 1973; Aradine, 1973; Briggs and Von Voorst, 1974; Kane, 1975; Rubin, 1972; Golin, 1981). Each of these definitions contain common elements considered essential for successful teamwork including: (1) diverse professional contributions; (2) common objectives; (3) a system of communication and continuous intercommunication; (4) collaborative efforts; (5) interpersonal skills; and (6) continuous evaluation and examination of individual effort.

Typical of these definitions of the ID team process is the one provided by ACMRDD (1979, p. 2):

> An approach to diagnosis, evaluation and individual program planning and implementation in which professional and other personnel, including the individual being served, and when appropriate, the individual's family participate as a team. Each participant, utilizing the skills, competencies, insights, and perspectives his or her training and experience provide, focuses on identifying the developmental needs of the individual and devising ways to meet them, without the constraints imposed by assigning particular domains of behavior or development to particular disciplines only. Participants share all information and recommendations, and develop, as a team, a single, integrated individual program plan to meet the individual's identified needs.

This definition provides a foundation for answering

the two research questions addressed in the present study. The definition describes the tasks of the team as that of ". . . diagnosis, evaluation and individual program planning and implementation. . ." The processes through which the team accomplishes its tasks, as described in this definition, are by crossing traditional disciplinary boundaries, sharing all information and recommendations, and together developing an integrated program plan. Without engaging in these behaviors, the team will operate in a multidisciplinary or unidisciplinary mode.

Not all professionals will find it easy to cross professional boundaries or to accept others encroaching upon their turf. In an interdisciplinary setting, professional jealousies must be replaced by task-sharing (Frank, 1962). Professionals who have been through years of rigorous pre-service training may find it difficult to yield their autonomy. This may be especially true of members representing such established professions as medicine.

Characteristics of ID Teams

Medicaid provides a major funding source for residential facilities for the mentally retarded. Similar to ACMRDD Standards, Medicaid regulations mandate that all residents are provided active treatment and opportunities for developmental growth. Gardner (1980, p. 13) summarized the following characteristics of ID teams according to

Medicaid criteria:

- The resident actively participates in the ID team process;
- Direct care staff play an active role in the team process;
- The parent, guardian or advocate participates in the ID team process;
- All staff have a collective responsibility for ensuring that the plan succeeds;
- The team identifies the total developmental needs of the resident;
- Plans for the resident are made according to strengths and developmental needs which may combine and cross professional disciplines;
- The ID team collectively assigns priorities to the resident's needs to develop a single, comprehensive program plan for the resident.

These criteria provide the researcher in the current investigation with a framework of what to look for in observing ID teams in a residential facility for the mentally retarded.

An interdisciplinary team may be described in terms of descriptors such as team membership requirements, assignment of roles, definition of case managership, and operational formats (Elder, 1980). However, in its most

meaningful sense, interdisciplinary care is an attitude (Johnston and Magrab, 1976). Elder (1980, p. 17) notes that "For professionals to interact in a truly collaborative manner, the elements of trust, respect and mutual dependence must be present." Interdisciplinary collaboration is strengthened and works more effectively when, in the process of interaction, each participant becomes:

1. More aware of the type of contribution, such as information giving, encouraging or summarizing, that is needed at any given time;
2. More able to provide a range of these interactive functions; and
3. More skilled in giving feedback to other participants (Elder, 1980, p. 18).

While observing ID teams in PRFs, one would attempt to measure the degree of collaboration by considering the types of contributions made by different team members during the meeting such as asking questions, giving information, and/or suggesting alternatives or solutions to problem situations.

Golin (1981) identified a number of characteristics that seem to be common to ID teams in a variety of settings. While this set of criteria is not all inclusive, it is helpful in deciding whether a group should be considered an ID team. The nine characteristics identified by Golin

(1981, pp. 6-9) were further divided into three main categories: (1) composition; (2) functions; and (3) tasks. Each of these areas is described below:

Composition

- A team consists of two or more individuals.
- Communication may be direct and face to face or indirect.
- There is an identifiable leader.

Functions

- Teams function both within and between organizational settings.
- Roles of participants are defined.
- Teams collaborate.
- There are specific protocols of operation.

Task

- The team is child centered.
- The team is task oriented.

These criteria provide a framework for describing the characteristics of ID teams in PRFs. These characteristics will be briefly discussed according to Golin's (1981) criteria.

Composition of ID Teams in PRFs

In residential centers for the mentally retarded, the team usually consists of individuals such as a team leader, direct care staff from the first and second shifts,

a psychologist, a nurse, and social worker. Those persons who work most directly with the resident may be thought of as the core members of the team. To this core must be added other persons who may be needed to develop an adequate program plan for the resident. When special problems or needs are present, additional staff with the expertise in the problem area may be called to the meeting on a consultative basis. Efforts should be made by those members to participate in the meeting rather than submitting written reports or recommendations (ACMRDD Standards, 1979).

A major benefit of the ID process is the continuing education and role expansion of team members. By working with representatives of other disciplines in a problem-solving setting, team members learn what other disciplines may contribute, and thereby increase their own skills and competencies (ACMRDD, 1979).

While team members work together on a daily basis in implementing the resident's program plan, they are required to meet at least twice a year. A meeting is held every six months to review the resident's need for continued institutionalization. Another meeting is held at least once a year to review the resident's program plan.

There is an identifiable leader for ID teams in PRFs. This person is referred to as the team leader. The team leader is responsible for chairing the meeting

according to protocol established by the institution. Assigned leadership of the team may or may not rotate depending upon the organization of the facility.

Functions of ID Teams in PRFs

The administration and organization of the PRF provides the support system for ID teams. Professionals from other agencies, such as a community mental retardation agency, may attend team meetings. The roles of the team participants in the PRF are defined in terms of the professional competencies of each team member and the nature of the task to be done. While teachers provide education services, physical therapists, for example, provide services related to the resident's physical disabilities. Role overlap and flexibility are characteristic of ID teams in PRFs. For example, the speech therapist, occupational therapist and teacher may all be working toward improvement of a resident's eating problem. ID team members must collaborate and coordinate their activities to provide optimum services for the residents.

Tasks of ID Teams in PRFs

The primary concern of the teams in the PREs are the residents who are being served. The Rules and Regulations To Assure the Rights of Residents of Facilities Operated by the Department of Mental Health and Mental

Retardation, Commonwealth of Virginia (1983), for instance, mandate that residents and/or their authorized representative participate to the fullest extent possible in the development of the resident's program plan. The team must make an effort to comply with the resident's preferences and wishes when compatible with the resident's training goals.

The teams in residential facilities are primarily task oriented. They exist to provide diagnostic, assessment and program services to the residents living in the PRFs. Golin (1981) noted that ID teams would have goals that were task oriented as well as maintenance goals. Maintenance goals focus on the group process itself and enhance the harmony among team members. Failure to attend to the maintenance goals may interfere with the team's ability to accomplish its assigned tasks.

Summary

ID teams in PRFs are composed of a variety of professional and paraprofessional staff. The team's composition is interdisciplinary in nature and requires the direct participation of those staff who coordinate the resident's program and of the direct contact staff who provide the resident daily care and programming, rather than merely the supervisors of these staff.

The teams are characterized by a mutual sharing

among members of information and recommendations regarding residents' individualized needs. Members must collaborate and coordinate services without relinquishing professional accountability. Through face-to-face contact with representatives having diverse expertise and knowledge regarding the resident, the team members are responsible for developing an integrated program plan. Through this process members can increase their own knowledge, skills and competencies.

Role Behavior within ID Teams

While teams are assigned various tasks related to the aims of the individuals they serve, the success with which they accomplish their tasks depends upon the degree to which individual members can coordinate their activities as members of a single unit. This process of collaboration and coordination is affected by the manner in which individuals perceive their own roles on the team and the roles of other team members. Role behavior within ID teams is influenced by a variety of factors and interrelated processes. In the section that follows, role behavior and its impact on team functioning will be discussed under three areas: (1) coordinate vs. integrative teams; (2) role perception and expectations; and (3) the impact of power and status differences among team members.

Integrative versus Coordinate Models

ID teams tend to function as either "integrative" or "coordinate" teams (Kane, 1975). Feiger (1979, p. 22) described coordinate teams as a group of specialized health personnel performing "role-specific" and "non-overlapping" tasks. The major focus of the coordinated team's interaction is information sharing and coordination. Proponents of coordinated teams such as Ellwood (in Kane, 1975) claim that parents are easily confused in a role-blurring interprofessional team with emphasis on consensual decision-making. Communicating and coordinating teams are likely to have a hierarchical differentiation of status, authority, and decision-making imposed (Feiger, 1979). Physicians will have more autonomy than any other team member. Consequently, the value of any particular team member stems from his similarity to the physician.

Integrative teams, in contrast to coordinated teams, are composed of specialized personnel performing role-specific tasks that are defined by their individual contributions to overall health goals (Feiger, 1979). He notes that attributes such as shared decision-making, overlapping roles, shifting leadership, and attention to group processes are desirable. Equal autonomy exists among members of the integrative team with values accorded to individual members based on contributions to the problem-

solving process. According to Charns (in Ewart, 1982), ". . . the greatest barriers to integration are the difficulties associated with exchange of needed information across professional descriptions, or departments, and the management of conflict." An essential element of the interdisciplinary process is that each member have respect and understanding of another's discipline and associate the interdependence of each profession for the other in the solution of complex problems (McCartin, 1978).

According to the ACMRDD definition of the interdisciplinary process, teams in residential facilities should function around an integrative model. The value accorded to individual members is not based on the status or authority of any individual member but rather upon their contribution to the total problem-solving process. Members of the various disciplines do not function as separate entities but as interdependent change agents in developing the resident's individual program plan.

Role Perceptions and Expectations

Team members may have preconceived notions regarding their ability to influence the decisions made by the team. The degree to which a team member believes his input will impact on the decision outcome will determine the extent to which he participates in the ID planning process.

In PRFs the majority of the team members will have professional degrees certifying and/or licensing them in a specialized area. Direct care staff, on the other hand, who are responsible for carrying out many of the program plans, will, in most cases, have no formal academic training for the job. Consequently, the participation of these team members may be limited if they perceive themselves as having less knowledge and status than professional staff serving on the team.

Role perception was the subject of a study of placement teams (PT) conducted by Fenton (no date). She surveyed PT members regarding appropriate activities for four target roles: (1) principal; (2) psychologist; (3) special education teacher; and (4) regular education teacher. The author found that the four team members had a restricted view of the activities appropriate for the other three roles. Expectations of PT members were predicated on a hierarchical staffing structure of the school. These expectations may limit participation for those members who perceive themselves at the lower end of the status continuum. The regular teachers, for example, may perceive themselves as having less status within the school hierarchy. Subsequently, members who participate less are likely to be less satisfied with the team process. When a team member identifies with the team, he is likely to show greater concern for

accomplishing the goals set by the team. Members are also likely to feel less hostility about their work and a sense of belonging.

Gilliam (1981) surveyed 130 participants at 27 IEP meetings to determine which roles were perceived as (a) most important to the IEP process; (b) most influential in decision-making; and (c) contributing the most to decisions reached. Data were collected on a questionnaire completed before and after the IEP meeting.

Prior to the meeting, the highest ranked roles included special education teachers, psychologists, parents and regular education teachers. However, the author found that the premeeting and postmeeting rankings were quite dissimilar with the exceptions of special education teachers and psychologists. Members such as parents, regular education teachers and social workers were ranked much higher in importance than in contribution and influence. For supervision and direction of special education, the opposite was true.

For the four most highly ranked positions, the roles and expected functions were closely related. The psychologist was perceived to have the most influence in diagnosis; the special education teacher, in planning and implementation; the director, in placement; and the supervisor, in due process decisions. Parents were perceived as low in

actual contribution and influence. The author offered two explanations for the influence hierarchy in IEP meetings. The most influential roles have areas of expertise which match one or more of the five delineated functions on the IEP. While parents and principals are expected to be influential, they have less actual influence in the specific functions of the IEP than other participants. A second explanation offered by the authors is that the most influential roles are those members who offer hard data in terms of test scores, diagnostic reports, and cummulative records, and who are able to contribute information based on the assessment process as they usually have hard data to contribute.

Gilliam (1981) attempted to derive much the same type of information as the present study, as both are directed toward defining the contributions of the team's members to the tasks of the team. While Gilliam derived his conclusions from survey data reported by the participants, in the present study, the author will attempt to determine which members are most influential by observing the teams while they are actually conducting team meetings.

The Impact of Power and Status Differences among Team Members

In another study of planning teams in public schools,

Fenton (1979) found that a group setting provides the opportunity for exploiting the power differential among school staff serving on the team. While individual status may be conferred upon a team member for reasons related to his behavior on the team, professional status is more likely to reflect the prestige of the individual's profession.

Studies have shown that higher-status individuals receive more communication, are better liked, and give less irrelevant communication to other members than persons of lower status in the group (Thibaut and Kelley in Golin, 1981). "The reality of power," says Brill (1976, p. 96) "is a factor that anyone working in human services must be prepared to deal with, and nowhere to a greater extent than in the team model of practice." Brill (1976) conceptualizes the power structure in a team as being both formal and informal. The formal structure consists of the positions which, by virtue of their designated positions, status and role, possess power to control, punish or reward. The informal power holders are those who possess the power by virtue of their capacity for natural leadership and referent quality or knowledge. The team must learn when the power is both within itself and within the organization of which it is a part. An environment must be created in which the traditionally powerless are able to differ without fear

of retaliation (Brill, 1976).

Hurwitz, Zander and Hymovitch (in Golin, 1981) found in a study of the effects of power in groups of mental hygiene workers that high-power members communicated more often than low-power members and received more communication from both high- and low-power members. Subsequently, low-power members experience uneasiness in their interaction with high-power members and react in an ego-defensive manner in the group situation.

According to the theoretical model of ID teams in PRFs established by ACMRDD Accreditation Standards (1979), all members of the team should collaborate and share information in jointly developing an integrated program plan for the resident. The team setting in PRFs provides the opportunity for potential exploitation of the power and status differential among members. There is a wide variation in academic requirements among staff working in a residential facility. While a psychologist and a speech pathologist, for example, are required to have masters degrees, direct care staff are not required to have a high school diploma. Subsequently, there is a wide range in salary levels among the team members.

All team members must conscientiously strive to diminish status discrepancies and encourage full participation in the interdisciplinary planning process. An

environment must be created where all members, regardless of position, feel accepted and are willing to contribute to the decision-making process.

Summary

ID teams in PRFs should operate using an integrative model where member status is based upon contributions to the problem-solving process versus status of individual members' positions. Behavior on teams will be affected by the degree to which members perceive that their input will influence the decisions made by the team. The team model provides a potential environment for exploitation of power and status differences. Members must work together to diminish power and status discrepancies among team members to create an environment where all members feel that their contributions will be accepted and deemed valuable by other members.

Methodology for Studying ID Teams

The purpose of this study is to (1) determine the contributions made by different team members to the task of the team; and (2) determine the group process dimensions (relative to the task functions) which occur among members of ID teams. As Golin (1981) stated, to date there does not exist an adequate theory of the team approach, and therefore, additional research is needed to establish a conceptual base for the team approach. Since a theoretical

base for teamwork has not been develcped, there are no formal preconceived operational definitions of teamwork. Without an established knowledge base regarding the behavior and use of ID teams, researchers studying teamwork must explore alternative research designs to replace traditional, empirical research methodologies.

For this particular investigation, a qualitative research design, where ID teams are observed in their natural environment, appears to be the most appropriate methodology. As Filstead (in Taylor and Bogdan, 1981) notes, a qualitative research approach allows the research to develop an open-ended, flexible research design. Taylor and Bogdan (1981, p. 72) characterize qualitative research as ". . . inductive, holistic, and oriented to people's subjective experience." This technique is particularly useful in recording member behavior on teams as it can handle forms of interaction that are in constant change (Denzin, 1970).

For a qualitative researcher, the validity of a study depends upon whether the researcher has utilized methods which provide first-hand knowledge of the phenomenon under inquiry as it exists in the world (Taylor and Bogdan, 1981). As Denzin (1970, p. 199) asks, "Can the observations of the participant observing be generalized to other populations (external validity)? Do the observations

represent real differences or are they artifacts of the observational process (internal validity)?" The researcher must demonstrate that the cases he studies represent the class of units to which the generalizations are made (Denzin, 1970). The researcher studying ID teams in a PRF or in a public school setting, for instance, must demonstrate that the teams observed are representative of other teams in similar settings if the study is to possess external validity.

With regard to internal validity, the qualitative researcher must be sensitive to any biasing features the subjects may possess. Qualitative researchers choose their subjects based on availability or specific interest. Seldom do they use random or stratified sampling techniques (Taylor and Bogdan, 1981). The study of large samples is frequently prohibited due to a lack of time and resources.

In studying ID teams, the researcher must be cognizant of the reactive effects of the observer (Denzin, 1970). The researcher cannot isolate the effects that the observers may have on the internal validity of the study. Observers may be seen as "foreign objects" by the team members (Denzin, 1970, p. 204).

In conducting a qualitative study, the researcher must also be aware of the changes in the observers. Researchers of ID teams should allow the observers to record

their own personal assessment of the situations to reduce the risk of the observer's loosing his objectivity. By recording in writing their own personal feelings, prejudices, evaluations and even hypotheses regarding the team observation, the qualitative researcher can further protect the internal validity of his study (Taylor and Bogdan, 1981).

The author located three studies in which teams were studied using an observational design. In each of the studies, the researcher had developed his own system for categorizing verbal behaviors. In only one of the studies was there an attempt to study changes in team behavior following a structured intervention.

Goldstein, Strickland, Turnbull and Curry (1980) used structured observation to examine the dynamics of the Individual Education Planning (IEP) Conference in a public school setting. They recorded which members spoke to whom about what topic in specified time intervals. Results suggested that the roles and responsibilities of the team members were not clearly defined, and that further specification and training in these roles would be beneficial. The results of this study revealed data that is of interest in regard to the present study. The mean number of participants was 3.7 with a range of 2-6. None of the observed conferences were attended by both parents. The child's

mother attended the majority of conferences. The mean length of the conference was 36 minutes while the range was 6-72 minutes. The resource teacher dominated the meeting. The resource teacher reviewed an already developed IEP with the parents who were the primary recipients of comments made during the meeting. Typically, the professional who was speaking directed comments to the parents to the exclusion of other professionals present at the meeting.

In analyzing the topics discussed at the conferences, the three most frequently mentioned were: (1) curriculum, (2) behavior, and (3) performance. Topics such as evaluation, placement, special services, rights, and responsibilities, future contacts and plans received little attention. The authors characterized explanations given by team members as "confusing." However, parents did not ask questions seeking clarification. The authors noted that evaluations were typically discussed at the beginning of the conference whereas parents were coded as participating more actively in discussions in the later portions of the conference of the fourteen (14) observed. Only one conference was actually devoted to specifying goals and objectives jointly between parents and the team.

The authors concluded that the purpose for the meeting could be viewed as informing parents of the nature of

an already developed IEP, obtaining any suggestions from them for modification and finally receiving their approval.

Due to the limited size, nature, and demographic restrictions, caution must be exercised in generalizing the results of this study to similar groups. However, the results of this study will provide a foundation for comparing the development of individual program plans for children in public schools and residents in public institutions.

Following observations of interdisciplinary health teams, Feiger and Schmitt (1979) found that differences among teams were due primarily to the presence of the physician. Furthermore, they found that the degree of collegiability existing among team members was positively related to patient outcome measures. Ewart (1982), noting the limited research on team development interventions, evaluated the effects of a health team development intervention on ID team processes in a state facility for the mentally retarded. Effects were measured by participant questionnaire responses, interviews with management and team leaders and by the direct observation of team meetings before and after the intervention. Following completion of the team development program, positive changes were found in members' perception of their team's general effectiveness, their leader's approachability, and the value of their meetings. No changes were found in member

participation and influence. Structured observational data showed increases in the frequency of interpretative statements, alternatives suggested, and decision-making suggestions during team meetings after team development. Questions asked and information given categories showed decreases.

Summary

Using a qualitative research design, the researcher interested in studying ID teams has a flexible, but systematic approach for exploring how members of a group behave in a designated environment. Unlike the more rigorous empirical methodologies, this technique allows the researcher to develop hypotheses based on data as it emerges during the course of the observations. The researcher must address any biasing features his subjects and/or his observers may possess to protect the internal validity of the study. The qualitative researcher must also be careful in generalizing the results of his study to larger groups. The external validity will be influenced by the size and representativeness of the researcher's sample. Due to the lack of research on the study of ID teams, qualitative research appeared at this time to offer the most appropriate methodology for exploration of this subject area.

Conclusions

The information presented in this review of the

literature has been, for the most part, of a descriptive nature. While the ID team model has been accepted and is widely used in a variety of settings, there is little research available regarding the utilization of the team approach or the outcomes in terms of resident change. The research that has been done so far was conducted primarily in laboratory or public school settings.

Although the tasks of the ID team in PRFs are dictated by existing standards, there is a critical lack of research addressing the manner in which the team accomplishes its task. There is evidence that member behavior is affected by role and status variables. Yet there is no research regarding how these factors influence ID teams in residential facilities.

The lack of a theoretical research base regarding the function of ID teams provides the rationale for use of a qualitative design in studying teams in residential facilities. The knowledge obtained through exploratory studies will provide the necessary foundation for future research endeavors.

CHAPTER 3

METHODOLOGY

Introduction

This was an observational or ethnographic piece of research which followed the techniques outlined by Denzin, 1970; Goldstein, Strickland, Turnbull, and Curry, 1980; Golin, 1981; and Taylor and Bogdan, 1981. Using a qualitative research design, the researcher observed ID teams in their natural environment in a residential facility for the mentally retarded. By using this research design, the researcher was able to observe, code and record member behavior on teams without being limited to any preconceived operational definitions of teamwork.

Twelve teams were selected for observation in a residential center for the mentally retarded. The facility, located in the eastern part of the United States, provided services for over 1,700 residents, the majority of whom were severely and profoundly retarded. Within the facility, there were seven large centers or units. Residents were assigned to the seven centers based upon such factors as age, handicapping conditions, medical condition, and adaptive behavior skills (See Description of Facility, Appendix D).

It was the policy of the facility that habilitation, health and residential services be provided to residents on the centers through the mediation of specifically designated ID teams. Specifically, each resident's ID team was

responsible for:

1. The evaluation and assessment of the resident's status and needs;

2. The development of long-range goals for the resident and the formulation of intermediate objectives to reach those goals;

3. The design and implementation of an Individual Program Plan (IPP)/Individualized Education Plan (IEP) for the resident to meet specified objectives/goals;

4. The recommendation of the program to the Director of the facility;

5. The periodic review of the resident's responses to programming and re-assessment of his/her needs;

6. The safeguarding of each resident's legal and human rights in the program planning;

7. The structuring of a positive and normalizing environment for the resident within his/her living area; and

8. The documentation of all results of evaluation, planning, goals/objectives, programs, resident responses and attention to rights.

The twelve teams were observed while conducting annual reviews of the residents' program plans. As stated previously, the ID teams were mandated by ACMRDD Standards to review individual plans at intervals determined by the team, but at least annually (1979, p. 13). During the review, the team must have:

1. Assessed the individual's response to activities designed to achieve the objectives stated in the individual program plan.

2. Modified the activities and/or the objectives as necessary;

3. Determined the services that are needed; and

4. Included consideration of the advisability of continued enrollment and/or alternative placements (ACMRDD Standards, 1979, p. 13).

While team meetings on the various centers differed in such variables as number of staff attending, meeting location, duration, and style of the meeting, all teams were required to complete certain activities to comply with Medicaid and ACMRDD Standards. In Table 1 an overview is provided of what generally was supposed to take place prior to, during, and after annual review meetings.

During the twelve observations, three activities were initiated to gain insight regarding the research questions presented in this study. First, the verbal responses of the team members were recorded by trained observers according to predetermined coding rules. This information was needed to answer the first research question regarding the nature of the various team members' contributions to the task activities dimensions of the ID team as defined by ACMRDD Standards. Specifically, the question asks which members contribute what types of information to the assessment, program planning, program implementation, and placement alternative categories.

Second, the observers noted the team's performance on nine factors identified by Friedlander (1966) that

TABLE 1 The Annual Review Meeting

Prior to the Meeting	Responsible Staff	During the Meeting	Responsible Staff	After the Meeting	Responsible Staff
1. Send notification to all staff and parents/relatives a. Staff b. Parents/relatives	Accredited Record Technician (ART) Social Worker	1. All appropriate disciplines present	Team Leader	1. Write letter to parents/relatives if necessary	Social Worker
		2. Report assessment data	Each discipline		
		3. Complete Annual Objective Review Form (see Appendix A)	Each discipline		
2. Reviews folder a. Current problem list b. Objectives c. Monthly summaries for program results d. Previous annual review e. Deferred problems	Each discipline	4. Review current problems and objectives in behavioral terms	Each discipline	2. Interpret results of meeting to resident, if necessary	Team Leader
		5. Review deferred problems	Team		
		6. Discuss changes and recommendations	Team		

(cont.)

Table 1 The Annual Review Meeting (cont.)

Prior to the Meeting	Responsible Staff	During the Meeting	Responsible Staff	After the Meeting	Responsible Staff
3. Prepare for Annual review a. assessment of resident's current functioning level. b. Current resolved and deferred objectives c. Recommendations	Each discipline	7. Update daily activity schedule. Document person responsible for follow through on schedule	Each discipline	3. Follow up on assigned recommendations	Team leader
		8. Prioritize problems			
		9. Remove dots from problems which are no longer prioritized			
4. Prepare ID Team Review Form (see Appendix A) a. List active and deferred problems	Team leaders	10. Review strengths list	Team	4. Forward Continued Institutionalization Form	Team leader
		11. Review resident's accessibility sheet	Team	5. Implement and monitor approved programs	Each discipline
b. List problems and objectives resolved	Each discipline	12. Discuss and recommend diet	Team		
5. Obtain input from third shift	Team leader Developmental aides, third shift	13. Complete ID team review form	Team		
		14. Complete Continued Institutionalization Form (see Appendix A)	Team		
		15. Write ID note	Team leader		

influence member behavior in a group. This information was needed to answer the second research question regarding those group process dimensions (relative to the task functions) which occur among members of ID teams.

Third, the observers were instructed to write their own personal observations regarding the team's effectiveness in accomplishing their assigned tasks. This information was used to obtain insight into the group process dimensions (relative to the task functions) which occur among members of ID teams. This activity also allowed the observers to depersonalize the observations by expressing their own comments regarding each observation.

In the section that follows, a detailed explanation will be provided of the methodology used during the observations. Specifically, the following activities will be addressed: (1) selection of the twelve teams; (2) selection of the subjects; (3) collection of resident data; (4) demographic data obtained regarding the team members; (5) protocol; (6) the observers; (7) recording of members' responses; (8) rating team behavior; (9) data analysis; and (10) written summaries of the twelve meetings.

Selection of the Teams

Twelve teams were selected for observation by the investigator representing each of the facility's seven centers. Two teams were selected from the centers having

the greatest number of residents. This represented eight of the twelve observations. Four teams were selected from those centers having smaller resident populations. A description of the twelve teams is displayed in Table 2.

The primary consideration in selecting a team was that the purpose of the meeting be to conduct an annual review of the resident's program plan as mandated by ACMRDD Standards (1979). The researcher was given a copy of the monthly calendar for scheduled meetings from each center. Meetings were observed that were mutually convenient for the observers.

Subjects

The subjects for the study included those staff members serving on ID teams in the centers. The ID teams consisted of individuals who represent the professions or service areas that were relevant for each resident (Intermediate Care Facility for the Mentally Retarded or Persons with Related Conditions, Survey Report, 1981). The numbers of and type of staff represented at each of the twelve observations is shown in Table 3.

A core group of staff were usually present at all annual review meetings. This group included:

1. Developmental aides from first and second shifts;

TABLE 2 Description of the Teams

Team #	Purpose
1	To provide services to geriatric residents over the age of 45.
2	To provide services to geriatric residents over the age of 45.
3	To provide services to residents in need of skilled nursing care.
4	To provide services to residents in need of extended nursing care.
5	To provide services to residents in need of skilled nursing care.
6	To provide services to residents who are potential candidates for discharge.
7	To provide services to residents who are potential candidates for discharge.
8	To provide services to residents of school age.
9	To provide services to residents of school age.
10	To provide services to lower functioning adult residents.
11	To provide services to residents having severe maladaptive behaviors.
12	To provide services to residents with multiple handicaps.

TABLE 3 Attendance at the Meetings

Observation	#	Team Leader	Teacher	Nurse	Social Wkr.	Psychologist	Speech Therapist	Recreator	Dev. Aide*	Family	Music Teacher	PT Aide	Spec. Act. Aide	Dental Educator	Resident	OT Aide	Dietician	ART	Advocate	Physician	PE Teacher	OT Supv.	Shift Supv.	Total Staff Attending	
	1	x	x	x	x	x	x	x	xx			x						x						11	
	2	x		x	x	x	x	x	xx		x	x		x	x			x						13	
	3	x	x	x	x	x		x	x		x	x	x	x										11	
	4	x	x	x	x		x	x	xx		x	x	x	x	x	x	x	x	x			x	x	20	
	5	x	x	x	x		x	x	x		x	x	x	x										11	
	6	x	x	x	x	x	x	xx	x	xx		x	x		x									14	
	7	x	x	x	x	x	x	x	xx	xx					x		x			x				15	
	8	x	x	x	x	x	x		x									x						8	
	9	x	x	x	x	x	x	x	x									x						9	
	10	x	x	x	x	x	x	x	x				x	x	x						x			12	
	11	x	x	x	x	x		x	x															7	
	12	x	x	x	x	x	x	x	xx			x		x								x		12	
		12	11	12	12	10	10	11	12	2	5	7	5	6	5	1	2	4	1	1	1	2	1		

*More than one representative for this discipline/position

2. A nurse;

3. A psychologist;

4. A social worker; and

5. A team leader.

Depending upon the individual needs of the resident, any of the following disciplines or staff were also represented at the meeting:

1. Dental educator;

2. Dietician;

3. Music therapist;

4. Physical therapy aide;

5. Speech pathologist;

6. Special activity aides for recreation and/or education; and

7. Teachers.

Additionally, the resident and his authorized representative (parent/relative/guardian) were invited to attend all team meetings. The resident's advocate was also invited to attend the team meetings. The advocates were staff members employed by the Department of Mental Health and Mental Retardation, not the facility, responsible for representing the rights and interests of individual residents. Physicians did not usually attend meetings. The nurses were responsible for presenting health and/or medical related information. The accredited record technicians (ART) attended the meetings to address questions

pertaining to the resident's record. The number of and type of staff represented at the meetings varied based upon the individual needs of the resident in question. In any one center, a staff member may have been assigned to serve on more than one team. This was especially true of support staff providing specialized services such as the speech pathologists, psychologists, social workers, physical therapy aides and teachers.

Resident Data

To obtain a profile of each resident discussed during the meetings, the following data were collected on each resident:

1. Age;
2. Classification of mental retardation;
3. Length of placement at the facility;
4. Adaptive behaviors;
5. Maladaptive behaviors;
6. Additional handicapping conditions;
7. Medications received;
8. Frequency of family contact;
9. Current problems; and
10. Training objectives.

Using Form #1 (Appendix A), this information was obtained by reviewing each resident's record. The infor-

mation was recorded in such a manner that the identity and confidentiality of the resident was protected at all times. A summary description of the twelve residents is provided in Table 4.

Demographic Data

For each of the twelve meetings observed, the following data were recorded:

1. Meeting location;
2. Number of staff attending the meetings;
3. Length of the meetings; and
4. Number of total average responses made by all members at the meetings.

This information was recorded using Form #2 (See Appendix A). To protect the identity of the teams, each team was referred to as Team #1, Team #2, Team #3 and so on. A summary of the data for the twelve meetings observed is displayed in Table 4. Each of these four variables will be discussed in greater detail in Chapter 4.

Protocol

Prior to initiating this research project, the author obtained approval from the facility's Research Committee. Subsequently, each of the seven center's directors were contacted and given an explanation of the nature of the study. The author requested a monthly schedule for ID team review meetings from each center.

TABLE 4 Demographic Data Summary of the Twelve Observations

Team Number	Resident's Age	Length of Residence (Years)	IQ	Classification	Meeting Location	Number of Staff Attending	Length of Meeting (Minutes)	Number of Average Responses
1	73	15	31	Severe	Dining Room	11	25	55.5
2	66	36	51	Moderate	Dining Room	13	20	137.5
3	26	15	3	Profound	Conf. Room	11	17	87.0
4	18	13	55	Moderate	Class-room	20	41	225.0
5	24	23	23	Severe	Conf. Room	11	16	81.5
6	45	15	17	Profound	Day Hall	14	20	121.0
7	37	35	24	Profound	Day Hall	15	22	91.0
8	18	6	33	Severe	Conf. Room	8	20	68.0
9	21	19	Not Avail.	Profound	Dining Room	9	15	40.5
10	31	21	34	Severe	Bed-room	12	20	83.0
11	37	29	28	Severe	Kitchen Area	7	12	50.5
12	40	18	29	Severe	Dining Room	12	20	81.0
Average	36.3	20.4	29.8			11.91	20.6	93.45

Prior to the beginning of each meeting observed, the author explained to the team the purpose of the observations. Staff were advised that all information would be coded in a manner such that no individuals could be identified. The observers advised the team members that any questions would be answered following the observation.

The Observers

Three observers, in addition to the author, were trained to observe the ID team meetings. Two observers, one of whom was always the author, attended each of the twelve meetings. The observers were employees of the facility who had served in varying capacities as members of ID teams. Prior to conducting the observations, the observers were trained to record the members' verbal responses according to the established coding rules. The observers conducted four trial observations using the recording forms prior to beginning the observations that were part of this study.

Recording of Member Responses during the Meetings

During the meeting, the observers independently coded statements made by the team members into one of the following four content categories using Form #3 (See Appendix A).

1. Assessment;

2. Program planning;

3. Program implementation; or

4. Placement Alternatives.

Additionally, each statement was coded as:

1. A question, information seeking statement;

2. An information giving statement; or

3. A statement suggesting a recommendation, solution, alternative, or interpretation to a problem.

For example, a teacher may have asked a question regarding available placements in the community for a resident. This would be coded as a question under the placement alternatives category. A developmental aide, for example, may have given information regarding a resident's progress in a feeding program. This would be recorded as an informational statement under the category of program implementation. A psychologist, on the other hand, may have given diagnostic information regarding the resident's intellectual capacity. This would be recorded as an informational type statement under the category of assessment. A description of each of these categories is provided in Table 5.

The observers adhered to the recording rules defined in Table 6 for recording the verbal responses made by those staff attending the meeting. The observers used tally marks to indicate the number of statements made by a particular individual in a designated category. For example, discussion at the meeting was initiated by a team leader who

TABLE 5 Category Descriptions for Coding Responses

Category	Description
1. Assessment	Statements about the resident's physical development and health, sensorimotor development, communicative development, social development, affective development, cognitive development, and adaptive behaviors or independent living skills. The assessment process includes any statements referring to the following: physical examination and health assessment; dental evaluation; medication history; nutritional status; visual screening; auditory screening; speech and language screening; social assessment; and educational, vocational, psychological or developmental assessments.
2. Program Planning	Statements referring to the development, addition, deletion, modification or deferral of goals, objectives, plans and/or activities in the resident's program plan.
3. Program Implementation	Statements referring to the implementation of the program plan including persons responsible for the plan; services provided; the training environment and materials.
4. Placement Alternatives	Statements referring to the placement of the resident including the residential facility or alternative community placements.
5. Questions, Information Seeking Statements	All statements asking for information, suggestions, opinions or requesting reports.
6. Informational or Factual Statements	All statements giving factual information, dealing only with what is observed, without interpretation.
7. Recommendations, Suggestions, or Alternative type Statements.	All statements which suggest recommendations, interpretations, opinions, going beyond empirical data to make inferences about what has been said.

TABLE 6 Recording Rules

The observers adhered to the following protocol for recording member behavior:

1. Each participant was identified by position only;
2. Only verbal statements were recorded;
3. Each statement was recorded by category and participant;
4. Each response was recorded only once regardless of length, unless there was a change in response category;
5. Each change in category was recorded as a new response; and
6. Each change in respondent was recorded as a new response.

(Adopted from Golin and Ducanis, 1981, p. 180).

asked for a report from the nurse regarding the resident's health status. Using Form #3, the observers would code this as a "question" under the category of "assessment" initiated by the team leader. Assuming that the nurse provided factual information regarding the resident's health status, the response would be coded as "information" under the category of "assessment" provided by the nurse. If the nurse's statement consisted of a long report of information about the resident, this statement would be coded only once, even if it lasted for five or ten minutes. However, if the nurse asked a question or made a recommendation, the response would be coded in those respective categories.

To provide a picture of the members' interaction at the beginning, middle and end of the meetings, data were collected during each observation in five minute intervals. Thus, every five minutes, the observers began recording using a new Form #3. The observers had stop watches available to monitor the time.

Rating Team Behavior

Following each observation, the observers also independently rated the team members' behavior on nine factors identified by Friedlander (1966) associated with group behavior. These variables are defined in Table 7. Using the Observer Rating Scale for Group Behavior (see Form #5, Appendix A), each observer rated the team's

TABLE 7

DEFINITIONS OF THE VARIABLES FOR THE OBSERVER RATING SCALE

Group Effectiveness accounts for the greatest proportion of variance on the scale. It is considered to be a measure of the group's ability to solve problems and formulate policies through creative, realistic team efforts.

Leader Approachability refers to members' perceptions that their leader is approachable and they can establish a comfortable relationship with him. Groups low on this dimension withdraw from the leader, do not behave according to their feelings, do not push their ideas, and seem intent on passive catering to the leader at the possible sacrifice of group output.

Mutual Influence describes the extent to which group members mutually influence each other and the leader and assume responsibility for setting group goals.

Personal Involvement and Participation is descriptive of groups in which members want, expect, and achieve active participation in group meetings.

Intragroup Trust Versus Intragroup Competiveness represents a bipolar dimension ranging from a high degree of trust and confidence among group members to a group that can be characterized more as a collection of individuals who are reluctant to sacrifice their individual personal opinions and ideas for the sake of a working consensus. This reluctance occurs in an environment of destructive competition where conflict is merely submerged.

Worth of Group Meetings is a generalized measure of feelings about the meetings of one's group as good, valuable, strong, and pleasant, or as bad, worthless, weak, unpleasant, and so on, as indicated by responses to semantic differential items.

Submission to Versus Rebellion Against Leader indicate that groups scoring low in this dimension tend to be rebellious, while groups scoring high on this dimension tend to submit to the leader when disagreements arise.

Leader Control describes the extent to which the leader initiates and controls the group process, mainly through domination of communications in a one-way direction. Such groups with higher leader control express tension and a desire not to have an expert on hand.

Role and Idea Conformity expresses pressure within the group toward conformity to a set of member-perceived expectations for both role behavior and ideation within the group.

Adopted from Friedlander, F., 1966.

performance on each of these nine factors using a five point value scale ranking from a low of 1 to a high of 5.

Data Analysis

The data collected by the observers during the meeting using Form #3 were summarized for each meeting on Form #4 (see Appendix A). The average response contribution for each meeting was computed by tallying the total number of responses in each of the categories and dividing by two (the number of observers).

The information listed in Table 8 was compiled using the aggregate data from the twelve meetings observed. Data will be presented using charts, tables and graphs for visualization purposes in Chapter 4. This information provides valuable insight for answering the first research question regarding the relative contributions of the team members in accomplishing the tasks of the team.

Information obtained from the Observer Rating Scale for Group Behavior (see Form #5, Appendix A) was recorded for each observation. The scores assigned by the two observers were averaged for each of the nine variables across the twelve observations.

Written Summaries of the Twelve Meetings

In addition to the descriptive data collection phase, a major portion of the information collected was a

written summary of each of the twelve ID team meetings. Following each meeting, a summary was written depicting those variables that appeared to have significantly impacted upon the team members' behavior during the meetings. For each of the twelve meetings, the following information is provided in the results section:

1. A profile of the resident discussed at the meeting, using the information collected with Form #2 (Appendix A);

2. A description of the physical location and seating arrangement during the meeting; and

3. A summary of the observers' comments regarding the meeting. This was the most important aspect of the written summary. The observers' comments focused on those variables described in Table 7. The discussion attempted to highlight the manner in which the team's behavior affected the structure and outcome of the meetings. This information will be valuable in addressing the second research question referring to those group process dimensions (relative to the task functions) which occur among the members of the ID teams.

Summary

The information collected in this study was obtained through systematic observation of ID teams in a PRF. The teams were observed in their natural environment while conducting annual reviews of resident program plans. The observers were "complete observers" in that they did not participate in the meetings in any manner. Their role was solely that of an observer.

As the meetings differed both within and across the seven centers, the observers were continuously forced to redefine existing concepts of the ID team process in a residential facility. In the section that follows, the twelve observations will be discussed both collectively and individually.

TABLE 8 Summary of Data Across All Twelve Observations

1. Number of total average responses per meeting;
2. Percentage of members' contributions across twelve observations;
3. Percentage of contributions in each content area across all observations;
4. Percentage of contributions in each process area across all observations; and
5. Percentage of the individual members' contributions in each of the content areas across the twelve observations.

CHAPTER 4
RESULTS

Introduction

This study was designed to answer the following research questions:

1. What are the members' relative contributions to the task activities dimension of the ID team as defined by ACMRDD Standards? and
2. What are the group process dimensions (relative to the task functions) which occur among members of the ID teams?

This chapter presents and summarizes the information obtained from the twelve observations of ID team meetings as they relate to the research questions. An overview of the observations is given that includes descriptive information about the teams and the physical facilities in which the meetings were held. The structure and format of the meetings is discussed with particular attention to the role of the team leader in determining the structure of the meetings. The content of the twelve meetings is addressed with reference to the following four areas: (1) assessment; (2) program planning; (3) program implementation; and (4) placement alternatives.

Particular attention is given to discussing which members of the team contributed what information in the four content areas. This information is essential in

answering the first research question regarding the members' relative contributions to the task activities dimension of the ID team as defined by ACMRDD Standards.

The final portions of this chapter are devoted to discussing the group behaviors observed during the meetings. Also, each meeting will be described using common denominators that can later be used to draw comparisons and determine those process variables that appeared to impact upon the effectiveness of the team in accomplishing its task. This information is needed to answer the second research question pertaining to those group process dimensions (relative to the task functions) which occur among ID team members.

Overview of the Meetings

Over a two-month interval, twelve ID teams were observed while conducting annual reviews of residents' program plans. The staff were very cooperative in providing information regarding the meeting schedules and assisting with the necessary arrangements to conduct the observations. There was some expected apprehension among team members regarding the presence of the observers and especially the presence of the tape recorder. The researcher attempted to allay these feelings by reviewing the commitment to confidentiality and by offering to address any questions or concerns. The majority of the team members

did not ask any questions regarding the presence of the observers. This may have been due to the fact that the team leaders were notified in advance of those meetings that were to be observed. Subsequently, the team members, in the majority of the meetings, already knew that the observers would be present.

A descriptive summary of the twelve meetings was provided in Table 4 (p. 50). The residents ranged in age from a low of 6 years to a high of 73 years. The majority of the residents were diagnosed as severely and profoundly retarded and therefore believed to be representative of those residents living at the facility.

As shown in Table 4 (p. 50), the meetings were conducted in a variety of locations on the centers, usually between the hours of 1:30 p.m. and 3:30 p.m. With the exception of Teams #3 and #5, the meetings were conducted in rooms that were either unable to accommodate the number of staff attending the meeting or subject to frequent environmental distractions. Teams #3 and #5 conducted their meetings in a quiet conference room with adequate space to accommodate the members. The dining rooms where Teams #1 and #2 met were very small and poorly ventilated. The classroom where Team #4 met was so large that the team leader had difficulty maintaining control of the group. The day halls where Teams #6 and #7 met were subject to a

high level of noise including telephones ringing, staff mopping the floor and residents wandering into the meetings. Although the dining rooms where Teams #8, #9 and #12 met were larger, the meetings were not free from environmental interruptions by food operations employees. Team #10 met in a residents' bedroom that was far too small to accommodate the staff. Several staff had to sit on the residents' beds which seemed to be a violation of the residents' privacy. Team #11 was forced to move to a kitchen activity area to conduct its meeting due to overscheduling of the conference room. This meeting was also plagued by noise from staff preparing for a picnic. As a result of the poor physical facilities, members were frequently forced to sit with their backs to other members. At times the team leader responsible for chairing the meeting was unable to make eye contact with all members of the team. Thus, opportunities for effective communication were frequently reduced by the physical environment in which the meetings were held.

As shown in Table 4 (p. 50), the number of staff attending the ID team meetings ranged from a low of 8 to a high of 20. The length of the meetings ranged from 12 to 41 minutes. The number of staff attending the meetings did not appear to significantly impact upon the length of the meetings. Teams #2, #6, #8, #10 and #12 each met for

twenty minutes while the number of staff ranged from 8 to 14.

The average number of responses ranged from a low of 40.5 with Team #9 to a high of 225.0 with Team #4. The teams that had the highest number of total average responses were Teams #2, #4 and #6. The residents discussed by Teams #2 and #4 had the highest intellectual functioning ability as they were diagnosed as moderately mentally retarded. As shown in Table 4 (p. 50), the other residents discussed at the meetings were diagnosed as either severely or profoundly mentally retarded. This raises an interesting question regarding the resident's level of mental retardation and the subsequent intensity of the annual review as conducted by the ID team. Team #4 was discussing a school-age resident who was 18 years of age and, consequently, is mandated to have an IEP and 5½ hours of daily instruction (Education for All Handicapped Children's Act, 1975; Regulations and Administrative Requirements for the Operation of Special Education Programs in Virginia, 1981). Additionally, this resident has numerous physical disabilities. These factors combined may have accounted for the high level of interaction and response by the members of Team #4.

The response rates for Teams #8 and #9, however, who were also reviewing program plans for school-age

residents, was well below the average rate of 93.45. A smaller number of staff attended these meetings than seen with Team #4

Structure of the Meetings

As chairpersons of the meetings, the team leaders were primarily responsible for determining the degree of structure and the style of the meetings. While some leaders seemed confident and prepared for the meetings, other leaders appeared apprehensive and unprepared for the meetings. Despite the poor seating arrangements and physical facilities previously discussed, the leader usually took no initiative to ameliorate the situation. Frequently, they talked with their backs facing team members. At times, it was also difficult to hear what they were saying.

In some meetings, the leaders began by reading the resident's strength and problem lists. Then they would ask each discipline to report assessment data relative to their discipline. In other meetings, the leaders began the meeting by asking the members to read their assessment data. In several meetings, the leader made no introductory statements but simply "looked at" a member who then began giving his report.

The meetings did not appear to be conducted according to any set structure. However, there were three activities that took place in all of the meetings:

1. The members read a report assessing the resident's status in a particular area;
2. The members reviewed the problems, objectives and plans discussing any proposed changes and recommendations; and
3. The team leaders asked the members whether or not the resident's placement in the institution was still appropriate for his needs.

Each team varied with regard to the degree and intensity with which they engaged in these three activities. The effectiveness of the group as well as the involvement of the members appeared to be closely related to the behavior of the team leader in assertively seeking out and clarifying information presented by the team members. The behavior of the team leaders during each of the twelve meetings will be discussed in more depth in the written summaries of the observations.

Content of the Meetings

The observers attempted to code contributions made by the various team members into one of the following content areas:

1. Assessment;
2. Program Planning;
3. Program Implementation; and
4. Placement Alternatives.

The definitions for each of these four areas were provided

in Chapter 1. The distribution of responses in the four categories across the twelve observations is shown in Table 9. These data were obtained from the information coded and recorded during observations using Form #3 (see Appendix A) which were subsequently totalled and averaged on Form #4 (see Appendix A). Data for each observation were recorded using Form #4. In Appendix B, data from the twelve observations are shown on separate copies of Form #4. Figure 1 shows the distribution of the responses in each of the four content areas across all twelve observations.

As shown in Table 9 and Figure 1, the teams as a whole devoted the most amount of discussion to issues related to the assessment process (39%). The ACMRDD Standards (1979) mandate that the team members give updates regarding the resident's condition in a variety of areas including his/her physical, health, dental, vision, hearing, language, educational, psychological and developmental status. Over 1/3 of the total percentage of responses made addressed the assessment area.

Comments made by the team members directed toward modification of the program plan were categorized under program planning. As shown in Figure 1, the twelve teams devoted 24% of the discussion at all twelve meetings to this function.

TABLE 9
PRECENTAGE AND FREQUENCY OF RESPONSES
IN EACH CONTENT CATEGORY

OBSERVATION #	ASSESSMENT	PROGRAM PLANNING	PROGRAM IMPLEMENTATION	PLACEMENT ALTERNATIVES	TOTAL RESPONSES PER OBSERVATION
1	39 (21.5)	14 (8.0)	12 (6.5)	35 (19.5)	55.5
2	53 (74.0)	15 (21.0)	24 (33.5)	8 (11.0)	139.5
3	39 (34.0)	42 (36.5)	19 (16.5)	0 (0.0)	87.0
4	27 (60.5)	57 (129.0)	8 (19.0)	7 (16.5)	225.0
5	44 (35.5)	12 (9.5)	45 (36.5)	0 (0.0)	81.5
6	21 (25.0)	17 (20.5)	48 (57.5)	15 (18.0)	121.0
7	51 (46.5)	13 (11.5)	32 (29.0)	4 (4.0)	91.0
8	26 (17.5)	22 (15.0)	43 (29.5)	9 (6.0)	68.0
9	48 (19.5)	27 (11.0)	17 (7.0)	7 (3.0)	40.5
10	41 (34.0)	14 (11.5)	42 (35.0)	3 (2.5)	83.0
11	42 (21.0)	15 (7.5)	36 (18.0)	8 (4.0)	50.5
12	37 (30.0)	35 (28.0)	17 (14.0)	11 (9.0)	81.0
Average percentage across all observations	39 (419)	24 (309)	29 (302)	9 (955)	1,123.50
Average Response per Category	35.0	26.0	25.0	8.0	94.0

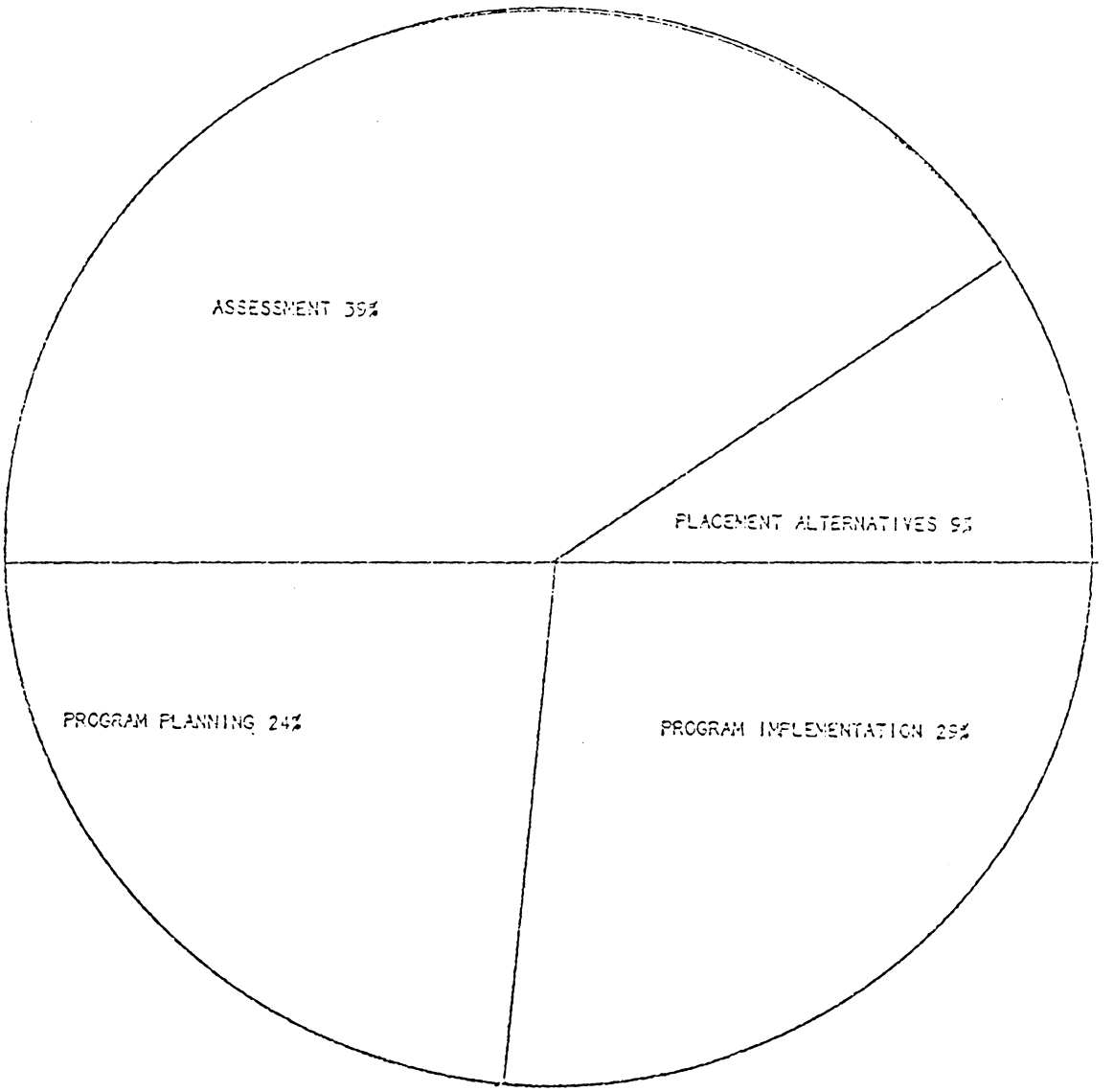

FIGURE 1. Percentage of Responses in each Content Area across all Observations

More comments were directed toward discussing those factors affecting the manner in which the residents' programs were carried out on a daily basis. The teams devoted 29% of all responses to the category of program implementation. This was a category where all staff, professional and paraprofessional, could give formal or informal input.

The least amount of discussion was devoted to the category of placement alternatives. As shown in Table 9, Team #1 devoted the most amount of discussion to transferring the resident from his current environment to a group home for adults. The team subsequently engaged in much discussion regarding the necessary arrangements for the transfer. During the other meetings, the team leaders asked the team if they felt the resident's current placement was appropriate. The members usually responded in unison that the present placement was appropriate. Otherwise, there was relatively little discussion regarding placement alternatives.

Type of Responses

Additionally, the observers also coded whether the team members: (1) asked a question; (2) gave informational or factual statements; or (3) made recommendations, suggestions, or problem-solving type statements. The observers recorded the type of statement made by the team members using Form #3 (see Appendix A). Data for each observation

is shown on Form #4 in Appendix B. As illustrated in Table 10 and Figure 2, the members' responses were primarily of an information-giving nature. Approximately 62% of all responses were coded in this category. This statistic corresponds to the assessment data as members appeared to spend much of their time during ID team meetings presenting information related to assessment concerning their own specific discipline.

Less time was spent by the team in asking questions (27%) and offering recommendations (11%). These data suggest that the team members seldom questioned information presented by other members. The member who asked the most questions was the team leader whose function as chairperson was to ask members to present a summary of the resident's progress during the past year. Consequently, if there were few questions raised, there were also few recommendations regarding changes in the resident's program plan, the implementation of the program, or the resident's placement.

Nature of the Members' Contributions to the Team Meetings

One of the major research questions addressed in this study was "what are the members' relative contributions to the task activities dimension of the ID team as defined by ACMRDD Standards?" In other words, which

TABLE 10
PERCENTAGE AND FREQUENCY OF RESPONSE
IN EACH PROCESS CATEGORY

OBSERVATION #	QUESTIONS	INFORMATION GIVING	RECOMMENDATIONS	TOTAL
1	19 (11)	65 (36)	15 (8.5)	55.5
2	28 (38)	56 (78.5)	17 (23)	139.5
3	24 (21)	65 (56.5)	11 (9.5)	87.0
4	26 (57.5)	60 (136)	14 (31.5)	225.0
5	27 (21)	68 (55.5)	6 (5.0)	81.5
6	29 (35.5)	66 (80)	5 (5.5)	121.0
7	30 (27.5)	63 (57.5)	7 (6.0)	91.0
8	21 (14.5)	71 (48.0)	8 (5.5)	68.0
9	25 (10.5)	47 (19.0)	27 (11.0)	40.5
10	32 (26.5)	60 (49.5)	8 (7.0)	83.0
11	27 (13.5)	63 (32.0)	10 (5.0)	50.5
12	32 (26.0)	64 (52.0)	4 (3.0)	81.0
Average Percentage Across Observations	27 (302.5)	62 (70).5)	11 (120.5)	1,123.50
Percentage of Total Responses per Process Category	27% (25.0)	62% (98.0)	11% (10.0)	(94.0)

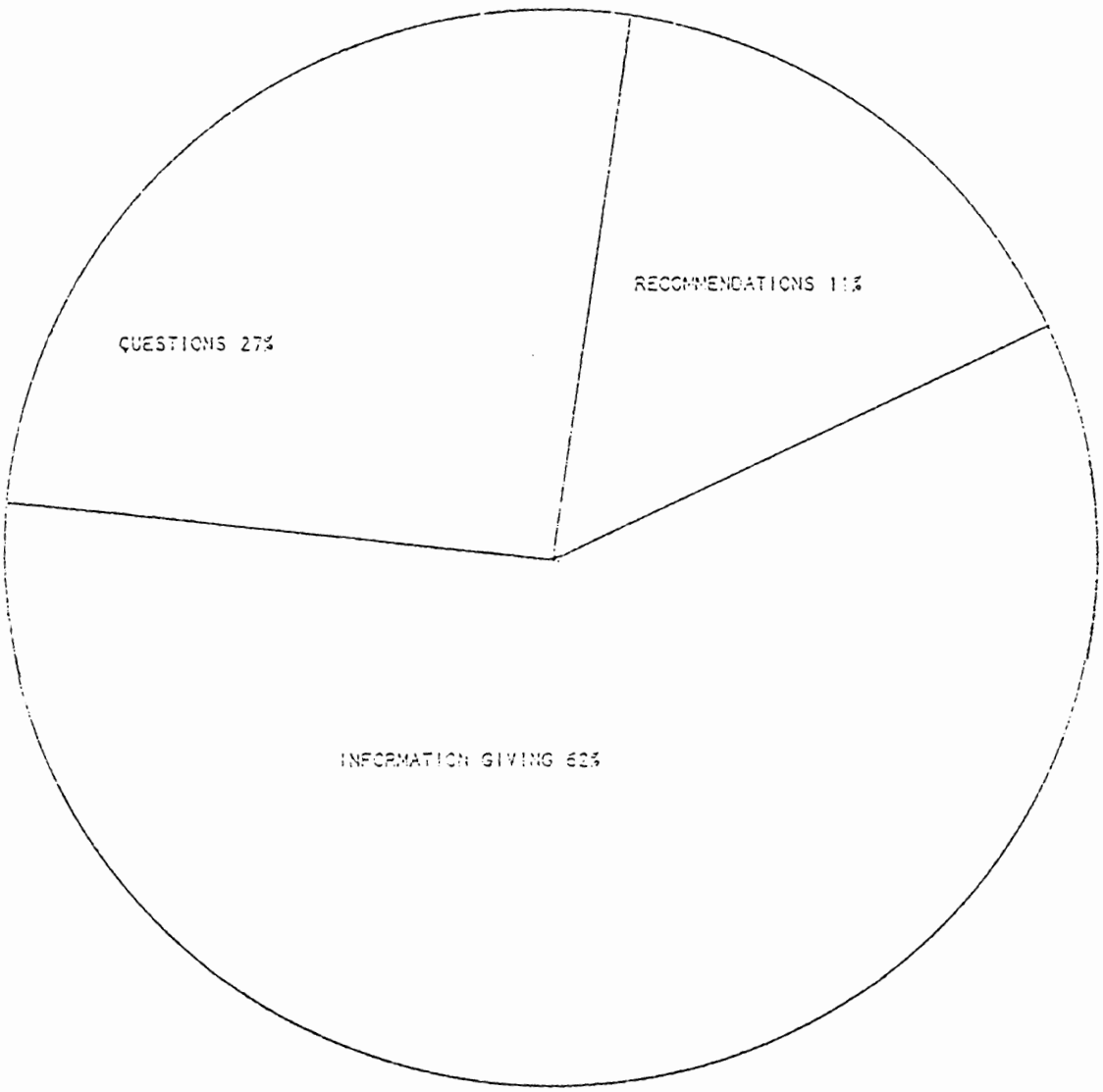

FIGURE 2. Nature of the Team Members' Responses

members give what information to the assessment, program planning, program implementation, and placement alternative categories? The nature of each member's contribution to each of the twelve meetings is shown on Form #4 in Appendix B. In the discussion that follows, a summary of the manner in which the various members responded across all of the observations will be presented.

As shown in Table 3 (p. 46) different positions and disciplines were represented at each meeting. The four positions that were represented at each of the twelve meetings were: (1) team leader; (2) nurse; (3) social worker; and (4) developmental aides. Those staff attending at least ten meetings included: (1) teachers; (2) psychologists; (3) speech therapists; and (4) recreators. The average percentage of responses for the team members across all observations is displayed in Figure 3 and Table 11. These data were computed by tallying the total number of responses taken from Form #4 for each observation and dividing by twelve. In Figures 4-7, the percentage of the members' contributions across the four content areas is shown. The distribution for each meeting is also shown in Tables 12 through 15. In the section that follows, the behavior of the various groups of staff will be collectively discussed including the team leaders, teachers, nurses, social workers, psychologists, speech therapists, developmental

aides, paraprofessional staff and the resident and his parents or relatives.

Team Leaders

The team leaders dominated the discussion throughout all of the observations in each of the four content areas (see Figure 3). Their responses comprised 35% of the total responses. They played the role of meeting chairperson and were responsible for seeing that all necessary information was presented by the different disciplines. In some of the meetings, the team leaders read the resident's problem and strength list (Teams #2, #3, #4, #5, #10, #11, #12). This provided an opportunity for all members to review the resident's strengths and deficiencies. The team leaders gave less concrete information or hard data regarding the resident's assessment status or his program plan, its implementation or his current placement. The leader's role was primarily that of asking questions and summarizing or clarifying statements made by other team members. This observation was particularly interesting in view of the fact that team leaders are assigned the role of "Individual Program Coordinators" (IPC) in the facility for those residents assigned to them. The IPC is responsible for supervising the implementation of the resident's program plan by the direct care staff.

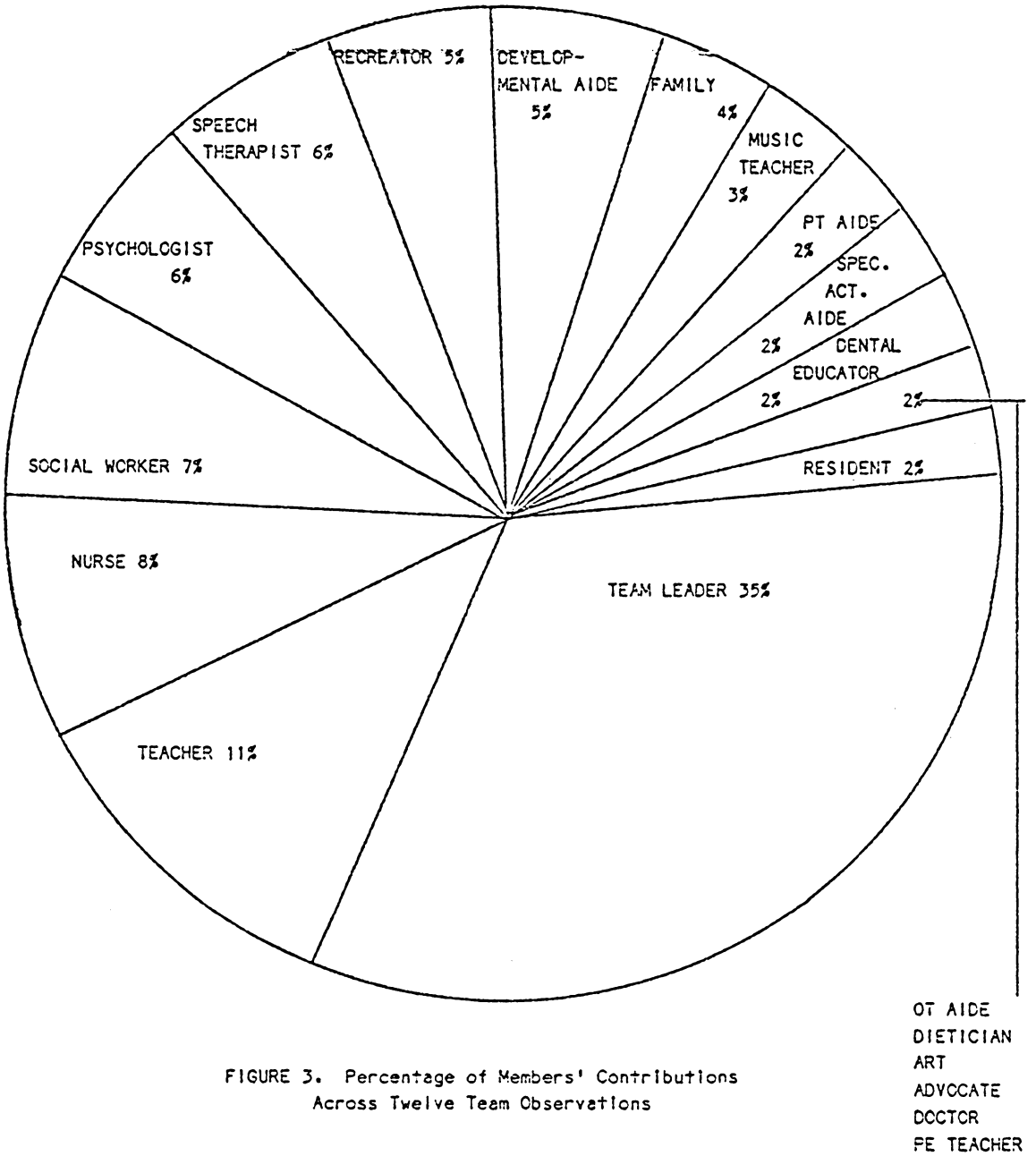

FIGURE 3. Percentage of Members' Contributions Across Twelve Team Observations

TABLE 11 (Percentages)

Profile of Members' Responses

Observation Number	Dev. Aide	Nurse	PT AIDE	Psychologist	Recreator	Social Worker	Special Act. Aide	Teacher	Music Teacher	Year Leader	Dental Educator	Speech Therapist	Family	Resident	OT Aide	Physician	Advocate	Dietician	PE Teacher	ART	OT Supervisor	Shift Supervisor
1	9	10	1	26	7	26	*	14	0	16	*	9	*	*	*	*	*	*	*	*	*	*
2	7	13	4	5	15	11	*	*	3	24	6	1	*	6	*	*	*	*	*	1	*	*
3	5	6	8	7	3	5	4	15	4	34	3	*	*	*	*	*	*	*	*	*	*	*
4	4	4	4	*	1	1	1	13	20	33	4	4	*	2	3	*	5	1	*	4	0	0
5	0	6	2	*	3	1	9	10	9	44	9	1	*	*	*	*	*	*	*	*	*	*
6	6	2	3	12	5	9	0	7	*	32	*	9	11	12	*	6	*	*	*	*	*	*
7	2	0	*	8	4	4	*	8	*	16	*	10	36	0	*	*	*	2	*	*	*	*
8	0	13	*	10	*	7	*	26	*	36	*	7	*	*	*	*	*	*	*	0	*	*
9	0	14	*	4	7	3	*	14	*	27	*	30	*	*	*	*	*	*	*	0	*	*
10	13	13	*	2	2	1	2	3	*	45	2	8	*	*	*	*	*	*	4	*	*	*
11	2	4	*	8	3	4	*	19	*	60	*	*	*	*	*	*	*	*	*	*	*	*
12	12	10	2	4	4	14	5	2	*	47	2	1	4	*	3	*	*	*	*	*	0	*
Average	5	8	2	6	5	7	2	11	3	35	2	6	4	2	.5	.5	.4	.2	.3	.1	0	0

* Did Not Attend the Meeting

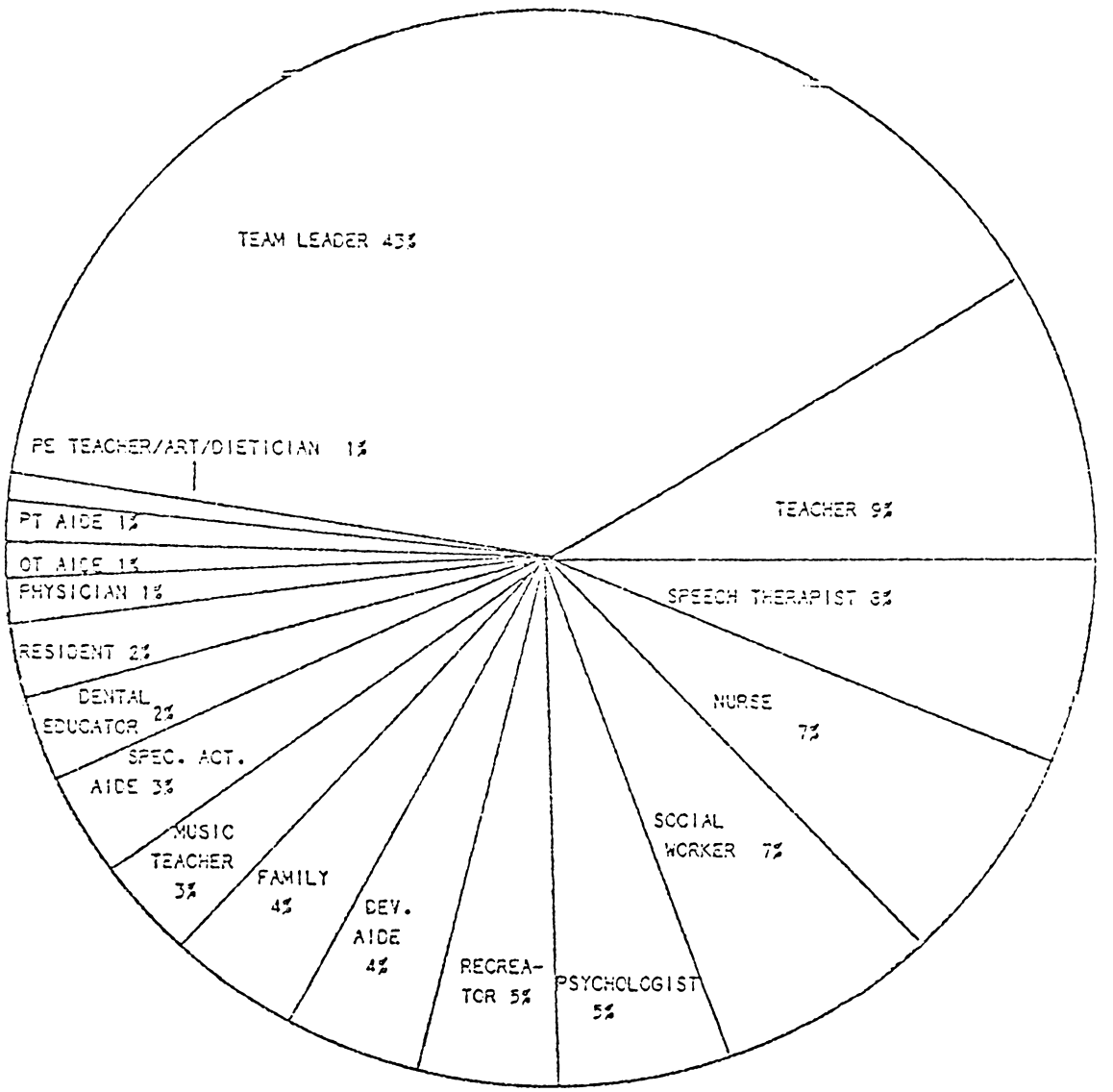

FIGURE 4. Percentage of Members' Contribution to the Assessment Category

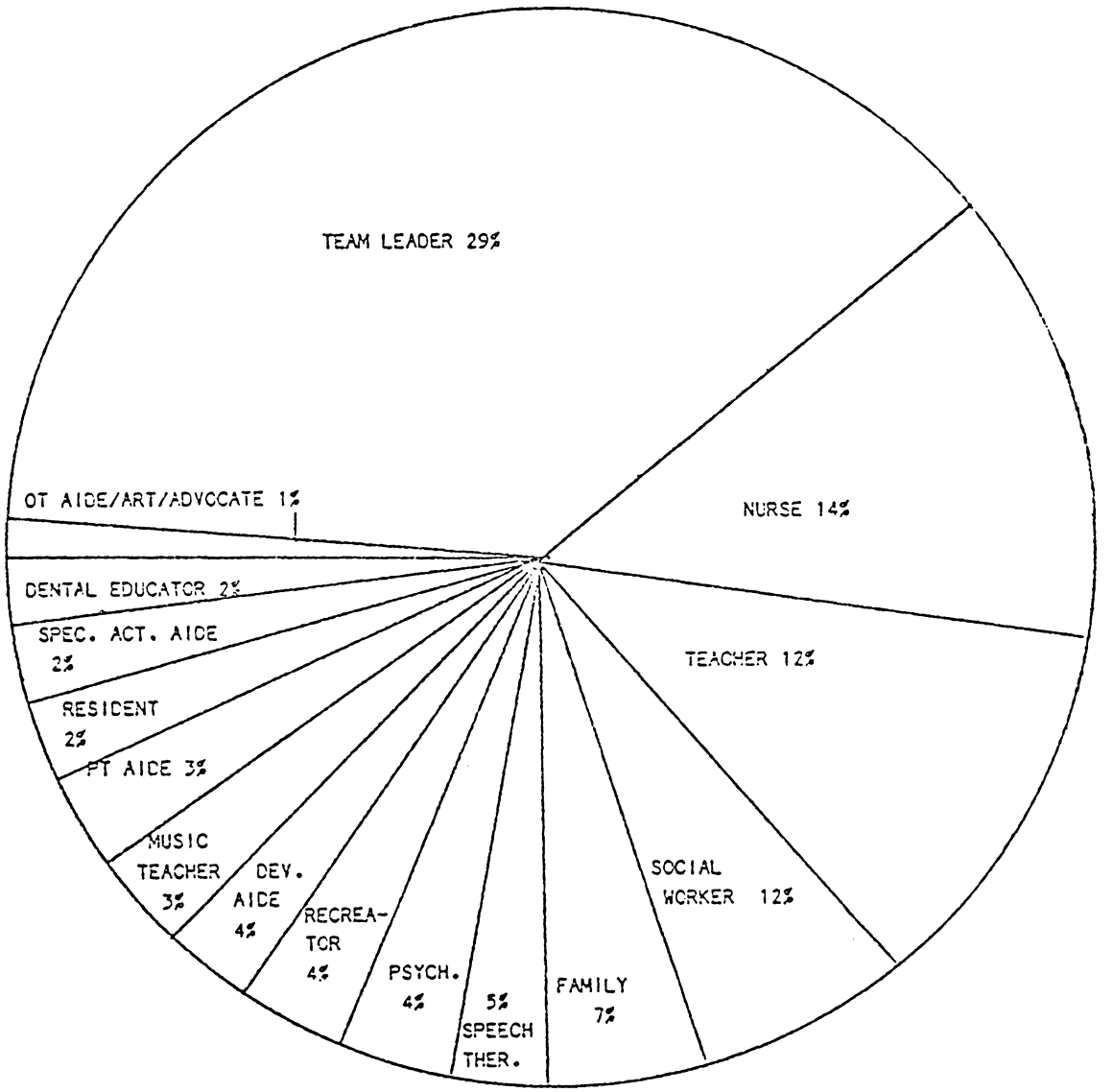

FIGURE 5. Percentage of Members' Contribution to the Program Planning Category

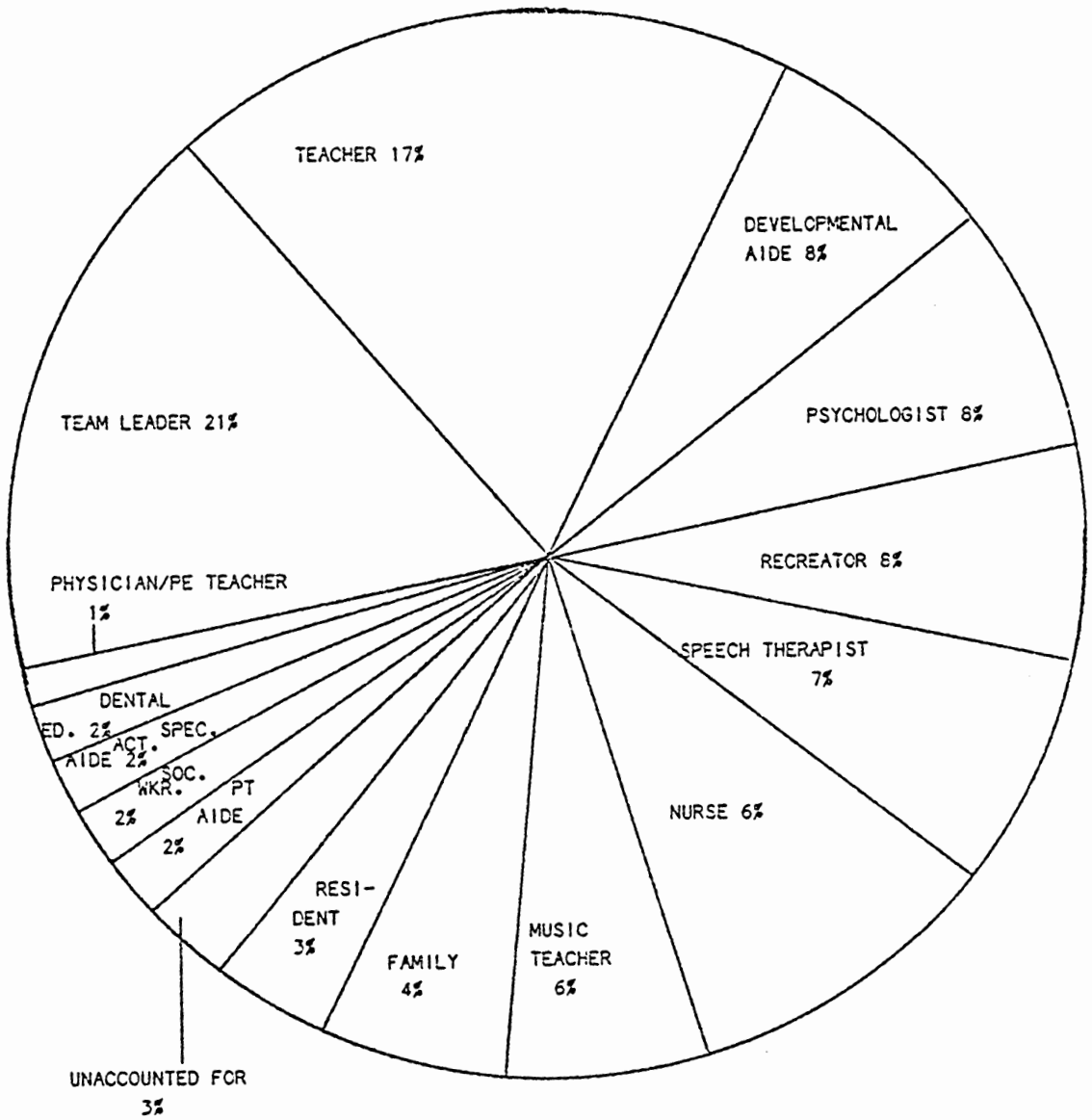

FIGURE 6. Percentage of Members' Contribution to the Program Implementation Category

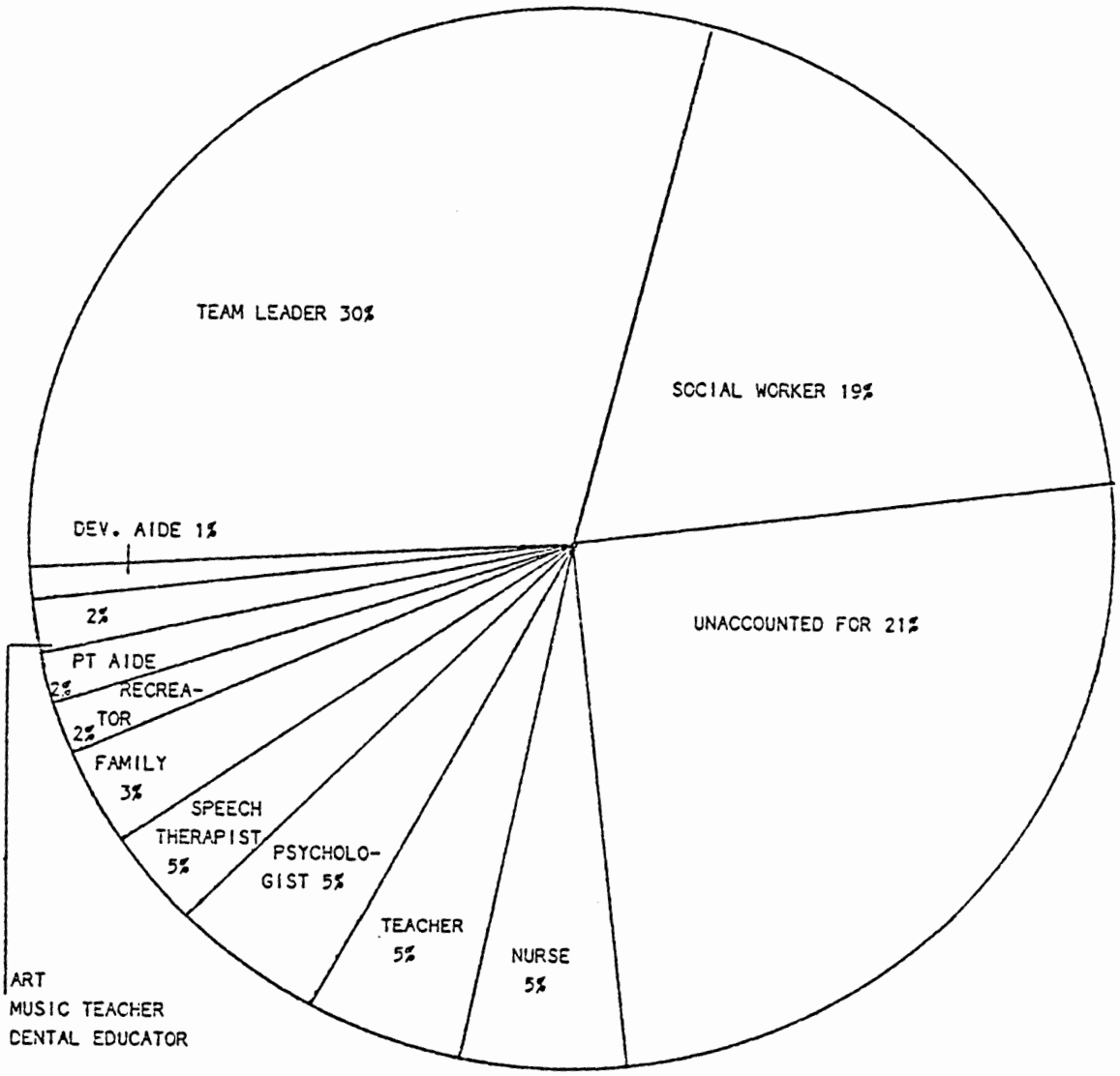

FIGURE 7. Members' Contribution
to the Placement Alternative Category

TABLE 12
PERCENTAGE OF MEMBERS' RESPONSES TO THE ASSESSMENT CATEGORY

Observation Number	Dev. Aide	Nurse	PT AIDE	Psychologist	Recreator	Social Worker	Special Act. Aide	Teacher	Music Teacher	Team Leader	Dental Educator	Speech Therapist	Family	Resident	OT Aide	Physician	Advocate	Dietician	PE Teacher	ART	OT	Supervisor	Shift Supervisor
1	14	9	5	7	5	16	*	16	*	23	*	5	*	*	*	*	*	*	*	*	*	*	*
2	4	16	2	4	20	9	*	*	10	28	4	11	*	9	*	*	*	*	*	0	*	*	*
3	13	1	0	10	1	15	1	12	3	38	4	*	*	*	*	*	*	*	*	*	*	*	*
4	7	1	4	*	0	1	0	12	12	48	3	3	*	1	1	*	0	4	*	3	0	0	
5	0	0	0	*	0	4	10	7	8	56	8	6	*	*	*	*	*	*	*	*	*	*	
6	0	6	6	16	0	0	0	2	*	56	*	0	11	12	*	*	*	*	*	*	*	*	
7	1	0	*	0	3	6	*	4	*	24	*	11	31	0	*	15	*	2	*	*	*	*	
8	0	14	*	9	*	17	*	37	*	9	*	14	*	*	*	*	*	*	*	0	*	*	
9	0	15	*	5	5	5	*	5	*	29	*	25	*	*	*	*	*	*	*	0	*	*	
10	0	12	*	3	3	3	4	4	*	49	3	13	*	0	*	*	*	*	6	*	*	*	
11	0	2	*	0	0	5	*	7	*	86	*	*	*	*	*	*	*	*	*	*	*	*	
12	10	10	0	3	3	7	*	0	*	54	3	0	*	*	*	*	*	*	*	*	0	*	
Average	4	7	1	5	5	7	3	9	3	43	2	8	4	2	1	1	0	.5	.5	.25	0	0	

* Did Not Attend the Meeting

TABLE 13

PERCENTAGE OF MEMBERS' RESPONSES TO THE PROGRAM PLANNING CATEGORY

Observation Number	Dev. Aide	Nurse	PT AIDE	Psychologist	Recreator	Social Worker	Special Act. Aide	Teacher	Music Teacher	Team Leader	Dental Educator	Speech Therapist	Family	Resident	OT Aide	Physician	Advocate	Dietician	PE Teacher	LRT	OT Supervisor	Shift Supervisor
1	25	25	*	12	6	12	*	12	*	6	0	*	*	*	*	*	*	*	*	*	*	*
2	19	14	7	4	2	7	*	*	7	17	17	0	*	0	*	*	*	*	*	*	*	*
3	1	12	18	7	3	0	19	11	25	1	*	*	*	*	*	*	*	*	*	*	*	*
4	2	5	3	*	2	0	1	12	21	30	2	3	*	1	4	*	9	0	*	4	0	0
5	0	5	5	*	0	0	5	16	10	59	0	0	*	*	*	*	*	*	*	*	*	*
6	0	2	0	7	10	5	0	5	*	24	*	0	19	26	*	*	*	*	*	5	*	*
7	0	0	*	0	4	0	*	4	*	4	*	22	65	0	*	0	*	0	*	*	*	*
8	0	20	*	0	*	0	*	27	*	53	*	0	*	*	*	*	*	*	*	0	*	*
9	0	14	*	9	9	5	*	14	*	22	*	27	*	*	*	*	*	*	*	0	*	*
10	0	48	*	0	0	0	0	0	*	52	0	0	*	0	*	*	*	*	0	*	*	*
11	0	13	*	0	7	0	*	33	*	0	*	*	*	*	*	*	*	*	*	*	*	*
12	4	4	4	4	7	18	*	4	*	54	0	4	*	*	*	*	*	*	*	*	0	*
Average	4	14	3	4	4	12	1	12	3	29	2	5	7	2	.33	0	.75	0	0	.75	0	0

* Did Not Attend the Meeting

TABLE 14

PERCENTAGE OF MEMBERS' RESPONSES TO THE PROGRAM IMPLEMENTATION CATEGORY

Observation Number	Dev. Aide	Nurse	PT AIDE	Psychologist	Recreator	Social Worker	Special Act. Aide	Teacher	Music Teacher	Team Leader	Dental Educator	Speech Therapist	Family	Resident	OT Aide	Physician	Advocate	Dietician	PE Teacher	ART	OT Supervisor	Staff Supervisor
1	0	3	*	0	25	0	*	38	*	0	*	7	*	*	*	*	*	**	*	*	*	*
2	10	7	6	9	16	9	*	*	6	22	3	0	*	4	*	*	*	*	*	0	*	*
3	0	3	6	0	6	0	12	12	9	45	6	*	*	*	*	*	*	*	*	*	*	*
4	0	5	0	*	0	0	0	5	50	16	0	5	*	18	0	*	0	0	*	0	0	0
5	0	12	4	*	7	0	8	12	8	27	11	10	*	*	*	*	*	*	*	*	*	*
6	14	0	4	15	4	3	0	10	*	31	*	0	7	12	*	*	*	*	*	*	*	*
7	3	0	*	24	7	0	*	17	*	2	*	7	36	0	*	3	*	0	*	*	*	*
8	0	12	*	10	*	7	*	20	*	42	*	8	*	*	*	*	*	*	*	0	*	*
9	0	0	*	0	14	0	*	43	*	0	*	33	*	*	*	*	*	*	*	0	*	*
10	31	4	*	3	3	0	9	3	*	36	1	7	*	0	*	*	*	*	3	*	*	*
11	5	4	*	22	5	3	*	31	*	31	*	*	*	*	*	*	*	*	*	*	*	*
12	36	21	0	7	14	0	*	7	*	7	7	0	*	*	*	*	*	*	*	*	*	4
Average	8	6	2	8	8	2	2	17	6	21	2	7	4	3	0	.75	0	0	.75	0	0	0

* Did Not Attend the Meeting

TABLE 15

PERCENTAGE OF MEMBERS' RESPONSES TO THE PLACEMENT ALTERNATIVE CATEGORY

Observation Number	Dev. Aide	Nurse	PT AIDE	Psychologist	Recreator	Social Worker	Special Ed. Aide	Teacher	Music Teacher	Team Leader	Deaf Educator	Speech Therapist	Family	Resident	OT Aide	Physician	Advocate	Dietician	PE Teacher	ASL	OT Supervisor	Shift Supervisor
1	0	0	*	0	5	56	*	5	*	18	*	21	*	*	*	*	*	*	*	*	*	*
2	0	14	0	9	9	32	*	*	9	14	9	5	*	0	*	*	*	*	*	0	*	*
3	0	0	0	0	0	0	0	0	0	0	0	*	*	*	*	*	*	*	*	*	*	*
4	0	0	12	*	0	9	0	33	0	24	0	0	*	0	0	*	0	0	*	6	0	0
5	0	0	0	*	0	0	0	0	*	0	0	0	*	*	*	*	*	*	*	*	*	*
6	0	0	0	6	6	47	0	8	*	11	*	0	22	0	*	*	*	*	*	*	*	*
7	0	0	*	0	0	25	*	0	*	63	*	0	13	0	*	0	*	0	*	*	*	*
8	0	0	*	42	*	0	*	17	*	42	*	0	*	*	*	*	*	*	*	0	*	*
9	0	33	*	0	0	0	*	0	*	0	*	33	*	*	*	*	*	*	*	0	*	*
10	0	0	*	0	0	0	0	0	*	100	0	0	*	0	*	*	*	*	0	*	*	*
11	0	0	*	0	0	13	*	0	*	31	*	*	*	*	*	*	*	*	*	*	*	*
12	11	11	11	0	0	44	*	0	*	22	0	0	*	*	*	*	*	*	*	*	*	*
Average	1	5	2	5	2	19	0	5	.75	30	.75	5	3	0	0	0	0	0	0	.50	0	0

* Did Not Attend the Meeting

Teachers

The teachers contributed the second highest percentage (11%) of responses across the twelve observations. The teachers contributed significantly to those meetings where the residents were of school age (Teams #4, #8, and #9). As these residents are required to have an IEP for which the teacher assumes a major responsibility, this finding is not surprising. The teachers made the greatest number of responses (17%) in the area of program implementation (see Figure 6). This is consistent with the teacher's role in carrying out the educational aspects of the resident's program plan.

Nurses

The nurses contributed approximately 8% of the total responses made across all twelve observations (see Figure 3). During each of the observations, nurses participated in the meetings. They provided a summary of the resident's health status. The nurses' major contribution was in the area of program planning (see Figure 5). Frequently, the nurses noted areas where medical related objectives needed to be modified. A physician was present at only one of the meetings (Team #6). It was interesting to note that during this meeting, the nurse made no comments throughout the entire meeting. All information

related to the resident's health or medical condition was given by the physician.

Social Workers

As expected, the social workers contributed more to the placement alternative area than to any other area. (See Figure 7.) Frequently, the social workers commented on plans to transfer or discharge the resident from his current living area. Social workers frequently read a report summarizing the extent of the family's contact with the resident. The social workers provided little input to the implementation of the resident's program (see Figure 6). More frequently, the social worker had input with regard to modification of the current program plan (see Figure 5).

Psychologists

The psychologists' contributions across all twelve observations were superseded by the team leader, teachers, nurses and social workers (see Figure 3). It was interesting to note that the psychologists' contribution to the assessment category was only 5% of the total responses (see Figure 4). This appeared to conflict with the psychologists' traditional role as diagnostician. They had relatively little information to contribute regarding the resident's psychological or developmental status. They provided more information pertaining to the implementation

of the program than to any other content area (see Figure 6). The psychologists made the greatest number of responses in the area of program implementation in Teams #6, #7, and #22. The residents discussed in these meetings each had some type of behavior problem for which the psychologists had developed a program to decrease the behavior.

Speech Therapists

The speech therapists attended eleven of the twelve meetings. They made approximately 6% of the total responses made by all team members (see Figure 3). They contributed the most information to the assessment category (see Figure 8). They gave detailed reports in reference to the resident's speech and language status. The speech therapists also made recommendations for residents to receive audiological evaluations if they had not previously been assessed.

Developmental Aides

Developmental aides were those staff who work directly with the residents on a daily basis. They serve as the residents' primary caregivers and are responsible for carrying out the majority of the residents' programs. As shown in Table 3 (p. 46), at least one and sometimes two or more aides from the different shifts were represented at all meetings. Across the twelve observations

the developmental aides contributed 5% of the total responses (see Figure 3). The aides, as expected, had the most information to contribute to the program implementation category. The aides gave comments in an informal manner without referencing a written report.

In general, the developmental aides appeared to be somewhat reluctant to spontaneously speak out unless they were called upon by the team leader. The leaders in Teams #5, #8, and #9 made no attempt to actively solicit comments from the developmental aides. In Team #9, the aide who attended the meeting was asked to do so just minutes before the meeting. Therefore, it appeared that she had no time to prepare to meaningfully contribute to the meeting.

Paraprofessional Staff

In addition to the developmental aides, there were numerous paraprofessional staff represented at the meetings. These staff included special activity aides, recreators, dental educator assistants, physical and occupational therapy aides and ARTs. As shown on Figure 3, the paraprofessional staff contributed from 1 to 5% of the total responses made.

Residents

Residents attended four of the twelve meetings.

The team members made a conscientious effort to get the residents meaningfully involved in the planning process. The residents, however, as shown in Figure 3, had few comments to make. Typically, the residents were asked if they were satisfied with their living arrangements, food, and program plan.

Relative/Family Participation

In two of the twelve meetings, parents and relatives were represented (see Table 4). In these meetings, the family members commented frequently throughout the meetings. The parents in Team #7 were very actively involved in the discussion, providing many informal observations about their son's behavior and frequently asked questions regarding the program plan.

Advocates

Of the twelve meetings observed, the advocates were represented in two meetings (Observations #4 and #11). The advocates had little input into the meetings.

Interval Data

Using Form #3, the observers coded the responses made by the team members in five minute intervals. The purpose of this activity was to determine the intensity

of the members' responses throughout the entire meeting. The meetings lasted for an average of twenty minutes or four intervals.

As shown in Table 16, the comments were fairly equitably distributed throughout the four intervals. The response rate ranged from a high of 29% in the first interval to 24% in the fourth interval.

Team #4 was unique in that the meeting lasted for almost 40 minutes. The intensity of the discussion varied throughout the intervals. In intervals #4, #5, #6, and #7, the team members were discussing a behavior problem exhibited by the resident. More team members were involved in the discussion, and subsequently, there were more responses made during these intervals. In summary, the percentage of responses seemed to be fairly consistent during each of the intervals for each observation.

Observer Ratings of Team Behavior

The observers' ratings on the factors identified in the Group Behavior Inventory are summarized in Table 17. The average scores are also plotted in Figure 8. The possible values ranged from a low of 1 to a high of 5. The observers' ratings on the Group Behavior Inventory ranged from a low of 2.79 in mutual influence to a high of 4.12 on role and idea conformity. It appeared that the team members did not mutually influence each other to a great

degree. The members usually presented information related to their own respective program area and did not attempt to influence other members in modifying their program plans.

The higher score on role and idea conformity seemed to reflect the notion that members perceived themselves as responsible only for their own individual areas. The members appeared to be generally satisfied with their respective roles as members of the ID teams.

The teams scored in the moderate range (3.66) in group effectiveness. Group effectiveness is defined as the group's ability to resolve problems and formulate creative solutions to remediate problem situations. As there were relatively few problem situations discussed, it was difficult to measure the teams' behavior in this area. The observers tended to look also at the effectiveness with which the team conducted the review including staying on task and addressing the problems of individual residents.

Generally speaking, the members seemed to perceive their leader as being approachable. The leader received an average score of 3.87 on approachability (see Figure 8). The leader usually seemed relaxed during the meetings and carried on informal conversation with the members in a similar fashion prior to and after the meetings. Again, the leaders were seldom confronted with controversial issues from the team members. The members' behavior seemed to be

more a result of their own apathy or lack of interest than fear of potential suppression by the team leader.

It was difficult for the observers to rate the degree of trust versus competitiveness among the group members in the short duration (twenty minutes) which most meetings lasted. The observers usually rated the teams in the moderate range because of the insufficient time element. The members did not appear to be competing with each other during the meetings. Again, there were few real problem-solving situations where members were actually required to sacrifice their personal ideas and opinions to reach a consensus.

It was also difficult to measure the degree to which the members felt the meetings were worthwhile without directly asking them. In rating this variable the observers looked for member responses that were of a positive or negative nature regarding the resident, team, and/or the facility in general. The observers usually rated the teams in the moderate range as there were few comments of an affective nature expressed by team members.

For the most part, the team members did not express submissive or rebellious behavior toward the leaders. As team leaders seldom had to display assertive behavior to deal with problem situations, the members likewise did not have occasion to respond to the situations.

The leaders were rated as moderate (3.45) in exerting control over the teams. While the leaders did dominate the discussion, their comments were more procedural than substantive in nature. Their control was not such that there was tension among group members or only one-way communication. The leaders appeared to be open to input from other members. However, due to limited participation by other members, the data revealed increased participation on the part of the leaders.

Summary of the Twelve Observations

In the previous section, information was provided of a general nature regarding the observation of the ID teams at the residential center. In Table 18, a summary description of each of the twelve observations is provided. In Appendix B, a written summary of each of the twelve observations is given. The information is presented using the following format:

1. Resident Profile - A summary of the resident's status will be presented using information taken from the resident's record using Form #1.

2. Physical Setting - The facility in which the meeting was held will be described along with the seating arrangement.

3. General Observations - A summary will be provided of those factors that appeared to impact upon the effectiveness of the group including but not limited to

   a. Team leader behavior;

b. Mutual influence among team members;

c. Personal involvement and participation;

d. The degree of collaboration among the members; and

e. Degree of trust, respect and dependence present among members.

TABLE 16
PERCENTAGE OF RESPONSE PER INTERVAL

TEAM #	1	2	3	4	5	6	7	8
1	44	27	26					
2	20	22	25	33				
3	27	29	30	14				
4	16	8	12	21	16	22	18	5
5	39	32	28					
6	24	20	31	26				
7	16	20	24	25	16			
8	29	19	15	37				
9	33	23	43					
10	26	28	28	18				
11	44	50	6					
12	30	26	28	16				
Average	29	25	24	24	16	--	--	--

TABLE 17 OBSERVER RATINGS OF GROUP BEHAVIOR

Factor	Observer #1												Observer #2												Average of Observer Ratings												Average Across All Observations
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	
1. Group Effectiveness	1	5	4	3	4	4	4	2	2	5	2	5	1	4	4	5	4	5	4	4	3	5	3	5	1	4.5	4	4	4	4.5	4	3	2.5	5	2.5	5	3.66
2. Leader Approachability	3	5	4	5	5	5	5	2	1	4	3	5	3	5	4	4	4	4	4	3	3	4	3	5	3	5	4	4.5	4.5	4.5	4.5	2.5	2	4	3	5	3.87
3. Mutual Influence	2	4	5	4	2	2	2	2	2	3	1	3	1	4	3	3	3	3	2	3	4	3	3	3	1.5	4	4	3.5	2.5	2.5	2	2.5	3	3	2	3	2.79
4. Personal Involvement and Participation	1	5	3	5	2	4	3	2	1	3	1	4	1	5	3	5	3	4	3	3	2	4	3	4	1	5	3	5	2.5	4	3	2.5	1.5	3.5	2	4	3.08
5. Intragroup Trust vs. Intragroup Competition	3	3	4	4	4	4	4	3	2	4	3	4	4	5	4	4	4	3	4	4	3	4	3	4	3.5	4	4	4	4	3.5	4	3.5	2.5	4	3	4	3.66
6. Worthiness of the Meeting	3	4	4	4	3	4	4	3	3	4	2	4	1	5	4	4	4	3	3	3	3	5	3	4	2	4.5	4	4	3.5	3.5	3.5	3	3	4.5	2.5	4	3.50
7. Submission to vs Rebellion against the Leader	2	3	3	3	3	3	3	4	3	3	2	4	3	3	5	3	4	2	4	5	4	5	3	4	2.5	3	4	3	3.5	2.5	3.5	4.5	3.5	4	2.5	4	3.37
8. Leader Control	1	2	3	3	4	3	2	3	3	5	5	4	2	4	4	3	5	3	3	5	4	5	3	4	1.5	3	3.5	3	4.5	3	2.5	4	3.5	5	4	4	3.45
9. Role and Idea Conformity	4	3	3	4	5	4	5	5	4	5	5	4	4	3	5	4	4	4	4	4	4	5	3	4	4	3	4	4	4.5	4	4.5	4.5	4	3	4	4	4.12

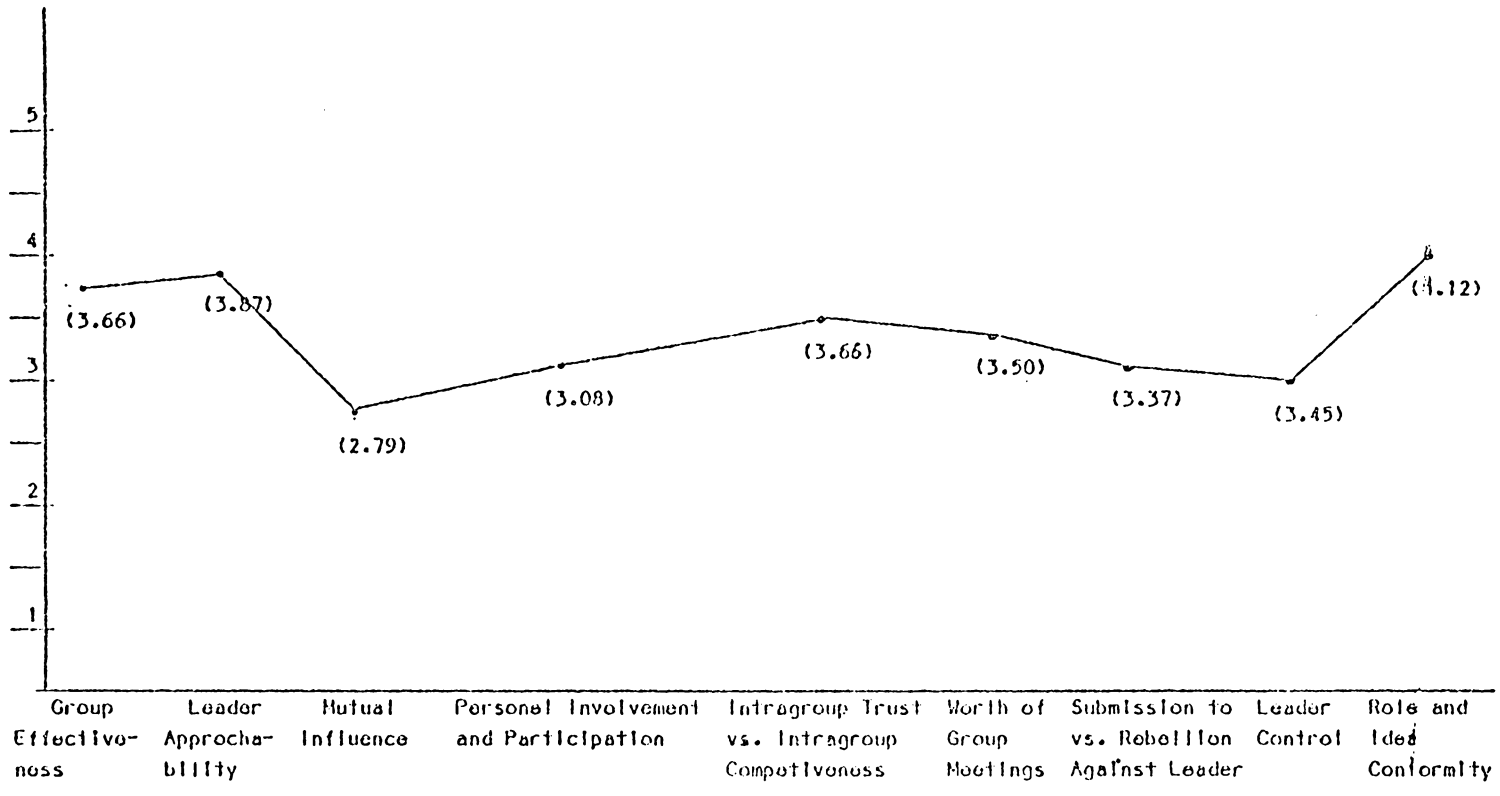

FIGURE 8. AVERAGE OBSERVER RATINGS ACROSS TWELVE OBSERVATIONS

TABLE 10

SUMMARY DESCRIPTION OF THE TWELVE OBSERVATIONS

OBSERVATION #	RESIDENT PROFILE	PHYSICAL FACILITIES	GENERAL OBSERVATIONS
1	73 year old female; resident for 13 years; severe range of retardation; curses and threatens others; receives psychotropic medication; Program includes participation in monthly activities; maintenance of personal hygiene skills; decreasing maladaptive behaviors	Small dining room on residential living area; seating arrangement not conducive to effective communication; members spoke with backs to other members.	Team leader played a passive role in conducting the meeting; took no initiative to solicit participation of all members; total number of average responses (55.5) below average; little spontaneous interaction among team members; members did not question information presented; majority of comments made in the categories of assessment and placement alternatives; members primarily made informational type statements.
2	66 year old male; resident for 36 years; moderate range of retardation; spastic paraplegic; frequently hits other residents; receives psychotropic drugs; training objectives focus on development of personal hygiene skills; participation in music activities.	Small dining room; room too small to accommodate the 13 staff; room poorly ventilated; difficult to always hear members.	High number of total average responses (137.5); team leader actively involved in the meeting; leader continuously asked substantive questions, gave information, and made recommendations throughout the meeting; resident attended the meeting; conscientious effort to involve resident in the meeting; team devoted majority of comments toward assessment, and program implementation categories; members primarily made informational statements.

TABLE 18 - Summary Description of the Twelve Observations (cont.)

OBSERVATION #	RESIDENT PROFILE	PHYSICAL FACILITIES	GENERAL OBSERVATIONS
3	26 year old female; resident for 15 years; profound range of retardation; severe spasticity; requires skilled nursing care; program focuses on maintenance health care objectives.	Quiet conference room on residential living area; room contained large conference table; some members seated with their backs to others; free from environmental disruptions.	Team leader conducted the meeting in an efficient, organized manner; all members of the team participated in the meeting; Team engaged in an interdisciplinary discussion regarding the proposed use of a special adaptive cup for the resident; active degree of information sharing among the team members; mutual sharing of information regarding this proposal; majority of comments directed toward assessment and program planning categories; no comments regarding placement alternatives; majority of comments made using informational type statements.
4	18 year old male; resident for 13 years; moderate range of retardation; spastic diplegic; programs in education and music; occasionally refuses to participate in programming.	Large classroom; majority of members not seated near leader; very difficult to hear what was being said during the meeting; members frequently talked in small groups without directing comments to total group.	Largest number of staff (20); longest meeting (41 minutes); greatest number of responses (225.0); resident attended the meeting and had highest IQ of any resident discussed during the observations; team leader was actively involved in the meeting; difficult for team leader to control the group within the physical setting; all members contributing to the meeting except the shift supervisor and OT supervisor; majority of comments directed toward the assessment and program planning categories; majority of comments made using informational type statements.

TABLE 18 - Summary Description of the Twelve Observations (cont.)

OBSERVATION #	RESIDENT PROFILE	PHYSICAL FACILITIES	GENERAL OBSERVATIONS
5	29 year old female; resident for 25 years; severe range of retardation; hydrocephalic; cerebral palsied; lacks minimal self-sustaining skills; requires skilled nursing care; program focuses on development of language and socialization skills.	Conference room on residential living area; well ventilated; contained large conference table; seating arrangement such that some members not communicating face to face with other members.	Meeting similar to observation #3, with regard to team leader behavior, length, number of staff, total average number of residents; and resident characteristics; no comments made by developmental aide; team devoted most amount of discussion to the assessment and program implementation categories; no comments made in placement alternative category; team members usually made informational type statements.
6	45 year old female; resident for 15 years; profound range of retardation; functioning level appeared to be higher than that indicated by the psychological data; possesses all other self-help skills; able to verbally express herself; training program included development of pre-vocational skills; physical therapy;	Dayhall of residential living area; members seated in circular fashion; team leader stood up during the meeting.	Resident and relatives attended the meeting; active exchange of information between the family members and other team members, especially the psychologist; high number of responses; team leader made conscientious effort to get resident involved in the review of her program plan; Members spoke spontaneously; all members gave input with the exception of the speech therapist and special activity aide; majority of comments directed toward the assessment and program implementation categories; majority of statements made using informational type statements.

TABLE 18 - Summary Description of the Twelve Observations (cont.)

OBSERVATION #	RESIDENT PROFILE	PHYSICAL FACILITIES	GENERAL OBSERVATIONS
6 (cont.)	self abusive at times; receives psychotropic medication; has frequent family contact.		
7	37 year old male; resident for 35 years; profound range of retardation; possesses all self-help skills; frequently exhibits aggressive behavior; receives psychotropic medication; training program focuses on personal hygiene skills; frequent contact with parents.	Small dayhall on residential living area; members sat on sofas and chairs around the room; meeting subject to frequent environmental disruptions including phones ringing; staff mopping the floor; residents wondering into the meeting.	Team leader same individual who conducted observation #6; both resident and his parents attended the meeting; team leader less actively involved in this meeting than observation #6; parents very involved in the discussion; no involvement from the resident during the meeting; little participation from the three direct care staff attending the meeting; no input from recreator, one of the teachers, and the nurse; physician present at this meeting; gave an extensive overview of resident's physical condition; most of the interaction seemed to be between the team and the resident's parents; little interaction among team members; team made most comments in the areas of assessment and program implementation categories; comments made using informational type statements.
8	18 year old male; resident for six years; severe range of retardation; frequently displays aggression toward others; lacks personal hygiene skills;	Large training/meeting room that was formerly a dayhall on the residential living area; quiet location for meeting; conference table used during meeting.	Discussion dominated by the teacher and team leader; team leader somewhat passively involved in the meeting; asked questions of a technical nature regarding the program plan; little substantive input from the team leader; psychological data quickly presented by psychologist; no questions asked regarding information presented by team members despite lack of progress in decreasing maladaptive behaviors; meeting appeared to be more multidisciplinary than interdisciplinary in nature; below

TABLE 18 - Summary Description of the Twelve Observations (cont.)

OBSERVATION #	RESIDENT PROFILE	PHYSICAL FACILITIES	GENERAL OBSERVATIONS
8 (cont.)	currently working on simple pre-academic skills.		average number of total average responses made by team members (68.0); majority of comments directed toward the program implementation category; overwhelming number of statements of an informational type nature.
9	21 year old resident; resident for 19 years; profound range of retardation; training program emphasizes the development of self-help and motor skills; receives 5½ hours of programming.	Large dining room; tables available; food service staff conducting meeting on the other side of room; relatively free from environmental disruptions.	Meeting lasted for 15 minutes; lowest number of responses (40.5) seen in any meeting; same team leader who conducted observation #8; outward expressions of anger on part of teacher; comments ignored by other team members; very limited interaction among team members; no comments from the developmental aide; active involvement from the speech therapist; majority of comments made in the categories of assessment and program planning; majority of statements made using informational type statements.
10	31 year old male; resident for 21 years; severe range of retardation; epileptic; frequently displayed aggressive behavior; training program focused on decreasing maladaptive behaviors; developing basic self-help skills; prevocational and leisure time skills.	Bedroom on residential living area; not conducive to effective communication among team members; several members had to sit on the residents' beds; members seated with their backs to other members.	High level of leader control; conducted the meeting in an organized manner; high level of participation from direct care staff; all members present; resident attended the meeting but was not involved in the review of the program plan; special activity aide contributed more to review of educational program than teacher; members appeared somewhat apprehensive about the presence of the observers; majority of comments made in the assessment and program implementation categories; majority of statements of an informational nature.

TABLE 18 - Summary Description of the Twelve Observations (cont.)

OBSERVATION #	RESIDENT PROFILE	PHYSICAL FACILITIES	GENERAL OBSERVATIONS
11	37 year old male; resident for 29 years; displays aggressive behavior on a frequent basis; placed on a restrictive behavioral unit; training programs emphasize deceleration of maladaptive behaviors; development of self-help skills; language skills; leisure time skills.	Kitchen activity area on residential building; other staff members preparing for a picnic in an adjacent area; members had to meet in the kitchen area due to conflict with conference room.	Meeting lasted for only 12 minutes; low number of total responses (50.5); 8 staff attended the meeting; meeting characterized by lack of substantive content among team members; several program areas had deferred objectives; no members questioned what new objectives would be or why they had been deferred; limited input regarding resident's success in behavioral program; no one questioned why program had not been successful, despite resident's placement on a restrictive (locked) living area; majority of comments directed toward the assessment and program implementation categories; majority of comments made using informational type statements.
12	40 year old male; resident for 18 years; multi-handicapped with vision impairments; frequently displays aggressive behaviors; training program includes development of self-help skills; leisure time activities; speech and language skills; and gross motor skills.	Large dining room area on residential living area; staff from food operations on other side of room; acoustics in the room very poor.	Great deal of enthusiasm displayed by team leader; high level of involvement from developmental aide staff in the area of program implementation; team leader dominated discussion; conducted the meeting in an organized fashion reviewing resident's problems, strengths, accessibility sheet and ID team review sheet; members appeared somewhat apprehensive about presence of observers; majority of comments directed toward the assessment and program planning categories; primarily, members gave information rather than asking questions or making recommendations.

CHAPTER 5

DISCUSSION

Introduction

Using an exploratory approach, the researcher in this study examined the manner in which twelve ID teams in one residential center conducted annual reviews of residents' program plans. Each of the twelve meetings was observed by two trained observers (one of whom was the researcher) who coded and recorded, using a set of predetermined rules, the responses made by the various team members into one of four content categories: (1) assessment; (2) program planning; (3) program implementation; and/or (4) placement alternatives. The observers also coded whether the responses made were: (1) questions; (2) informational type statements; and/or (3) recommendations, suggestions, or discussion type statements. The information obtained by the observers was utilized in answering the first research question: what are the members' relative contributions to the task activities dimension of the ID team as defined by ACMRDD Standards?

The observers rated the twelve teams on the following nine variables: (1) group effectiveness; (2) leader approachability; (3) mutual influence; (4) personal involvement and participation; (5) intragroup trust versus intragroup competitiveness; (6) worthiness of the meeting;

(7) submission versus rebellion against the leader; (8) leader control; and (9) role and idea conformity. The observers independently rated the team's behavior on each of these variables.

The observers also summarized their comments following each meeting giving special attention to the variables that appeared to have impacted upon the individual group's behavior. The objective of this exercise was twofold. First, it provided additional insight into those group process variables that influenced the team members' behavior in accomplishing their task, that of reviewing the resident's program plan. Second, the exercise provided the observers with the opportunity to express in writing their observations of each meeting. Hopefully, this exercise lead to more objective coding and recording in subsequent observations. This information was used to answer the second research question regarding those group process dimensions (relative to the task functions) which occur among members of ID teams.

In the final chapter, the results of the observations will be discussed with particular regard to the two research questions. Explanations will be offered as to why certain members responded in certain content categories and others did not. Conclusions will be presented as

to why certain teams appeared more effective in conducting the review meetings than other teams. Limitations encountered in conducting the study are discussed. In the final portions of this chapter recommendations are presented for improving the ID team process in a residential setting. Finally, suggestions for conducting future research investigations in this area are also presented.

Contributions to the Task Activities Dimension

As shown on Table 3 (p. 46), attendance at the twelve ID team meetings ranged from a low of 8 to a high of 20 staff. There were eight disciplines and positions represented at ten or more of the twelve meetings including (1) team leaders; (2) teachers; (3) nurses; (4) social workers; (5) psychologists; (6) speech therapists; (7) recreators; and (8) developmental aides. Specifically, what information did the various team members contribute to the assessment, program planning, program implementation and placement alternative categories? The percentage of responses in each of the four content categories across all twelve observations is shown in Table 9 (p. 69). The percentage of the responses made in each of the three process categories is displayed in Table 10 (p. 73). In the following section, discussion will focus on the members' responses in each of the four content areas. Attention will also be given to the nature of the members' responses.

Assessment

As shown on Table 9 (p. 69) and Figure 1 (p. 70), the twelve teams directed the majority of their comments (39%) to assessment related issues. The team leaders (see Figure 4, p. 79; Table 12, p. 83) dominated the discussion regarding assessment issues throughout the twelve observations contributing 43% of all responses. Their role seemed to be more that of a facilitator. They were continuously asking other team members to give information in this content area. They also read the resident's problem and strength list which was counted under the assessment category. The team leaders, however, did not give any concrete or "hard data" regarding their individual assessment of the resident's status in any one area. Rather they summarized information given by other members and read information about the resident from his/her folder.

Other team members, including the teachers, speech therapists, nurses, social workers, psychologists, and recreators (see Figure 4, p. 79, and Table 12, p.83) gave 5-9 % of the information regarding the resident's status in specific areas. These members usually read formal reports regarding the resident's behavior, skills, or condition with regard to certain areas including speech and language, health, family contacts, educational,

psychological or developmental assessments. The members read their reports using informational type statements. They were rarely questioned by other team members. Even when assessment data revealed no progress in several meetings, the other members of the team did not challenge or question the data.

Gilliam (1981) found that psychologists in public school IEP meetings were perceived as having the most influence in diagnosis. Unlike psychologists in a public school setting, the psychologists observed in these meetings did not dominate the discussion in the assessment category. They offered little practical information regarding the resident's psychological or developmental status. They did, however, appear to play a more active role in those meetings with residents who had behavioral problems. This lack of participation by the psychologists may have been due in part to deficiencies in their preservice training which limited their ability to assess and plan programs for severely and profoundly handicapped persons.

The observation that ID teams in a residential center most frequently discussed assessment issues regarding the resident differs from findings in a public school setting. Goldstein, Strickland, Turnbull and Curry (1980) found that evaluation received little attention by the

teams discussing student IEPs. The difference in emphasis may be due in part to the ACMRDD requirement (1979, p. 9, Standard 1.2.12.3) that each individual resident receives an assessment annually or when otherwise determined by the ID teams.

Program Planning

Each resident at the facility was required to have a written plan of intervention and action developed on the basis of assessment results. The program plan specified goals and objectives designed to enable the resident to maximize his potential. The purpose of the annual review meeting is to modify the program plan as necessary to ensure its relevancy to the current needs of the individual resident.

As shown in Table 9 (p. 69) and Figure 1 (p. 70), comments directed toward the program planning category comprised 24% of the comments made by the team members. This finding was somewhat surprising in view of the fact that the primary purpose of the annual review meeting was to discuss the program plan. While various comments were made regarding an extension of objectives and the addition or deferral of objectives, there was little informational exchange regarding the content of the objectives. Members did not question the content of the objectives even when it was noted

that certain objectives had been deferred. Medicaid Standards (see p. 16) and ACMRDD Standards stipulate that all staff have a collective responsibility for ensuring that the program plan succeeds. This was not necessarily characteristic of teams in this study. Additionally, the teams did not prioritize program objectives during the meeting as required by ACMRDD Standards (1979).

Based on the observations and the data as shown in Figure 5 (p. 80) and Table 13 (p. 84), it appears that discussion regarding the program plan was usually initiated by either the team leader, nurse, teacher or social worker. In Gilliam's (1981) survey of IEP meetings in public schools, he found that the special education teacher was perceived as having the most influence in planning and implementation. However, the teacher in the residential facility clearly did not dominate the discussions with regard to resident program plans. With the exception of one meeting (Observation #8), the teacher of school age residents likewise did not play a significant role in discussion in the program planning area.

While the purpose of the annual review meeting is to review the content of the program plan, the team members did not address specific goals and/or objectives unless there was some modification such as an extension and/or deferral of objective. Unless the team member had

reviewed the resident's records prior to the meeting, it appeared that they were not updated regarding the resident's specific goals and objectives. The team members, in presenting their reports regarding the resident, did not include a review of specific goals and objectives. Consequently, the majority of the team members may not have been aware of what plans were being reviewed. This finding was similar to that of Goldstein, Strickland, Turnbull and Curry's (1980) conclusions that special services and plans, among other topics, received little attention in public school IEP conferences.

Program Implementation

As shown on Figure 6 (p. 81) and Table 14 (p. 85), there was a greater diversity of participation across this content area. The team leaders did not dominate this content category to the degree that they dominated other areas. It was in this area that the developmental aides responded most frequently. This finding was not surprising as developmental aide staff are responsible for carrying out the program plans on a daily basis. The teachers were also actively involved in this particular area.

The program implementation category included discussion of those factors related to the implementation of the resident's program plan; persons responsible for the program; services the resident needs; the training

environment; and training materials. For the most part, comments in this area were of an informal nature. This was especially true of comments made by the direct care staff. The teams rarely discussed any additional services the resident may have needed. As seen in other areas, the members primarily made informational type statements. There were few questions or recommendations made regarding the implementation of the resident's programs.

While the ID teams in the residential setting directed over one-fourth (29%) of all their comments to program implementation issues, special services and responsibilities received little attention in IEP conferences in public schools (Goldstein, Strickland, Turnbull and Curry, 1981). The increased frequency of comments directed toward the program implementation category may have been due to the larger number and diversity of staff who attended annual review meetings in the residential environment as compared to the smaller number of staff attending IEP meetings in public schools. While Goldstein, Strickland, Turnbull and Curry (1980) found that the mean number of participants in public school IEP meetings was 3.7 with a range of 2-6, the mean number of participants attending annual review meetings was 12 with a range of 8-20 (see Table 4, p. 50).

Placement Alternatives

As shown in Figure 7 (p. 82) and Table 15 (p. 86), the placement alternative category received the least amount of attention (9%) by the team members. This was also characteristic of IEP planning meetings in public schools where placement received little attention.

The team leaders and social workers dominated the discussion in this area. The team leaders routinely asked if the team believed the resident's current placement was appropriate. The members would usually respond by shaking their heads. Sometimes one or two members would say "yes." Rarely did the group respond vocally in unison to the team leader's question. The social worker would present information regarding discharge planning if the resident had been identified as appropriate for discharge. In one meeting (Observation #1), the social worker gave an overview of a new adult home that was opening on the facility's grounds as a joint endeavor between the facility and the local community services board.

Summary

In summarizing the contributions of the team members in accomplishing the tasks of the team, it appeared that the team leaders definitely dominated the meetings. However, as noted earlier, their responses were more procedural than substantive in nature. They served as

chairpersons of the meetings and were responsible for serving as the resident's individual program coordinator (IPC). They asked the members to give information or to clarify certain information. However, they seldom raised questions, challenged or suggested alternatives to information proposed by other staff including para-professional and professional staff.

The observational data suggest that few professional staff questioned, challenged or suggested alternatives to information proposed by fellow team members. This finding was similar to Ewart's (1982) conclusion. In observing ID teams in a residential facility, she found that few unit staff with the exception of the unit leaders raised questions, challenged, or suggested alternatives to the treatment plans proposed by professional staff. In the present study there were few questions or recommendations suggested by either direct care (unit staff) or professional staff.

The ID teams in this study appeared to operate more as multidisciplinary than interdisciplinary groups. The members seemed to lack skills in giving feedback to fellow team members. In general, the teams were more characteristic of coordinate versus integrative teams. Characteristics of integrative teams such as shared decision-making, overlapping roles, and shifting leadership

described by Kane (1958) were not observed across the twelve groups.

As Browne (in Ewart, 1977, p. 107) asked ". . . is the purpose of the meeting to solve problems or merely to share information?" It seemed that the purpose of the annual review meeting was to discuss an already developed program obtaining any suggestions from other team members for modification. However, there were few suggestions for improving upon or modifying the program plan. This finding was similar to that of Goldstein, Strickland, Turnbull, and Curry (1980) who concluded that the purpose of the IEP meeting was to inform parents of the nature of an already developed IEP.

It seemed somewhat unrealistic to think that in a large institution such as this where the majority of residents were severely or profoundly retarded with multiple handicapping conditions that the teams were not confronted more frequently with problem situations. It may have been that the annual review meetings were not perceived as the appropriate setting for resolving problems. Due to the presence of the observers, team members may have been reluctant to present their concerns. The behavior of the team members may have been reflective of a growing apathy on their part and general dissatisfaction with the ID team process.

Variables Affecting Team Members' Behavior

The second research question in this study addressed those group process dimensions (relative to the task functions) which occur among members of ID teams. In Table 7 (p. 56) there were nine variables listed that were perceived as having an impact upon the behavior of the teams in completing their task, that of reviewing the resident's program plan. The nine variables were independently rated by the observers in each of the twelve meetings using the Observer Rating Scale for Group Behavior (see Form #5, Appendix B). It was at times difficult for the observers to objectively rate the teams on these variables. This was especially true of those meetings which were quite short in duration and characterized by a low total in average member response contributions.

There were three variables that presented particular difficulties. They were intragroup trust versus competitiveness, worth of group meetings and submission to versus rebellion against the leader. As the meetings were fairly short in duration (twenty minutes), there was not enough time to adequately observe the nature of the relationship between the members and to effectively ascertain whether it was one of trust or competitiveness. The observers did not believe that they could sufficiently determine how the members felt about the worthiness of the meetings without

directly asking them. This activity was not initiated as part of the study.

Due to the lack of controversial issues presented by the teams, there were few opportunities to observe either submissive or rebellious behavior on the part of the team members directed toward the leader.

The remaining six variables appeared to have more relevance and significance to this study including: (1) group effectiveness; (2) leader approachability; (3) mutual influence; (4) personal involvement and participation; (5) leader control; and (6) role and idea conformity. Each of these variables are discussed in the following section with regard to the behaviors observed across the twelve ID team meetings.

Group Effectiveness

Group effectiveness refers to the group's ability to solve problems. As discussed in the previous section, there were relatively few problem situations presented in the twelve meetings. There were, however, three observations where the teams were presented with specific problem situations that bear discussion. In Observation #3 the resident's teacher suggested that the resident be provided with a special adaptive feeding cup. This team did an excellent job of exchanging information and collaborating in response to this suggestion. This discussion was

prompted by a recommendation of a team member. It was of particular interest that this team was reviewing a program for a resident with the lowest IQ of any resident discussed and with multiple physical and medical complications.

In Observation #4 the music teacher recommended that an objective and plan should be written for the resident's refusal to participate in programs. The team leader was reluctant to agree with the recommendation because the unit was currently without a psychologist. The team leader preferred that the problem be deferred until such time that a psychologist could be hired. The music teacher, recognizing the difficulty in recruiting and hiring psychologists, was not satisfied with this recommendation. None of the other team members made any comments regarding this situation. A compromise was reached when the team leader suggested that the music teacher collect data regarding the resident's behavior for thirty days. As of this date, four months following the observation, the psychologist position has not been filled.

In Observation #9 a teacher expressed feelings of anger in response to a question asked by the social worker regarding the resident's placement in his classroom. This exchange took place prior to the beginning of the meeting. The social worker made no response to the teacher. The team leader who was substituting for the regular leader

began the meeting without acknowledging the teacher's comments. The team did an effective job of extinguishing the teacher's behavior. He did not mention his concern again. However, following presentation of his information, the teacher left the meeting.

In reviewing the effectiveness of the teams in solving problems, there was only one situation observed where the team members appeared to have engaged in a genuine interdisciplinary effort to resolve a problem. In the second observation (#4), there was some effort on the part of the team leaer to resolve the situation. In the third (#9) observation, there was no effort to deal with the obvious frustrations expressed by the teacher. Generally, the teams collectively received a moderate rating with regard to their ability to resolve problems. However, this observation was made based on three meetings. As discussed earlier, the other teams did not discuss situations that required problem-solving skills. This may have been indicative of the group's tendency to avoid discussion of difficult situations.

Leader Approachability

Leader approachability refers to the members' perception that their leader is approachable. As discussed in Chapter 4, the team leader clearly dominated discussion across all twelve of the observations (see Figures 3-7,

pp. 77-82). The team leaders were responsible for creating an environment in which all members felt free to contribute to the review of the resident's program plan. The team leaders appeared to be influential in getting the members involved in the meetings. In those observations where the teams had above average response rates (Observations #2, #4, #6), the team leaders were actively involved in the meetings, encouraging and soliciting participation from the members. In those observations with below average contributions (Observations #1, #8, #9), the team leaders were less active in seeking member participation.

It was somewhat difficult to ascertain the degree to which the members perceived their leader as approachable due to the small number of problem situations actually discussed at the meetings. The observational data suggest, however, that the behavior of the team leader was influential in increasing or decreasing participation of other team members.

Mutual Influence

Mutual influence refers to the extent to which the group members mutually influence each other. Because the team members seldom discussed any controversial matter that required debate and subsequent compromise, as members presented information with few questions or challenges from their fellow members, it appeared that the members were not

significantly influenced by other members.

Personal Involvement and Participation

This variable refers to the extent to which the individual team members participate in the team meetings. As shown in Figure 3 (p. 77) and Table 11 (p.78), participation in the twelve meetings varied from 0-35%. While the team leader dominated the meeting contributing 35% of all the comments made, a total of 38% of the comments were made by professional staff including the teachers, nurses, social workers, psychologists and speech therapists. The remaining 27% of the comments were made by other staff including recreators, developmental aides, family, music teachers, PT aides, special activity aides, dental educator assistants, OT aides, dieticians, physicians, ART, advocates, PE teachers and the resident.

As discussed in Chapter 2, all members of the ID team should collaborate and share information in jointly developing an integrated program plan for the resident. While all members were free to contribute to the review meeting, they did not participate to the extent that they could have. Those team members who contributed concrete assessment data and substantive information regarding the resident's program plan including the teachers, nurses, social workers, psychologists, and speech therapists, participated in the meetings with greater frequency than

other members with the exception of the team leader. In Gilliam's (1981) study of IEP meetings, he found that teachers, psychologists, special education directors and special education supervisors were found to have the most influence in the IEP meetings. He hypothesized that these members were perceived as being more influential because they provided hard data in terms of test scores, diagnostic reports, and cummulative records.

In 25%, or three of the twelve meetings, the developmental aides made no contribution during the meetings. The developmental aides did not have any written mechanism for presenting information to the group. Based on the observational data, the developmental aides responded less frequently on a spontaneous basis but more frequently as called upon by the team leader. In five out of the twelve meetings, more than one developmental aide attended the meetings representing first and second shifts. Thus in the remaining meetings, there was no representation from second or third shift. Medicaid Standards (p. 16) require that direct care staff play an active role in the ID team process. While there was some representation from second shift, there was no input from developmental aide staff from the third shift. There was no indication at the meetings that the team leader had approached the staff on the third shift regarding their input into the review

meeting. While the aide staff are responsible for carrying out a major portion of the residents' program plans, they contributed a small 8% of the total responses made at all twelve meetings. Their limited participation may have been due to a preconceived perception that they have less knowledge and status than professional staff serving on the team. They may also believe that their input into the ID team meeting will have little impact on decision outcomes. If either of these suggestions are true, one can conclude as did Yoshida (1978), that those members who participate less are likely to be less satisfied with the team process in general. Simply attending the meeting does not translate into member participation or satisfaction (Yoshida, 1978). Failing to identify with the team may result in a lack of concern on the part of these staff members in accomplishing the goals set by the team for the resident. Subsequently, they may also develop feelings of hostility about their work and loose their sense of belonging to the group and organization.

Leader Control

Leader control is defined as the extent to which the leader initiates and controls the group process. The team leaders as a group controlled the meetings. There was little evidence of shifting leadership observed in the twelve meetings. The leaders displayed varying degrees of

leader control. While some leaders appeared to be somewhat passive and reluctant to get involved in the meetings, other leaders bordered on being aggressive in conducting the meetings. There appeared to be a greater degree of participation in those meetings where the leader specifically asked each member to comment with regard to certain areas. This action appeared to generate more member participation than those leaders who left it to the individual members to offer their comments on a volunteer basis.

Role and Idea Conformity

Generally speaking, the teams seemed to display a rather high degree of role and idea conformity. Although this variable was difficult to rate, it appeared that the members perceived their role to be primarily that of presenting information relative to his/her particular program area. Based upon the observations, it seemed that the members seldom perceived themselves as crossing traditional territorial boundaries and providing feedback in program areas other than their own.

In addition to the nine variables previously discussed that impacted on the group's behavior, three other variables emerged during the course of the observations that also seemed to impact upon the teams' behavior while reviewing program plans. These included: (1) resident profile; (2) attendance of individuals other than staff at

the meetings; and (3) physical setting and seating arrangement. Each of the three items are discussed separately in the following section.

Resident Profile

Resident profile was a term used to describe the degree to which the individual resident's condition impacts upon the team members' behavior. To what extent, if any, does the resident's age, degree of retardation and adaptive behavior level impact upon the team in reviewing the program plan?

The observational data suggest that those teams discussing residents with high IQs and adaptive behavior skills generated more discussion. This was seen in Observations #2, #4 and #6. Even though the resident in Observation #6 was classified as profoundly retarded, she had a higher level of adaptive behavior than observed with other residents. She attended the meeting and was able to express herself quite well. She also had a job as a part-time employee at the center.

However, while the data may suggest that residents with higher functioning levels did generate more ID team discussion, an interesting feature was observed in Observation #3. While the resident had the lowest IQ (3) of any resident discussed, this team was the only team that appeared to engage in a true interdisciplinary exchange of

information.

One would expect that school age residents would perhaps have generated more discussion as they are required to have 5½ hours of instructional programs on a daily basis. However, this was not necessarily true of the three observations (#4, #8, #9) with residents of school age. In Observation #4 the team had the greatest number of total average responses of any of the twelve teams. Also, the most number of staff attended the meeting, and it lasted the longest period of time. The opposite was found with Observations #8 and #9 where the number of total average responses were considerably below the average across all twelve observations.

Attendance of Individuals Other than Staff at the Meetings

This variable led to the following observations regarding the degree to which the team members' behavior was affected by the presence of "foreigners" at the meetings including family members, advocates and the observers:

1. As noted in the previous section, the residents attended four of the twelve observations. In three of these meetings there were significantly above average response levels.

2. The teams, especially the team leaders, made a conscientious effort to get the resident involved in the meeting asking him or her to state their preferences or to express any complaints they may have had.

3. Parents or relatives attended two of the twelve

meetings (Observations #6 and #7). In Observation #6 where both the resident and relatives attended the meeting, there was an above average number of responses. It appeared to the observers that when parents or relatives attended the team meetings, the members appeared to direct more of their comments to the parents rather than to the other team members.

4. Advocates attended two of the twelve meetings (Observations #4 and #11). They made very few comments and seemed to exert little to moderate influence over the teams. In Observation #4, the team leader at times asked the advocate for clarification regarding certain issues. The advocate in this meeting was instrumental in getting the resident to the meeting. At the beginning of the meeting the resident was not at the meeting. However, after the advocate suggested that he should be there, a staff member brought the resident to the meeting. Had more advocates attended the meetings, they may have exerted more influence over the teams.

5. The presence of the observers seemed to make the team members somewhat apprehensive. The presence of the tape recorder seemed to also increase the anxiety levels of some team members. Prior to the beginning of the meetings, the observers would explain that their purpose was to explore what takes place in ID team meetings in a residential center for the mentally retarded. However, members sometimes commented that they thought the observers were part of an undercover survey team. It was as if some of the members were threatened by the presence of the observers. In four of the twelve meetings, the observers were unable to tape the meetings. Sighs of relief were expressed by the team members.

Physical Setting and Seating Arrangement

The meetings as shown in Table 4 (p. 50) were held on the residential living buildings in dining rooms, dayhalls, classrooms, bedrooms, the kitchen area and conference

rooms. As discussed in Chapter 4, the majority of the physical settings were unsatisfactory as they were either too crowded or were subject to frequent environmental interruptions. Despite the poor physical environment, in some of the meetings, the seating arrangements could have been easily modified to improve communication among the team members. However, neither the team leader nor other team members took the initiative to improve the physical environment. While the physical facility and seating arrangement do not guarantee collaboration among the team members, they can facilitate the interdisciplinary process by offering an environment in which the members can effectively communicate with each other.

Summary

In reviewing variables that affected the behavior of the teams, several summary statements can be made. In general, there were relatively few situations where the teams exerted problem-solving skills. In those three situations where the teams did exert such skills, only one team displayed an interdisciplinary effort to resolve a problem situation.

The team leaders seemed to play an important role in encouraging and stimulating the involvement of other team members. Due to the lack of situations necessitating problem-solving skills, it was somewhat difficult to

ascertain the degree to which the members influenced each other. However, it appeared that the team leader was potentially influential in prompting the participation of other staff especially the para-professional staff.

Professional staff participated in the meetings more frequently than did para-professional staff. This factor seemed to be related to the concrete or "hard" data that professional staff members contributed as opposed to the more informal comments made by the para-professional staff.

The teams seemed to generate more discussion when discussing higher functioning residents. The presence of the residents also appeared to increase the amount of team discussion. When parents or relatives attended the meetings, it appeared that the teams directed more comments to the parents or relatives versus fellow team members. The presence of the observers seemed to arouse anxiety among some team members.

The physical environment, in general, was not conducive to promoting communication among the team members. However, there was little effort on the part of the team leader or other team members to alter the existing physical setting.

Limitations of the Study

As discussed in Chapter 1, the study was subject

to limitations and certain operational barriers. While the observers were trained and given the opportunity to utilize the recording mechanisms in trial observations, there existed the definite opportunity for recording and coding errors on the part of the observers. While some of the meetings were audio-taped, there were four meetings where, due to power failures or the unavailability of an electrical outlet, that the meetings could not be taped. Therefore, there was no preservation of the verbal interactions of the meetings. The presence of the observers and the recorder, as expected, seemed to arouse feelings of anxiety among some members.

As the investigation was an exploratory study, many of the conclusions drawn were based on the personal observations and conclusions of the observers. It was difficult to objectively rate the teams' behavior using the Observer Rating Scale. The ratings were subject to individual interpretation by the observers and, subsequently, potential bias. While there were three observers in addition to the author, the data may have been more consistent had there been just one additional observer. However, due to schedules and conflicts with work schedules, it was impossible to conduct the observations without the availability of additional observers.

Restatement of Findings and Recommendations for Improving Annual Review Meetings

The results of this study provide descriptive information regarding the manner in which ID teams function in one large residential facility. The significance of this research, however, is based upon the degree to which information derived from the study can be applied toward improving ID team meetings in the facility. In the section that follows, a restatement of the major findings is provided along with recommendations for improving annual review meetings. A summary of the recommendations is displayed in Table 19.

The reader is cautioned to use discretion in generalizing the results of this study to other residential facilities, especially smaller institutions. The reader is reminded that the institution in which this study was conducted is unique in that it is one of the largest in the country providing services for over 1,700 residents. The interdisciplinary model has been in operation for only ten of the facility's seventy-three year history.

Content of Annual Review Meetings

During the review meetings, the team members directed the majority of their comments to the assessment category followed by contributions to the program implementation, program planning, and placement alternative

categories. While the purpose of the review meeting is to modify the goals, objectives and activities written in the program plans, the teams observed in this study did not place their major emphasis in this area. Rather, it seemed that the purpose of the meeting was to review an already developed program plan.

It may be that the current amount of attention directed to the program plan is sufficient. If so, the implication is that the residents are attaining the skills and achieving the goals identified in the plan. However, if this is not the case, the resident's failure to achieve new skills may be, in part, related to the manner in which the teams are reviewing the plans and their possible failure to modify the program to better meet the needs of the individual resident.

It is recommended that the facility's Program Evaluation Team conduct a comprehensive review of data regarding the rate at which residents are achieving program objectives. Based on information obtained from this review, the facility's administrative staff may choose to mandate that annual review meetings be conducted according to a uniform structure that incorporates a more intense review of the program plan.

The meeting could be conducted according to an approved format that would provide additional opportunities

for discussion of the program plan among team members. The following steps should be included:

1. Introductions, if necessary, and statement of the purpose of the meeting by the team leader;
2. Review of the resident's problem and strength list;
3. Complete review of current goals, objectives and plans by appropriate staff;
4. Written summary statements from all staff across the three shifts responsible for implementing programs defined in the program plan;
5. Question and answer period facilitated by the team leader regarding the resident's progress in each program area;
6. Call for recommendations by the team leader regarding the goals/objectives/plans;
7. Prioritization of the objectives by ID team members; and
8. Summarization by the team leader of the proceedings of the meeting.

Team Leaders

Two conclusions emerge from this study regarding the behavior of team leaders. First, the team leader is the most active participant in annual review meetings. The team leaders dominated the discussion in all four content areas. As stated previously, the team leader appeared to play more the role of a facilitator for the group meetings. The information provided by the team leaders was more procedural than substantive in nature. While the team

leaders exerted high levels of participation and control at the meetings, their domination of the meetings appeared to be, in part, due to the lack of assertive or aggressive behavior on the part of other team members. The team leaders seemed to be filling a "vaccum of power" without any challenge from other team members.

Second, the team leaders are influential in getting other team members to participate in the meetings, especially the direct care staff. In those meetings where the team leader actively solicited comments from staff, there was more discussion of the program plan. The team leader's behavior was especially influential in generating comments from the direct care staff.

There are several strategies that may be employed for capitalizing upon the influential role of the team leader and subsequently improving the quality of ID team review meetings. First, the team leader should be mandated to attend in-service training programs specifically designed to increase their effectiveness in conducting team meetings. The ultimate goal of such training would be to increase the degree of ID collaboration among the team members. The objectives of the training programs would include but not be limited to the following:

1. Team Leaders will become aware of the following dimensions associated with participation in ID team meetings identified by Bailey (1982,p.251);

a. Preconference preparation

(1) Preparing reports

(2) Submitting reports

(3) Reviewing reports

b. Providing information

(1) Providing information

(2) Delivery of information

(3) Use of technical terms

c. Participation in the group process

(1) Seeking information

(2) Suggesting goals or strategies

(3) Providing feedback

(4) Group discussion

(5) Flexibility

(6) Accepting responsibility

(7) Suggesting interdisciplinary goals

d. Distractions

(1) Arrival and departure

(2) Distracting behavior

e. Nonverbal behavior

(1) Group position

(2) Body language

2. Team leaders will become skilled in providing a range of those behaviors identified with participation in the group process.

3. Team leaders will become skilled in facilitating ID participation among other members of the team.

Second, team leaders will receive feedback regarding their individual performance in team meetings. The use of an observational scale such as the one described in this study or one developed by Bailey (1982) may provide more specific feedback than simply advising team leaders of a general need to improve the manner in which they conduct meetings. This activity could be implemented by staff development or other administrative personnel. The observations could be conducted in one of two ways. The team leader could be observed while conducting actual meetings. The leader may feel more comfortable, however, if initially their behavior was rated in mock meetings.

Third, as a general recommendation, the administration should consider establishing competency requirements for team leaders. Prior to assuming the position of team leader, individuals in this role should demonstrate competency in the task and process areas associated with the interdisciplinary service delivery model. While current job descriptions at the facility state that team leaders should be able to conduct meetings, the specific behaviors associated with this important task have not yet been identified. Competence in the task and process areas should become an integral part of performance evaluations for the team leaders.

Participation in Team Meetings

A general finding in this study was that professional staff including team leaders, teachers, nurses, social workers, psychologists and speech therapists exhibited higher levels of participation than direct care and paraprofessional staff, including physical and occupational therapy aides, dental educator assistants, special activity aides and recreators. While an average of twelve (12) staff attended annual review meetings, six (6) professional staff dominated the discussion. The question arises regarding the quality of programs that are developed without input from all members of the team, especially those staff who have the most extensive contact with the resident on a daily basis. Also, the facility is not getting the best return on its investment in the ID team model when staff are allowed to leave the residents to attend meetings in which they are non-productive members.

Bailey (1982, p. 10) suggested several strategies for increasing the likelihood of paraprofessional and direct care staff participation in ID team meetings that have direct relevance to the teams observed in this study:

1. Information about resident functioning may need to be solicited from direct care staff, rather than expecting them to volunteer;

2. Professionals need to be more cognizant of the importance of direct care staff contributing to the team process;

3. Provide opportunities for preliminary and informal series of discussions that might prove more effective in encouraging full participation by all team members; and

4. Provide feedback to individual team members on specific areas needing improvement, as well as training in those areas. The use of an observational scale that provided specific feedback would be better than simply indicating a general need for staff to improve their team participation.

Functioning Level of the Resident

The observational data obtained in this study suggest that those teams reviewing program plans for residents functioning in the moderate or high severe range of retardation generate more discussion than teams reviewing plans for residents functioning in the profound range of retardation. The implication is that the higher functioning residents may be receiving a better quality program than lower functioning residents.

ID team members should be informed of this finding so that they may be more conscientious in reviewing program plans for all residents. This finding reinforces the need for the existing advocacy system for the residents. Due to budgetary limitations, there are only four advocates presently on staff at the facility. It is physically impossible for the advocate to attend all ID team review meetings. However, they may wish to make a particular effort to attend those meetings where lower

functioning residents are being discussed.

Attendance at Review Meetings

Observational data also indicate that when parents and/or residents attend ID review meetings there was more discussion than at those meetings when these individuals did not attend. Rules and regulations regarding resident rights at the facility mandate that the resident and/or his authorized representative (parent, relative, or guardian) be invited to attend all team meetings regarding the resident. One could hypothesize that the teams conduct a more indepth review when these individuals are present than when they are not. Administrative staff and the advocates should continue to vigorously seek involvement on the part of the resident and/or his/her authorized representative. Also, the advocates may choose to prioritize attending those meetings where the resident is incompetent and does not attend the meeting and the authorized representative seldom or never attends team meetings. This would help to insure that a third party is attending specifically to represent the resident.

Special Rooms for ID Team Meetings

A general finding of this study was that teams did not have appropriate meeting rooms. Meetings were held in kitchens, dining rooms, bedrooms and dayhalls. It is

strongly recommended that the special rooms be designated on each building for ID team meetings. The rooms should be well ventilated with adequate lighting. The rooms should be in an isolated area, free from routine interruptions and furnished with conference tables and comfortable chairs. While this recommendation would necessitate additional expenditures at a time when funds are being reduced, the importance of creating an environment conducive to effective communciation among ID team members justifies the cost.

Additionally, team leaders as well as all team members should make a special effort to arrange their chairs so that they can be seen and heard by all members. The team leader should take the initiative to see that the seating arrangement is such that all members can communicate with each other prior to beginning the meeting.

Team Development Programs

While the interdisciplinary model has been in place for the past ten years at this facility, no program exists to insure that those staff who lead or serve on ID teams possess teamwork skills. Pre-service training for professional staff is usually limited to their own discipline's theory. New employees are required to attend a four hour training session on the ID process, designed to familiarize them with the interdisciplinary process.

However, due to time and organizational constraints, the staff do not receive sufficient training in teamwork skills. It appears that the staff serving on teams receive their education about team work on the job.

Based upon general findings of this study, it is recommended that several teams be selected on a pilot basis to participate in a team development program designed to enhance the group's functioning and to develop collaborative skills among the team members. The goal of this program would be to help the team members to better understand and use the group process to plan programs for the residents. Based upon results of the intervention program with the pilot teams, the administration may choose to mandate that all ID teams participate in a team development program.

TABLE 19

SUMMARY OF RECOMMENDATIONS
FOR IMPROVING ANNUAL REVIEW MEETINGS

1. Comprehensive review of program data by the Program Evaluation Team;

2. Modify format for conducting annual review meetings;

3. In-service training for team leaders as a group to improve leadership and teamwork skills;

4. Establishment of competency requirements for team leaders;

5. In-service training for staff serving on teams to improve teamwork skills;

6. Provide feedback to individual team members regarding performance on the team using structured observational scales;

7. Solicit information from direct care and paraprofessional staff rather than expecting them to volunteer information;

8. Increase professional staff's awareness of need for input from direct care staff;

9. Provide opportunities for informal team discussion regarding the resident prior to conducting the formal review meeting;

10. Advocates should make special effort to attend those meetings for residents who are profoundly retarded;

11. Advocates should make special effort to attend those meetings for residents who are determined not capable of understanding the proceedings at the meeting and/or whose authorized representative seldom or never attends;

12. Establish special rooms for conducting ID team meetings on each building;

13. Team leaders insure appropriate seating arrangement prior to beginning the meeting; and

14. Initiate a pilot team development program.

Recommendations for Future Research

Based upon the discussion and results of this exploratory investigation, the following research questions are presented as suggestions for future research endeavors with regard to ID teams in residential centers for the mentally retarded:

1. What variables associated with ID teams are predictors of resident success in accomplishing his/her goals and objectives? Are teams, for example, that demonstrate higher levels of member participation and mutual influence among members more successful in facilitating the resident's success in achieving established goals and objectives?

2. Is there a relationship between the intensity of the ID team's review of the program plan and the functioning level of the individual resident? To what degree is the functioning level of the resident in terms of IQ and adaptive behavior related to the behavior of the ID teams?

3. To what degree do ID team members differ in the magnitude of self-perceived participation during team meetings, especially with regard to contributing information, proposing and evaluating alternatives and finalizing decisions?

4. What is the relationship between the magnitude of participation in ID team meetings and the subsequent level of member satisfaction with the ID team process?

5. Assessment of the quality of decisions made by ID team members.

6. To what degree are ID teams in large institutions and small institutions similar in their approach in conducting annual review meetings?

7. What would be the impact of rotating leadership among members of the ID teams? Would this lead

to increased effectiveness and collaboration on the part of ID teams?

8. What impact does a team development intervention program have on improving ID collaboration among teams in a residential center for the mentally retarded?

Conclusion

The interdisciplinary team approach has been widely recognized and accepted across the nation as the optimal service delivery model in residential facilities for the mentally retarded. However, conclusions based upon the ID team meetings observed in this study raise concerns regarding the current implementation of the ID service delivery model. It is widely assumed that all members do actually contribute information, propose and evaluate alternatives and participate in finalizing decisions during team meetings. The findings from this study do not support this assumption. The staff observed in this study appeared uncommitted toward implementation of the ID service delivery model. Furthermore, the extent to which staff members in other PRFs across the country participate in ID team meetings has not been assessed. Neither has the quality of decisions reached by these teams been broadly examined.

If facility directors want complete acceptance of ID team decisions and total commitment of staff toward implementation of the decisions, alternative methods must be developed for increasing staff participation and assessing the quality of decisions reached by the ID teams.

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APPENDIX A

FORMS

Rev. Jan. 19, 1983

Annual Objectives Review
Program Evaluation Office

707-853
(Issued 3/9/83)

Center _____ Month _____ Number Residents Reviewed ____

(See following page for instructions for completing form)

Liv. Area	Resident's Name	Medical/Nursing Obj.				Program Objectives				Maint. Obj.			Tot. Obj. Deferred	Tot. Yearly Obj.
		Tot. Obj.	Cur. Obj.	Obj. Met	%	Tot. Obj.	Cur. Obj.	Obj. Met	%	Tot. Obj.	Obj. Met	%		
	Totals													

Reviews to include transfers to other agencies or facilities Reviewed by _____ P.C. _____ H.S.C.

Annual Objectives Review (page 2)

Guidelines for Completing "Annual Objectives Review" Form

Medical/Nursing and Program Objectives

-forms should be filled out at the time of the Annual Review meeting.

-should be separated to develop a total.

-first column under each sub-section should be the total number of objectives worked on during the past year.

-second column under each sub-section should be the total number of objectives for which the expiration date has not ended. An objective that was written prior to an extension should be considered not met. The extended objective would be considered as one of current objectives for which the expiration date falls following the Annual Review.

-third column under each sub-section should be the total number of objectives that were met on or before the original stated expiration date.

-fourth column under each sub-section should be left blank.

Maintenance Objectives

-first column should be the total number of maintenance objectives worked on during the past year.

-second column should be the total number of objectives that were met on or before the original stated expiration date. Objectives that show progress, skills maintained at same level, or objectives resolved during the year should be counted as "objectives met."

-third column should be left blank.

Total Objectives Deferred

-The total number of program objectives deferred is obtained from the deferred list in the P.O.R.

Total Yearly Objectives

-the total yearly objectives is the sum of the total objectives from each sub-section.

General Instruction

-The completed form of all Annual Reviews during the month to be sent to Program Evaluation Office by 5th of following month.

DMH 341

I.D. TEAM REVIEW

RESIDENT'S NAME: _____ REG. NO.: _____ LIVING AREA: _____

TYPE OF REVIEW: _____ DATE OF REVIEW: _____

HEIGHT: _____ Change since last review: _____ HEAD CIRCUMFERENCE: _____

WEIGHT: _____ Change since last review: _____

TYPE OF DIET: _____

CURRENT MEDICATIONS AND TREATMENTS: _____

_____

CURRENT PROGRAMS: _____

SPECIAL ACTIVITIES: _____

_____

RESIDENT PARTICIPATED IN MEETING: Yes __ No __ If no, Why? _____

FAMILY CONTACTS: _____

Date Rights Reviewed or Read: _____

Parent/Guardian notified of review: Yes __ No __ If no, Why? _____

Parent/Guardian attended review: Yes __ No __ If no, Why? _____

FURTHER ASSESSMENTS RECOMMENDED: _____

This resident's I.P.C. will be: _____

SUMMARY	ADDRESSOGRAPH
☐ Admission Team Conference ☐ Medical/Surgical ☐ Intra-Hospital Transfer ☐ Release ☒ Other I.D. TEAM REVIEW Facility _____ Dept of Mental Health and Mental Retardation	

DMH 341 (page 2)

LEVEL OF CARE RECOMMENDED: _____

DISCUSSION OF DISCHARGE PLANNING: _____

_____

RECOMMENDATIONS: _____

_____

PROBLEMS RESOLVED DURING LAST REVIEW PERIOD:

PROB. NO.	PROBLEMS	DATE RESOLVED

707-857
(Issued 3/18/83)

I.D. TEAM CONTINUED INSTITUTIONALIZATION STATEMENT

____30 day ____60 day ____90 day ____6 months ____Annual

NAME _____ REG. NO. _____

LIVING AREA _____ AGE _____

THE I.D. TEAM RECOMMENDS:

___A. Continued institutionalization pending completion of a comprehensive habilitation plan.

___B. Continued institutionalization pending availability of community alternative. Referral made to Discharge Coordinator on _____.

MEMBERS PRESENT: TITLE SHIFT

_____
DATE

_____
I.D. TEAM LEADER

_____
DATE

_____
CENTER DIRECTOR/UNIT MGR.

Virginia Statute 37.1-84.2

The Director of a State Hospital shall conduct a review of the progress of each patient admitted to his hospital at intervals of thirty days after admission of such patient; sixty days after admission of such patient; ninety days after admission of such patient and every six months thereafter to determine whether such patient should be retained at such State Hospital. A record shall be kept of the findings.

ADDRESSOGRAPH

Form #1

RESIDENT PROFILE SHEET

1. _____ _____ _____
   First Name Age Center/Unit
2. Diagnosis: Mild/Moderate/Severe/Profound
3. Intellectual Quotient _____
4. Etiology _____
5. Number of years residing at LTS&H _____
6. Developmental skill assessment data

____ gross motor	Self care skills
____ fine motor	____ eating
____ perceptual	____ dressing
____ conceptual	____ toileting

   Adaptive Behavior Score _____

   Maladaptive Behaviors _____
7. Additional handicapping conditions

   ____ Epilepsy _____

   ____ Cerebral palsy _____

   ____ Auditory impairment _____

   ____ Visual impairment _____

   ____ Ambulatory _____

   ____ Neural tube defect _____

   ____ Other _____
   (specify)
8. Medications _____
9. Family contact - Frequent Seldom Never
10. Current Problems -

    _____ _____

    _____ _____

    _____ _____

    _____ _____
11. Current Objectives -

    _____ _____

    _____ _____

    _____ _____

Form #2

I. Demographic Data

A. Team

1. Team # _____

2. Date of Meeting _____

3. Number of Staff Attending _____

4. Meeting Location _____

5. Length of Meeting _____

6. Total Number of Responses _____

7. Member(s) Making Greatest Number of Responses _____

8. Member(s) Making Least Number of Responses _____

B. Resident

1. Resident's Age _____

2. Number of Years Residing in the Facility _____

3. Classification of Mental Retardation _____

4. Additional Handicapping Conditions _____

_____

II. Observer's Comments

Form #3

RECORDING FORM Observer _____ Date _____ Interval# _____

Team Member	Resident	Team	ASSESSMENT			PROGRAM PLANNING			PROG. IMPLEMENT.			PLACEM'T ALTERNAT.			
			Quest.	Info.	Recom.	Quest.	Info.	Recom.	Quest.	Info.	Recom.	Quest.	Info.	Recom.	TOTAL
Team Leader															
Social Worker															
Nurse															
Psych.															
Dev. Aide															

Form #4

SAMPLE DATA

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	0 ( )( )( )	0 ( )( )( )	0 ( )( )( )	0 ( )( )( )	0 ( )( )( )
Nurse	(2.5) 14% ( )(2.5)( )	(3.0) 20% (.5)(1.5)(1.0)	(3.5) 12% (0)(3.0)(.5)	0 ( )( )( )	(4.0) 7% 13% 15% 27% (.5)(2.0)(1.5)
Physical Therapy Aide	Absent ( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Psychologist	(1.5) 9% (.5)(1.0)( )	0 ( )( )( )	(3.0) 18% (1.0)(2.0)( )	(2.5) 42% (1.0)(1.5)(0)	(7.0) 14% 10% 9% (2.5)(4.5)(0)
Speech Path. Recreator	(2.5) 14% (0)(2.0)(.5)	0 ( )( )( )	(2.5) 15% (0)(1.5)(1.0)	0 ( )( )( )	(5.0) 7% 7% 27% (0)(3.5)(1.5)
Social Worker	(1.0) 17% (1.0)(2.0)(0)	0 ( )( )( )	(1.0) 7% (0)(2.0)(0)	0 ( )( )( )	(3.0) 7% 8% (1.0)(4.0)( )
Special Activity Aide	Absent ( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Teacher	(6.5) 39% (2.0)(4.5)(0)	(4.0) 27% (0)(4.0)(0)	(7.5) 20% (0)(5.5)(.5)	(1.0) 17% (0)(0)(1.0)	(19.0) 22% 14% 29% 27% (2.0)(12.0)(1.5)
Team Leader	(1.5) 9% (1.5)(0)(0)	(8.0) 53% (3.5)(4.5)(0)	(11.5) 42% (3.5)(4.0)(1.0)	(2.5) 42% (0)(2.5)(0)	(24.5) 16% 37% 32% 18% (8.5)(15.0)(1.0)
Totals	(17.5) 26% (5.0)(12.0)(.5)	(15.0) 22% (4.0)(10.0)(1.0)	(24.5) 13% (4.5)(22.0)(3.0)	(6.0) 9% (1.0)(4.0)(0)	(68.0) (14.5)(48.0)(5.5)
					21% 71% 8%

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Explanation of Sample Data from Form #4

1. Average total number of responses made at the meeting by all members: 68.0

2. Average total number of responses made in each of the four content areas:

   a. Assessment - 17.5; 26% of total

   b. Program Planning - 15.0; 22% of total

   c. Program Implementation - 29.5; 43% of total

   d. Placement Alternatives - 6.0- 9% of total

3. Average total number of statements made in each of the three process categories:

   a. Questions - 14.5; 21% of total

   b. Informational Statements - 48.0; 71% of total

   c. Recommendations - 5.5; 8% of total

4. Average total number of statements made by each member at the meeting:

Member	Total Number	% of Total
Dev. Aide	0	0
Nurse	9.0	13%
Psychologist	7.0	10%
Speech Pathologist	5.0	7%
Social Worker	5.0	7%
Teacher	7.5	26%
Team Leader	24.5	36%

5. Average total number of statements made by each team member in each of the four content categories:

Member	Assess.	Prog. Plan	Prog. Imp.	Place. Alt.
Dev. Aide	0	0	0	0
Nurse	(2.5) 14%	(3.0) 20%	(3.5) 12%	0

Explanation of Sample Data from Form #4
page 2

Member	Assess.	Prog. Plan	Prog. Imp.	Place. Alt.
Psych.	(1.5) 9%	0	(3.0) 10%	(2.5) 42%
Sp. Path.	(2.5) 14%	0	(2.5) 8%	0
Soc. Wkr.	(3.0) 17%	0	(2.0) 7%	0
Teacher	(6.5) 37%	(4.0) 27%	(6.0) 20%	(1.0) 17%
Team Ldr.	(1.5) 9%	(8.0) 53%	(12.5) 42%	(2.5) 42%

Form #5

Observer Rating Scale for Group Behavior

OBSERVER #_____ OBSERVATION #_____

DATE_____ CENTER/UNIT_____

Please rate the team's performance on each of the following nine statements:

	low		mod		hi
1. The effectiveness of the team in completing its task.	1	2	3	4	5
2. Approachability of the leader.	1	2	3	4	5
3. The degree to which members mutually influence each other.	1	2	3	4	5
4. The degree to which members actively participate in the meeting.	1	2	3	4	5
5. Level of trust and competence versus competitiveness among members.	1	2	3	4	5
6. Worthiness of the meeting.	1	2	3	4	5
7. Level of submission versus rebellion against the leader.	1	2	3	4	5
8. The degree to which the leader controlled the group.	1	2	3	4	5
9. The degree to which members conformed to group expectation.	1	2	3	4	5

Observer Comments: _____

_____

_____

_____

_____

APPENDIX B

NATURE OF RESPONSE CONTRIBUTIONS

Observation #1

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
Developmental Aide	*(1's)(2's)(3's) 1.0 14% ( )(3.0)( )	(1's)(2's)(3's) 2.0 25% (.5)(1.5)( )	(1's)(2's)(3's) ( )( )( )	(1's)(2's)(3's) ( )( )( )	(1's)(2's)(3's) 10% 90% 9% (.5)(4.5)( ) 5.0
Nurse	2.0 9% ( )(2.0)( )	2.0 25% ( )(1.0)(1.0)	2.0 31% ( )(1.0)(1.0)	( )( )( )	66% 33% 18% ( )(4.0)(2.0) 6.0
Physical Therapy Aide	1.0 5% (1.0)( )( )	( )( )( )	( )( )( )	( )( )( )	100% 1% (1.0)( )( ) 1.0
Psychologist	1.5 7% ( )(1.0)(.5)	1.0 12% ( )(1.0)( )	( )( )( )	( )( )( )	80% 20% 41% ( )(2.0)(.5) 2.5
Recreator	1.0 5% ( )(1.0)( )	.5 6% ( )(.5)( )	1.5 23% ( )(.5)(1.0)	1.0 5% ( )( )(1.0)	50% 50% 7% ( )(2.0)(2.0) 4.0
Social Worker	3.5 16% ( )(3.5)( )	1.0 12% ( )(1.0)( )	( )( )( )	11.0 56% (2.5)(4.5)(3.0)	17% 62% 21% 26% (2.5)(9.0)(3.0) 14.5
Speech Therapist	1.0 5% ( )(1.0)( )	( )( )( )	1.5 7% ( )(.5)( )	4.0 21% (2.5)(1.5)( )	45% 55% 9% (2.5)(3.0)( ) 5.5
Teacher	3.5 16% ( )(3.5)( )	1.0 12% ( )(1.0)( )	2.5 38% ( )(2.5)( )	1.0 5% ( )( )(1.0)	87% 13% 14% ( )(7.0)(1.0) 8.0
Team Leader	5.0 23% (3.0)(2.0)( )	.5 6% ( )(.5)( )	( )( )( )	3.5 18% (1.5)(2.0)( )	50% 50% 16% (4.5)(4.5)( ) 9.0
Totals	(4.0)(17)(.5) 21.5 38%	(.5)(6.5)(1.0) 8.0 14%	(0)(4.5)(2.0) 6.5 11%	(6.5)(8.0)(5.0) 19.5 35%	(11)(36)(8.5) 55.5 19% 65% 15%

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #2

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	(4.0) 4% ( )(3.0)( )	(4.0) 19% (1.0)(3.0)( )	(3.5) 100% ( )(3.0)(.5)	( )( )( )	10% 85% 5% 7½% (1.0)(9.0)(.5) (10.5)
Nurse	(1.5) 16% (3.0)(8.0)(.5)	(3.0) 14% (1.0)(1.5)(.5)	(2.5) 7% ( )(1.5)(1.0)	(1.5) 14% (.5)( )(1.0)	24% 54% 16% 13% (4.5)(11.0)(3.0) (18.5)
Physical Therapy Aide	(2.0) 2% ( )(2.0)( )	(1.5) 7% (.5)(.5)(.5)	(2.0) 6% ( )(1.0)(1.0)	( )( )( )	9% 64% 27% 4% (.5)(3.5)(1.5) (5.5)
Psychologist	(3.0) 4% (1.0)(1.0)(1.0)	(1.0) 4% (.5)(.5)( )	(3.0) 9% ( )(2.0)(1.0)	(1.0) 9% ( )( )(1.0)	18% 43% 38% 5½% (1.5)(3.5)(3.0) (8.0)
Recreator	(14.5) 20% (9.0)(5.5)( )	(.5) 2% ( )(.5)( )	(5.5) 16% (.5)(3.0)(2.0)	(1.0) 9% ( )(1.0)( )	44% 47% 9% 15½% (9.5)(10.0)(2.0) (21.5)
Social Worker	(7.0) 9% (2.0)(5.0)( )	(1.5) 7% ( )(1.5)( )	(3.0) 9% (.5)(1.0)(1.5)	(3.5) 32% (1.0)(1.0)(1.5)	23% 57% 20% 11% (3.5)(8.5)(3.0) (15.0)
Dental Educator	(3.5) 4% (.5)(2.5)(.5)	(3.5) 17% ( )(2.0)(1.5)	(1.0) 3% ( )(1.0)( )	(1.0) 9% ( )( )(1.0)	6% 61% 33% 6½% (.5)(5.5)(3.0) (9.0)
Music Teacher	(.5) 1% ( )(.5)( )	(1.5) 7% ( )(1.0)(.5)	(2.0) 6% ( )(2.0)( )	(1.0) 9% ( )( )(1.0)	70% 30% 3½% ( )(3.5)(1.5) (5.0)
Team Leader	(21.0) 28% (14.5)(5.5)(1.0)	(3) (1.0)(1.5)(1.0)	(7.5) 22% (1.0)(3.5)(3.0)	(1.5) 14% ( )(1.0)(.5)	49% 34% 16% 24% (16.5)(11.5)(5.5) (33.5)
Sub-Totals	(30.0)(33.0)(3.0)	(4.0)(12.0)(4.0)	(2.0)(18.0)(12.0)	(1.5)(3.0)(6.0)	(37.5)(66.0)(23.0)

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #2

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Resident	(7.0) 9% ( )(7.0)( )	( )( )( )	(1.5) 4% ( )(1.5)( )	( )( )( )	100% 17% ( )(8.5)( ) (8.5)
ART	( )( )( )	(1.0) 4% ( )(1.0)( )	( )( )( )	( )( )( )	100% 17% ( )(1.0)( ) (1.0)
Speech Therapist	(1.0) 1% ( )(1.0)( )	( )( )( )	( )( )( )	(.5) 5% ( )( )	33% 66% 17% (.5)(1.0)( ) (1.5)
Total	(30.0)(4.0)(3.0)	(4.0)(13.0)(4.0)	(2.0)(19.5)(12.0)	(2.0)(3.0)(6.0)	(38.0)(76.5)(23.0) (137.5)
	(74) 54% ( )( )( )	(21.0) 15% ( )( )( )	(33.5) 24% ( )( )( )	(11.0) 8% ( )( )( )	28% 56% 17% ( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #3

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	(4.5) 13% (1.5)(3.0)( )	(.5) 1% ( )(.5)( )	( )( )( )	( )( )( )	30% 70% 5% (1.5)(3.5)( ) (5.0)
Nurse	(.5) 1% (.5)( )( )	(4.5) 12% (1.0)(2.5)(1.0)	(.5) 3% (.5)( )( )	( )( )( )	30% 45% 8% 6% (2.0)(2.5)(1.0) (5.5)
Physical Therapy Aide	( )( )( )	(6.5) 18% (1.5)(3.5)(1.5)	(1.0) 6% ( )(1.0)( )	( )( )( )	20% 60% 20% 8% (1.5)(4.5)(1.5) (7.5)
Psychologist	(3.5) 10% (2.0)(.5)(1.0)	(2.5) 7% (1.5)(.5)(.5)	( )( )( )	( )( )( )	58% 17% 25% 7% (3.5)(1.0)(1.5) (6.0)
Recreator	(.5) 1% ( )(.5)( )	(1.0) 3% ( )(1.0)( )	(1.0) 6% ( )(.5)(.5)	( )( )( )	80% 20% 5% ( )(2.0)(.5) (2.5)
Social Worker	(5.0) 15% (1.0)(4.0)( )	( )( )( )	( )( )( )	( )( )( )	20% 80% 5% (1.0)(4.0)( ) (5.0)
Special Activity Aide	(.5) 1% ( )(.5)( )	(1.0) 30% ( )(1.0)( )	(2.0) 12% ( )(1.5)(.5)	( )( )( )	85% 14% 9% ( )(3.0)(.5) (3.5)
Teacher	(4.0) 12% ( )(4.0)( )	(7.0) 19% (1.0)(5.0)(1.0)	(2.0) 12% ( )(1.0)(1.0)	( )( )( )	8% 77% 15% 15% (1.0)(10.0)(2.0) (13.0)
Team Leader	(13.0) 38% (2.0)(10.5)(.5)	(9.0) 26% (4.5)(3.5)(1.0)	(7.5) 45% (4.0)(3.5)( )	( )( )( )	35% 54% 5% 34% (10.5)(17.5)(1.5) (29.5)
Sub-Totals	(7.0)(23.0)(1.5)	(9.5)(17.5)(5.0)	(4.5)(7.5)(2.0)	( )( )( )	(21.0)(48.0)(8.5)

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #3

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Dental Educator	(1.5) 4% ( )(1.0)(.5)	(.5) 1% ( )( )(.5)	(1.0) 6% ( )(1.0)( )	( )( )( )	66% 33% 3% ( )(2.0)(1.0) (3.0)
Music Teacher	(1.0) 3% ( )(1.0)( )	(4.0) 11% ( )(4.0)( )	(1.5) 9% ( )(1.5)( )	( )( )( )	100% 7% ( )(6.5)( ) (6.5)
sub-total	( )(2.0)(.5)	( )(4.0)(.5)	( )(2.5)( )	( )( )( )	( )(8.5)(1.0)
Total	(7.0)(25.0)(2.0)	(9.5)(21.5)(5.5)	(4.5)(10.0)(2.0)	( )( )( )	(21.0)(56.5)(9.5) (87)
	(34.0) 39% ( )( )( )	(36.5) 42% ( )( )( )	(16.5) 18% ( )( )( )	( )( )( )	24% 65% 11% ( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #4

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
Developmental Aide	*(1's)(2's)(3's) (4.5) 7% ( )(3.0)(1.5)	(1's)(2's)(3's) (3.0) 2% ( )(2.5)(.5)	(1's)(2's)(3's) ( )( )( )	(1's)(2's)(3's) ( )( )( )	(1's)(2's)(3's) 73% 27% 4% ( )(5.5)(2.0) (7.5)
Nurse	(.5) 1% (.5)( )( )	(6.0) 5% (3.5)(1.5)(1.0)	(1.0) 5% ( )(1.0)( )	( )( )( )	53% 33% 13% 4% (4.0)(2.5)(1.0) (7.5)
Physical Therapy Aide	(2.5) 4% (1.0)(1.5)( )	(3.5) 3% (1.0)(2.5)( )	( )( )( )	(2.0) 12% (1.0)(1.0)( )	38% 62% 4% (3.0)(5.0)( ) (8.0)
Psychologist	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Recreator	( )( )( )	(2.0) 2% ( )(2.0)( )	( )( )( )	( )( )( )	100% 1% ( )(2.0)( ) (2.0)
Social Worker	(.5) 1% ( )(.5)( )	( )( )( )	( )( )( )	(1.5) 9% ( )(1.5)( )	25% 75% 1% (.5)(1.5)( ) (2.0)
Special Activity Aide	( )( )( )	(1.5) 1% ( )(1.5)( )	( )( )( )	( )( )( )	100% 1% ( )(1.5)( ) (1.5)
Teacher	(2.0) 12% (2.0)(4.5)(.5)	(15.5) 12% (3.0)(11.0)(1.5)	(1.0) 5% (.5)(.5)( )	(5.5) 33% (2.5)(3.0)( )	28% 66% 6% 13% (8.0)(19.0)(2.0) (24.0)
Team Leader	(20.0) 48% (9.0)(17.0)(3.0)	(39.0) 30% (11.0)(19.5)(8.5)	(3.0) 16% (1.5)(.5)(1.0)	(4.0) 24% (2.5)(.5)(1.0)	32% 50% 18% 33% (24.0)(31.5)(13.5) (75.0)
Sub-Totals	(12.5)(26.5)(5.0)	(18.5)(40.5)(11.5)	(2.0)(2.0)(1.0)	(6.0)(6.0)(1.0)	(39.5)(74.5)(18.5)

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #4

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Speech Therapist	(2.0) 3% ( )(2.0)( )	(4.5) 3% ( )(3.5)(1.0)	(1.0) 5% ( )(1.0)( )	( )( )( )	87% 13% 4% ( )(6.5)(1.0) (7.5)
Dietician	(2.5) 4% ( )(2.5)( )	(.5) 0% ( )(.5)( )	( )( )( )	( )( )( )	100% 1% ( )(3.0)( ) (3.0)
OT	(.5) 1% (.5)( )( )	(5.5) 4% (1.0)(3.5)(1.0)	( )( )( )	( )( )( )	25% 58% 17% 3% (1.5)(3.5)(1.0) (6.0)
Dental Educator	(2.0) 3% ( )(1.5)(.5)	(2.5) 2% ( )(1.5)(1.0)	( )( )( )	( )( )( )	67% 33% 2% ( )(3.0)(1.5) (4.5)
Advocate	( )( )( )	(11.5) 9% (1.0)(10.0)(.5)	( )( )( )	( )( )( )	9% 86% 4% 5% (1.0)(10.0)(.5) (11.5)
ART	2.0 3% (.5)(1.5)( )	(6.5) 5% (3.0)(2.5)(1.0)	( )( )( )	(1.0) 6% ( )( )(1.0)	37% 42% 21% 9% (3.5)(4.0)(2.0) (9.5)
Music Teacher	(1.0) 12% (1.0)(5.0)(1.0)	(26.5) 21% (7.5)(13.0)(6.0)	(4.5) 50% (3.5)(6.0)( )	(2.5) 15% ( )(2.5)( )	26% 58% 15% 20% (12.0)(26.5)(7.0) (45.5)
Resident	(.5) 1% ( )(.5)( )	(1.0) 1% ( )(1.0)( )	(3.5) 18% ( )(3.5)( )	( )( )( )	100% 2% ( )(5.0)( ) (5.0)
sub-total	(2.0)(13.0)(1.5)	(12.5)(35.5)(10.5)	(3.5)(10.5)( )	( )(2.5)(1.0)	(18.0)(61.5)(13.0)
Total	(14.5)(71.5)(6.5)	(31.0)(76.0)(22.0)	(5.5)(12.5)(1.0)	(6.0)(8.5)(2.0)	(57.5)(136.0)(31.5)
	(60.5) 27%	(129.0) 57%	(19) 8%	(16.5) 7%	26% 60% 14%

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #5

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Nurse	( )( )( )	(.5) 5% ( )( )(.5)	(4.5) 12% (1.0)(3.5)( )	( )( )( )	20% 70% 10% 6% (1.0)(3.5)(.5)(5.0)
Physical Therapy Aide	( )( )( )	(.5) 5% ( )(.5)( )	(1.5) 4% ( )(1.5)( )	( )( )( )	100% 2% ( )(2.0)( )(2.0)
Psychologist	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Recreator	( )( )( )	( )( )( )	(2.5) 7% ( )(2.5)( )	( )( )( )	100% 3% ( )(2.5)( )(2.5)
Social Worker	(1.5) 4% (.5)(1.0)( )	( )( )( )	( )( )( )	( )( )( )	33% 62% 1% (.5)(1.0)( )(1.5)
Special Ed. Activity Aide	(3.5) 10% (1.0)(2.5)( )	(.5) 5% ( )(.5)( )	(3.0) 8% ( )(1.5)(1.5)	( )( )( )	14% 44% 21% 9% (1.0)(4.5)(1.5)(1.0)
Teacher	(2.5) 7% ( )(2.0)(.5)	(1.5) 16% ( )(1.5)( )	(4.5) 12% (.5)(4.0)( )	( )( )( )	5% 68% 5% 10% (.5)(7.5)(.5)(8.5)
Team Leader	(20.0) 56% (7.0)(12.5)(.5)	(5.5) 54% (3.0)(2.5)( )	(10.0) 27% (7.0)(2.0)(1.0)	( )( )( )	48% 48% 4% 44% (17.0)(17.0)(1.5)(35.5)
Sub-Totals	(8.5)(18.0)(1.0)	(3.0)(5.0)(.5)	(8.5)(15.0)(2.5)	( )( )( )	(20.0)(36.0)(4.0)

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #5

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Music Teacher	(3.0) 8% ( )(2.0)(1.0)	(1.0) 10% ( )(1.0)( )	(3.0) 8% ( )(3.0)( )	( )( )( )	8% 14% 4% ( )(6.0)(1.0)(2.0)
Dental Educator	(3.0) 8% (.5)(2.5)( )	( )( )( )	(11.0) 11% (.5)(3.5)( )	( )( )( )	14% 8% 7% (1.0)(6.0)( )(7.0)
Speech Therapist	(2.0) 6% ( )(2.0)( )	( )( )( )	(3.5) 10% ( )(3.5)( )	( )( )( )	100% 7% ( )(5.5)( )(5.5)
sub-total	(.5)(6.5)(1.0)	( )(1.0)( )	(.5)(10.0)( )	( )( )( )	(1.0)(17.5)(1.0)
Total	(9.0)(24.5)(2.0)	(3.0)(6.0)(.5)	(9.0)(25.0)(2.5)	( )( )( )	(21.0)(55.5)(5.0)
	(35.5) 44% ( )( )( )	(9.5) 11% ( )( )( )	(36.5) 48% ( )( )( )	( )( )( )	27% 6.8% 6% ( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #6

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	( )( )( )	( )( )( )	(8.0) 14% ( )(8.0)( )	( )( )( )	100% 6% ( )(8.0)( ) (8.0)
Nurse	(1.5) 6% ( )(1.5)( )	(.5) 2% ( )(.5)( )	( )( )( )	( )( )( )	100% 2% ( )(2.0)( ) (2.0)
Physical Therapy Aide	(1.5) 6% (.5)(1.0)( )	( )( )( )	(2.5) 4% (1.5)(1.0)( )	( )( )( )	25% 25% 3% (2.0)(2.0)( ) (4.0)
Psychologist	(4.0) 16% (1.0)(3.0)( )	(1.5) 7% ( )(1.5)( )	(8.5) 15% (1.0)(5.0)(2.5)	(1.0) 6% ( )(1.0)( )	13% 10% 17% 12% (2.0)(10.5)(2.5) (15.0)
Recreator	( )( )( )	(2.0) 10% ( )(1.5)(.5)	(2.5) 4% ( )(2.5)( )	(1.0) 6% (1.0)( )( )	18% 73% 9% 5% (1.0)(4.0)(.5) (5.5)
Social Worker	( )( )( )	(1.0) 5% ( )(.5)(.5)	(1.5) 3% ( )(1.5)( )	(8.5) 47% ( )(7.5)(1.0)	86% 14% 9% ( )(7.5)(1.5) (11.0)
Special Activity Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Teacher	(.5) 2% ( )(.5)( )	1.0 5% ( )(1.0)( )	(5.5) 10% ( )(5.5)( )	(1.5) 8% (1.0)(.5)( )	12% 88% 7% (1.0)(7.5)( ) (8.5)
Team Leader	(14.0) 56% (7.5)(6.5)( )	(5.0) 24% (5.0)( )( )	(18.0) 31% (11.0)(7.0)( )	(2.0) 11% (1.0)(1.0)( )	63% 37% 32% (24.5)(14.5)( ) (39.0)
Sub-Totals	(9.0)(12.5)( )	(5.0)(5.0)(1.0)	(13.5)(30.5)(2.5)	(3.0)(10.0)(1.0)	(30.5)(58.0)(4.5)

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #6

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Resident	(2.5) 10% (1.0)(1.5)( )	(5.5) 26% ( )(5.5)( )	(1.5) 12% ( )(7.0)( )	( )( )( )	7% 93% 12% (4.0)(14.0)( )(18.0)
Family	(1.0) 4% (.5)(.5)( )	(4.0) 11% (.5)(3.5)( )	(4.0) 7% ( )(3.5)(.5)	(4.0) 22% (3.0)(.5)(.5)	30% 62% 7% 11% (4.0)(8.0)(1.0)(13.0)
Special CETA Worker	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Sub-Total	(1.5)(2.0)( )	(.5)(7.0)( )	( )(10.5)(.5)	(3.0)(.5)(.5)	(5.0)(22.0)(1.0)
Total	(10.5)(14.5)( )	(5.5)(14.0)(1.0)	(13.5)(41.0)(3.0)	(6.0)(10.5)(1.5)	(35.5)(80.0)(5.5)(31.0)
	(25.0) 21% ( )( )( )	(20.5) 17% ( )( )( )	(57.5) 48% ( )( )( )	(18.0) 15% ( )( )( )	29% 66% 5% ( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #7

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Speech Therapist	(5.0) 11% ( )(5.0)( )	(2.5) 22% ( )(1.5)(1.0)	(2.0) 7% ( )(2.0)( )	( )( )( )	89% 11% 10% ( )(8.5)(1.0) (9.5)
Parents	(14.5) 31% (7.0)(7.5)( )	(7.5) 65% (3.5)(2.5)(1.5)	(10.5) 36% (6.0)(4.5)( )	(.5) 13% (.5)( )( )	52% 44% 4% 36% (17.0)(14.5)(1.5) (33.0)
Dietician	(2.0) 2% ( )(2.0)( )	( )( )( )	( )( )( )	( )( )( )	100% 2% (2.0)( )( ) (2.0)
Physician	(7.0) 15% ( )(7.0)( )	( )( )( )	(1.0) 3% ( )( )(1.0)	( )( )( )	88% 12% 4% ( )(7.0)(1.0) (8.0)
Sub-total	(7.0)(21.5)( )	(3.5)(4.0)(2.5)	(6.0)(6.5)(1.0)	(.5)( )( )	(17.0)(32.0)(3.5)
Total	(14.5)(32.0)( )	(5.0)(4.0)(2.5)	(7.5)(20.0)(1.5)	(.5)(1.5)(2.0)	(27.5)(57.5)(6.0) (91.0)
	(46.5) 51% ( )( )( )	(11.5) 13% ( )( )( )	(29.0) 32% ( )( )( )	(4.0) 4% ( )( )( )	30% 63% 7% ( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #8

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Nurse	(2.5) 14% ( )(2.5)( )	(3.0) 20% (.5)(1.5)(1.0)	(3.5) 12% ( )(3.0)(.5)	( )( )( )	7% 15% 27% 13% (.5)(7.0)(1.5)(9.0)
Physical Therapy Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Psychologist	(1.5) 9% (.5)(1.0)( )	( )( )( )	(3.0) 10% (1.0)(2.0)( )	(2.5) 42% (1.0)(1.5)( )	17% 9% 10% (2.5)(4.5)( )(7.0)
Speech Ther.	(2.5) 14% ( )(2.0)(.5)	( )( )( )	(2.5) 8% ( )(1.5)(1.0)	( )( )( )	7% 27% 7% ( )(3.5)(1.5)(5.0)
Social Worker	(3.0) 17% (1.0)(2.0)( )	( )( )( )	(2.0) 7% ( )(2.0)( )	( )( )( )	7% 8% 7% (1.0)(4.0)( )(5.0)
Special Activity Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Teacher	(6.5) 37% (2.0)(4.5)( )	(4.0) 27% ( )(4.0)( )	(5.0) 20% ( )(5.5)(.5)	(1.0) 17% ( )( )(1.0)	14% 29% 27% 26% (2.0)(14.0)(1.5)(17.5)
Team Leader	(1.5) 9% (1.5)( )( )	(8.0) 53% (3.5)(4.5)( )	(12.5) 42% (3.5)(8.0)(1.0)	(2.5) 42% ( )(2.5)( )	59% 31% 18% 36% (8.5)(15.0)(1.0)(24.5)
Totals	(5.0)(12.0)(.5) (17.5) 26%	(4.0)(10.0)(1.0) (15.0) 22%	(4.5)(22.0)(3.0) (24.5) 43%	(1.0)(4.0)(1.0) (6.0) 9%	(14.5)(48.0)(5.5) 68.0 21% 71% 8%

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #9

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Nurse	(3.0) 15% (1.0)(2.0)( )	(1.5) 14% ( )(1.0)(.5)	( )( )( )	(1.0) 33% ( )( )(1.0)	9% 15% 14% 14% (1.0)(3.0)(1.5) (5.5)
ART	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Psychologist	(1.0) 5% ( )(1.0)( )	(1.0) 9% ( )( )(1.0)	( )( )( )	( )( )( )	5% 9% 4% ( )(1.0)(1.0) (2.0)
SAA Recreator	(1.0) 5% ( )(1.0)( )	(1.0) 9% ( )( )(1.0)	(1.0) 14% ( )(1.0)( )	( )( )( )	11% 9% 7% ( )(2.0)(1.0) (3.0)
Social Worker	(1.0) 5% ( )(1.0)( )	(.5) 5% ( )( )(.5)	( )( )( )	( )( )( )	5% 4% 3% ( )(1.0)(.5) (1.5)
Speech Ther.	(5.0) 25% ( )(3.5)(1.5)	(3.0) 27% ( )(.5)(2.5)	(3.0) 43% (2.0)(1.0)( )	(1.0) 33% ( )(1.0)( )	19% 32% 36% 38% (2.0)(6.0)(4.0) (12.0)
Teacher	(1.0) 5% ( )(1.0)( )	(1.5) 14% ( )( )(1.5)	(3.0) 43% ( )(3.0)( )	( )( )( )	21% 14% 14% ( )(4.0)(1.5) (5.5)
Team Leader	(7.5) 39% (4.5)(2.0)(1.0)	(2.5) 22% (2.0)( )(.5)	( )( )( )	(1.0) 33% (1.0)( )( )	71% 11% 14% 27% (7.5)(2.0)(1.5) (11.0)
Totals	(5.5)(11.5)(2.5) (19.5) 48%	(2.0)(1.5)(7.5) (11.0) 27%	(2.0)(5.0)( ) (7.0) 17%	(1.0)(1.0)(1.0) (3.0) 7%	(10.5)(19.0)(11.0) (42.5) 25% 47% 27%

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #10

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	( )( )( )	( )( )( )	(11.0) 31% ( )(11.0)( )	( )( )( )	( )(11.0)( ) (11.0) 13%
Nurse	(4.0) 12% (.5)(3.5)( )	(5.5) 48% ( )(1.0)(4.5)	(1.5) 4% ( )(1.0)(.5)	( )( )( )	2% 21% 71% 13% (.5)(5.5)(5.0) (11.0)
Speech Ther.	(4.5) 13% ( )(3.5)(1.0)	( )( )( )	(2.5) 7% ( )(2.5)( )	( )( )( )	12% 14% 8% ( )(6.0)(1.0) (7.0)
Psychologist	(1.0) 3% ( )(1.0)( )	( )( )( )	(1.0) 3% ( )(1.0)( )	( )( )( )	4% 2% ( )(2.0)( ) (2.0)
SAA Recreator	(1.0) 3% ( )(1.0)( )	( )( )( )	(1.0) 3% ( )(1.0)( )	( )( )( )	4% 2% ( )(2.0)( ) (2.0)
Social Worker	(1.0) 3% ( )(1.0)( )	( )( )( )	( )( )( )	( )( )( )	2% 1% ( )(1.0)( ) (1.0)
Special Ed. Activity Aide	(1.5) 4% ( )(1.5)( )	( )( )( )	(3.0) 9% ( )(3.0)( )	( )( )( )	9% 5% ( )(4.5)( ) (4.5)
Teacher	(1.5) 4% ( )(1.5)( )	( )( )( )	(1.0) 3% ( )(1.0)( )	( )( )( )	5% 3% ( )(2.5)( ) (2.5)
Team Leader	(16.5) 49% (11.5)(5.0)( )	(6.0) 52% (4.5)(1.0)(.5)	(2.5) 36% (8.5)(3.5)(.5)	(2.5) 100% (1.5)(1.0)( )	98% 21% 14% 45% (26.0)(10.5)(1.0) (37.5)
Totals	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #10

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
PE Teacher	(2.0) 6% ( )(2.0)( )	( )( )( )	(1.0) 3% ( )(1.0)( )	( )( )( )	6% ( )(3.0)( ) 4% (3.0)
Dental Educator	(1.0) 3% ( )(1.0)( )	( )( )( )	(.5) 1% ( )(.5)( )	( )( )( )	3% ( )(1.5)( ) 2% (1.5)
Totals	(12.0)(21.0)(1.0) (34.0) 41% ( )( )( )	(4.5)(2.0)(5.0) (11.5) 13% ( )( )( )	(8.5)(25.5)(1.0) (35.0) 42% ( )( )( )	(1.5)(1.0)( ) (2.5) 3% ( )( )( )	(24.5)(49.5)(7.0) (81.0) 32% 62% 8% ( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #11

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	( )( )( )	( )( )( )	(1.0) 5% ( )(1.0)( )	( )( )( )	3% ( )(1.0)( ) (1.0) 2%
Nurse	(.5) 2% ( )(.5)( )	(1.0) 13% ( )(1.0)( )	(.5) 3% ( )(.5)( )	( )( )( )	6% ( )(2.0)( ) (2.0) 4%
Physical Therapy Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Psychologist	( )( )( )	( )( )( )	(1.0) 22% ( )(3.0)(1.0)	( )( )( )	9% 20% 8% ( )(3.0)(1.0) (4.0)
Recreator	( )( )( )	(.5) 7% ( )(.5)( )	(1.0) 5% ( )(1.0)( )	( )( )( )	( )(1.5)( ) (1.5) 5%
Social Worker	(1.0) 5% ( )(1.0)( )	( )( )( )	(.5) ( )(.5)( )	(.5) 13% (.5)( )( )	4% 5% 4% (.5)(1.5)( ) (2.0)
Special Activity Aide	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
Teacher	(1.5) 7% ( )(1.5)( )	(2.5) 33% ( )(1.5)( )	(5.5) 31% (3.5)(1.0)(1.0)	( )( )( )	27% 20% 19% ( )(8.5)(1.0) (9.5)
Team Leader	(18.0) 86% (4.5)(12.5)(1.0)	(3.5) 47% (2.5)(.5)(.5)	(5.5) 31% (3.5)(1.0)(1.0)	(3.5) 87% (2.5)(.5)(.5)	96% 45% 60% 60% (13.0)(14.5)(3.0) (30.5)
Totals	(4.5)(12.5)(1.0)	(2.5)(3.5)(1.5)	(3.5)(12.5)(2.0)	(3.0)(.5)(.5)	(13.5)(32.0)(5.0) (51.5)
	(21.0) 41%	(7.5) 15%	(18.0) 36%	(4.0) 8%	27% 63% 10%

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #12

Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Developmental Aide	3.0 10% (1.0)(2.0)( )	1.0 4% ( )(1.0)( )	5.0 36% ( )(5.0)( )	1.0 11% (1.0)( )( )	8% 15% 12% (2.0)(8.0)( ) 12.0
Nurse	3.0 10% ( )(3.0)( )	1.0 4% ( )(1.0)( )	3.0 21% ( )(3.0)( )	1.0 11% ( )(1.0)( )	15% 10% ( )(8.0)( ) 8.0
Physical Therapy Aide	( )( )( )	1.0 4% ( )(1.0)( )	( )( )( )	1.0 11% ( )(1.0)( )	4% 2% ( )(2.0)( ) 2.0
Psychologist	1.0 3% ( )(1.0)( )	1.0 4% ( )( )(1.0)	1.0 7% ( )( )(1.0)	( )( )( )	2% 66% 4% ( )(1.0)(2.0) 3.0
SAA Recreator	( )( )( )	2.0 7% ( )(2.0)( )	2.0 14% ( )(2.0)( )	( )( )( )	8% 5% ( )(4.0)( ) 4.0
Social Worker	2.0 7% ( )(2.0)( )	5.0 18% ( )(4.0)(1.0)	( )( )( )	4.0 44% ( )(4.0)( )	19% 33% 14% ( )(10.0)(1.0) 11.0
Speech Therapist	( )( )( )	1.0 4% ( )(1.0)( )	( )( )( )	( )( )( )	2% 1% ( )(1.0)( ) 1.0
Teacher	( )( )( )	1.0 4% ( )(1.0)( )	1.0 7% ( )(1.0)( )	( )( )( )	4% 2% ( )(2.0)( ) 2.0
Team Leader	20.0 54% (12.0)(8.0)( )	15.0 54% (10.0)(5.0)( )	1.0 7% ( )(1.0)( )	2.0 22% (2.0)( )( )	92% 29% 47% (24.0)(14.0)( ) 38.0
Totals	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

Observation #12 Form #4

Nature of
Response Contributions
Average Summary

Member	Assessment	Program Planning	Program Implementation	Placement Alternatives	Totals
	*(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)	(1's)(2's)(3's)
Dental Educator	(1.0) 3% ( )(1.0)( )	( )( )( )	(1.0) 7% ( )(1.0)( )	( )( )( )	4% 2% ( )(2.0)( ) (2.0)
Totals	(13.0)(17.0)( ) (30.0) 37% ( )( )( )	(10.0)(16.0)(2.0) (28.0) 35% ( )( )( )	( )(13.0)(1.0) (14.0) 17% ( )( )( )	(3.0)(6.0)( ) (9.0) 11% ( )( )( )	(26.0)(52.0)(3.0) (81.0) 32% 64% 4% ( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )
	( )( )( )	( )( )( )	( )( )( )	( )( )( )	( )( )( )

*1's - Questions
2's - Informational Statements
3's - Alternatives, Suggestions, Decision-making type statements

APPENDIX C

SUMMARY DESCRIPTIONS

OF THE TWELVE ID TEAM OBSERVATIONS

Observation #1

Resident Profile

Mary was a 73 year old female who has resided at the facility for 15 years. She was formerly institutionalized for 22 years in a mental health facility prior to transfer to her current placement. Mary has been classified as severely mentally retarded with an intellectual quotient of 31 and has been diagnosed as having gross brain disease. A review of Mary's record revealed no additional handicapping conditions. Mary frequently exhibited maladaptive behaviors including cursing and threatening those around her. She received daily dosages of psychotropic medication for this behavior.

Mary's training program objectives included participation in monthly special activities; maintenance of oral health and personal hygiene skills; increasing awareness of self; and decreasing her maladaptive behaviors.

Mary seldom had contact with any relatives. She was invited to attend the review meeting but chose not to participate at the last minute.

Physical Setting

The meeting was held in a small dining room on the residents' living area. The seating arrangement, as shown in Figure 9, was not conducive to effective communication among the team members. Several of the members, including

the leader, frequently spoke with their backs to the other members.

General Observation

The team as a whole appeared to be ineffective in completing its assigned task, that of reviewing the resident's program plan. The team leader's role was administrative in nature. The leader played a very passive role in the meeting. She had limited input and her response rate was low when compared to the responses of other team leaders in the other observations (see Table 11, p. 78). The leader took no initiative to read the resident's problem or strength lists. She asked no questions regarding the program plan or the implementation of the program.

When compared to other meetings, the number of responses (55.5) was below average (see Table 4, p. 50). There was little spontaneous interaction among the team members. Only the social worker spoke at times other than when called upon by the team leader. The members gave little feedback to each other and did not question aspects of the program plan presented by other disciplines. While Mary frequently exhibited aggressive behavior toward others, little attention was given to discussing this behavior other than a brief review by the psychologist. The team did discuss transferring Mary to an adult group home. As

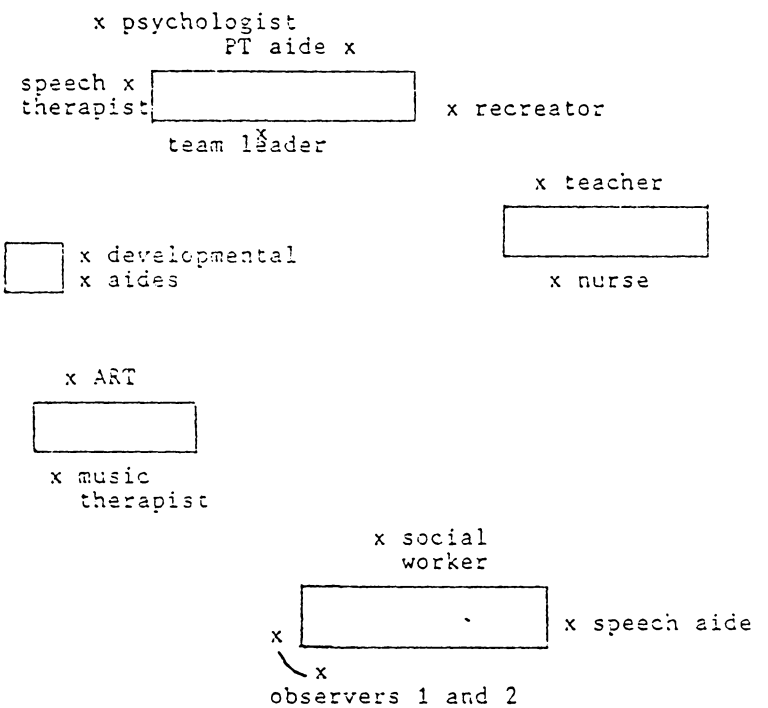

Figure 9. Seating Arrangement During Observation #1

shown in Tables 9 and 11 (see pp. 69 and 78), much of this information was given by the social worker.

Observation #2

Resident Profile

Jennings was a 66 year old resident who had resided at the facility for 36 years. He was classified as moderately mentally retarded with an intellectual quotient of 51. Jennings was a spastic paraplegic and confined to a wheelchair. Because he frequently hit others, he received daily dosages of psychotropic medication. His contact with family was infrequent.

Jennings' training objectives focused on the development of personal hygiene skills including brushing his teeth, shaving, and hand washing. He was also encouraged to participate in music activities.

Jennings attended the annual review meeting. However, he had little to say and slept throughout part of the meeting. He did, when asked, express displeasure with the food served in the cafeteria.

Physical Setting

Team #2 also met in a small dining room in the residential living area. The seating arrangement, as shown in Figure 10, was like Team #1 in that it was not conducive to effective communication among the team members.

The room was far too small to accommodate the thirteen members of the team. It was poorly ventilated and, at times, difficult to hear what the members were saying.

General Observations

In contrast to Team #1, there was more participation by the members of this team (137.5 responses). This response rate was greater for Team #2 even though the meeting was five minutes shorter that Team #1 and attended by only two more members. During this meeting, there was a greater exchange of information as members spoke out without being called upon by the leader.

The team leader was very actively involved in the meeting. She continuously asked questions, gave information, and made recommendations. She contributed 24% of all responses made at the meeting (see Form #4, p. 169). She called upon each member by name to give information regarding the resident's program plan. The leader's enthusiasm seemed to have an effect on the behavior of the other members.

While Jennings, age 66, and Mary, age 73, had very similar programs, this team gave more attention to the implementation of the program than did Team #1. The team believed that Jennings' current placement was appropriate, and therefore, little discussion was directed toward the category of placement alternatives.

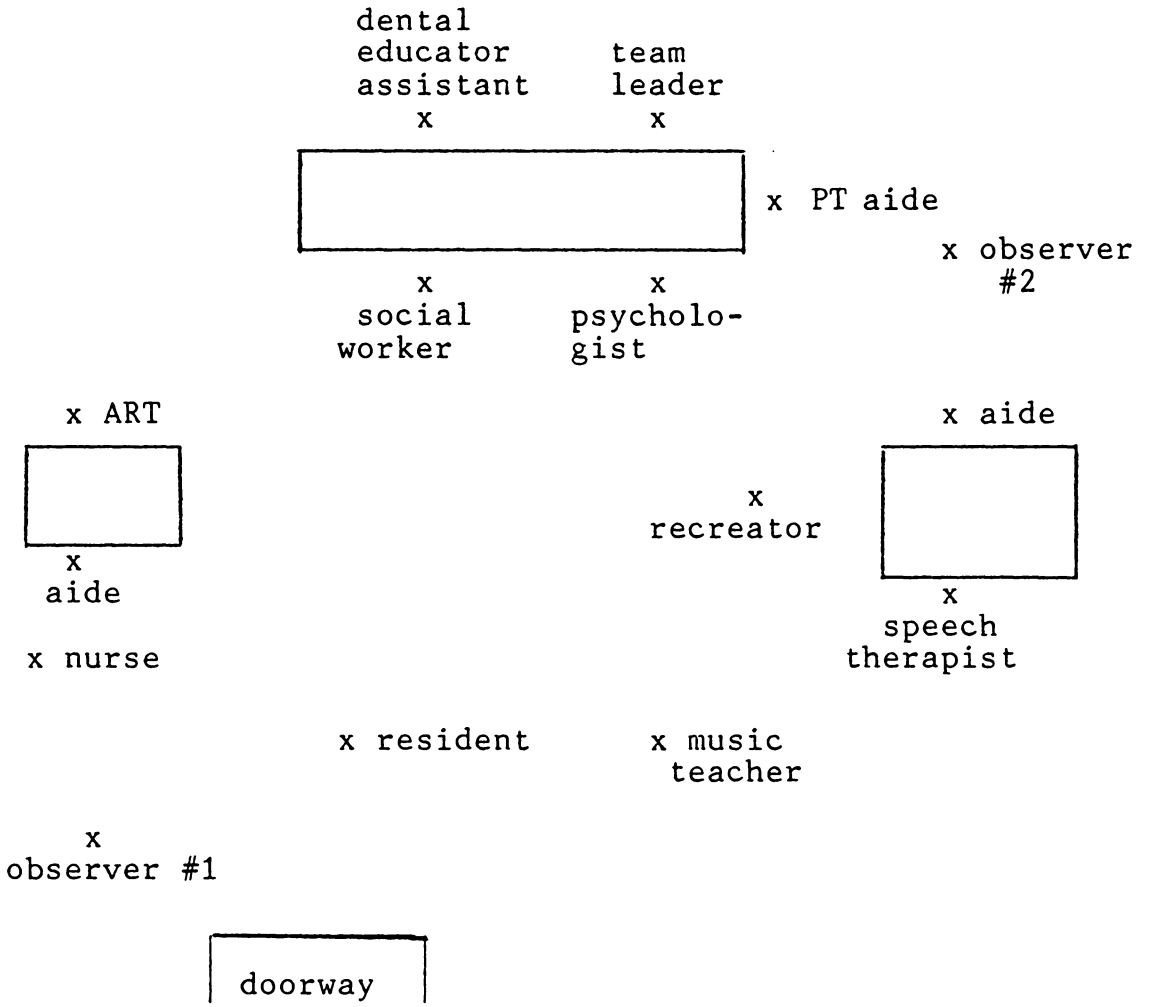

Figure 10. Seating Arrangement During Observation #2

Team #2 made a conscientious effort to get Jennings involved in the meeting. They questioned him regarding his preferences and choices. While Jennings was not responsive, the team members made an effort to get him meaningfully involved in the decision-making process.

Observation #3

Resident Profile

Sandra was a 26 year old female who has resided at the facility for 15 years. She was diagnosed as profoundly retarded with an intellectual quotient of 3. Sandra had multiple congenital deformities and possessed minimal life sustaining skills.

Due to her severe spasticity, Sandra had no gross or fine motor skills. She experienced difficulty in swallowing and had poor body alignment. She participated in a weekly music class to increase her communication skills.

Physical Facility

The meeting was held in a conference room on the residential living area. The room contained a large table with chairs enough to accommodate all eleven members. There were chairs also placed around the walls of the room. As shown in Figure 11, several members chose to sit against the wall rather than at the table. While some members were seated with their backs to others, the room itself

was an improvement over the facilities in which Teams #1 and #2 had met. It was free from environmental distractions and large enough to accommodate the team.

General Observations

The meeting lasted 17 minutes and resulted in an average of 87 responses by 11 team members. The leader conducted the meeting in an efficient business-like manner. While the leader did not dominate the meeting, she was very active, contributing 34% of all responses made (see Form #4, p. 171). She read the resident's problem and strength list and called upon individual team members to report information regarding Sandra's program. All members of the team contributed to the review.

As shown in Form #4 (Appendix B), 42% of the responses were directed toward the program planning category. This team became very involved in discussing the possibility of a special cup that could be used to help Sandra to improve her swallowing. It was an excellent example of the interdisciplinary process in action. While the teacher suggested the possibility of using the cup, the teacher, physical therapy aide and team leader all discussed the problem and pros and cons of using the special cup. There was a mutual sharing of ideas and evidence that the teacher's suggestion was accepted by the other team members.

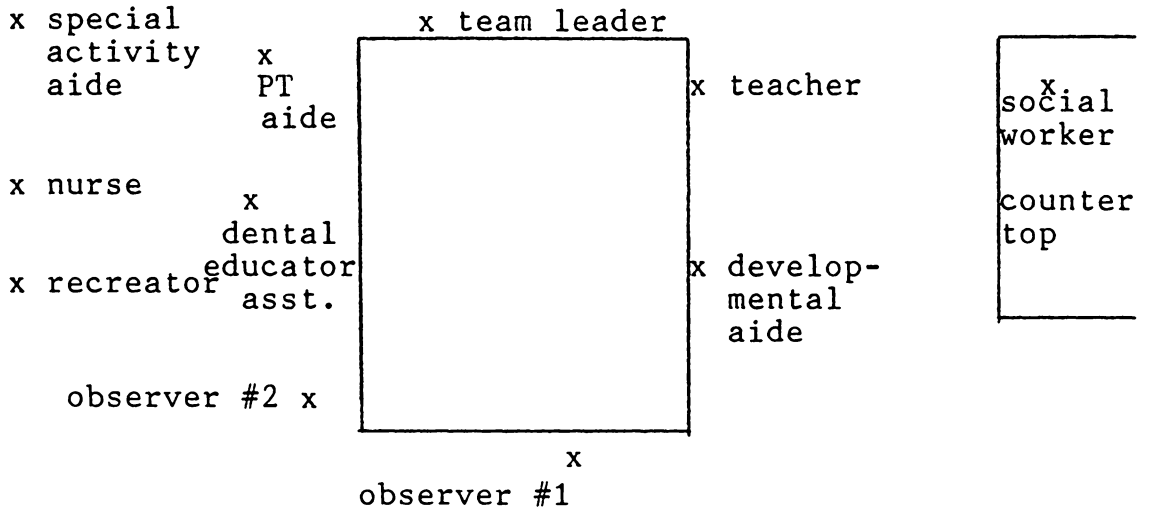

Figure 11. Seating Arrangement for Observation #3

The developmental aide who attended this meeting expressed an obvious fondness for Sandra by making several positive comments about her throughout the meeting. She was able to give specific examples of what Sandra could and could not do.

While one may have expected more involvement perhaps from the developmental aide, the special activity aide and the recreator in discussing the implementation of the program, this was not supported by the data (see Form #4, p. 171). The team's lack of attention (0%) to the placement alternative category is not surprising as the resident was diagnosed as needing skilled nursing care due to a permanently disabling medical condition.

Observation #4

Resident Profile

Steve was an 18 year old resident who had lived at the facility for 13 years. He was diagnosed as having gross brain disease of a postnatal classification. A psychological assessment revealed an intellectual quotient of 55, placing him in the moderate range of mental retardation.

Steve was a spastic diplegic who walked with the aid of a walker. He also had scoliosis and a severe speech impediment. Steve was able to take care of many of his personal needs despite his handicaps.

He participated in education and music programs to improve his developmental skills. He also received physical and occupational therapy. Occasionally, Steve would refuse to participate in his programs. He seldom had contact with his family.

Physical Facility

The meeting was held in a large classroom containing one table near the front of the room. The majority of those individuals attending the meeting were not seated near the table where the team leader sat. As shown in Figure 12, there was a considerable distance between the table and the other members. It was difficult to hear what was being said by members in the back of the room. Also, the arrangement was such that members often engaged in their own conversations disregarding the member who held the floor.

General Observations

This observation stood apart from other observations in several regards. As stated earlier, Steve was moderately retarded and as shown in Table 4, p. 50, he was the highest functioning of the twelve residents discussed at the meetings. Additionally, as shown in Table 4, the largest number of staff attended this meeting (20); it lasted the longest period of time (41 minutes) and the greatest number of responses were made at this meeting (225).

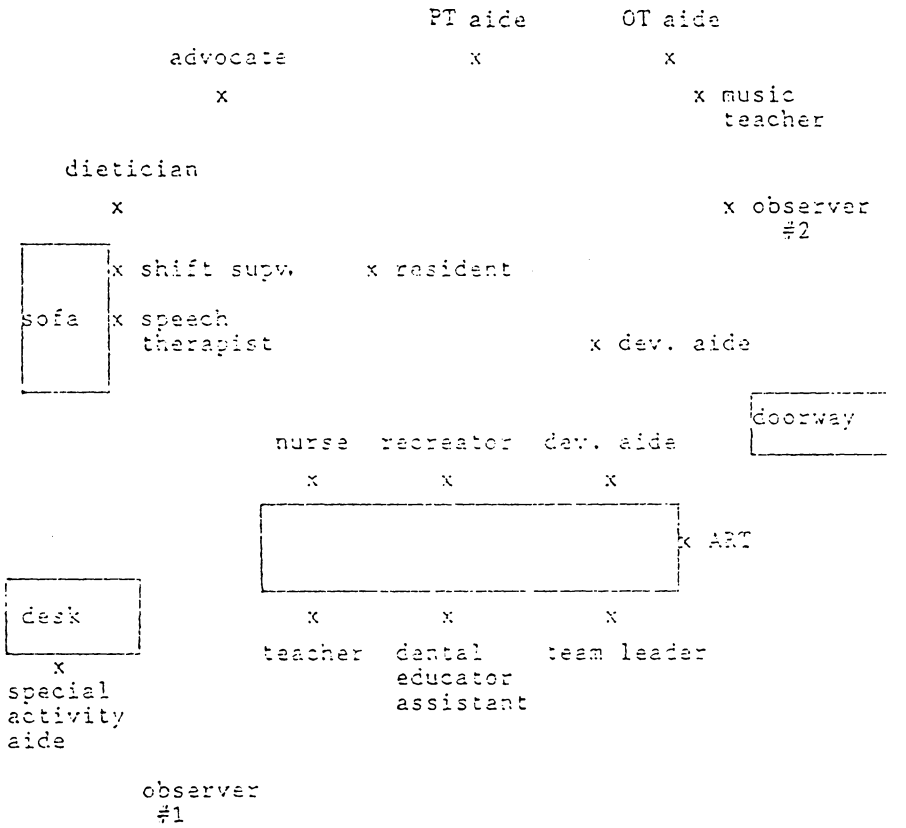

Figure 12. Seating Arrangement During Observation #4

The team leader was a very active participant in this meeting. He reviewed the resident's problem and strength list providing a sense of order and structure to the meeting. He encouraged the participation of other members and tried to keep the group on task. His job was extremely difficult with the large number of staff attending the meeting. It seemed that the problem of controlling the group could have been somewhat ameliorated by placing the members in a circle.

All of the members responded with the exception of the occupational therapy supervisor and the shift supervisor. As shown in Form #4 (p. 173), the majority of comments were made by the team leader, the music teacher and Steve's regular teacher. All other members each contributed under 5% of the total responses. It was interesting to note that while three developmental aides attended the meeting, their contributions totaled only 4% of the total responses (see Form #4, p. 173).

There was a drawn out discussion regarding Steve's refusal to participate in a music program. The team leader suggested that any program planning be deferred until a psychologist was hired to write behavioral programs. The music teacher, however, felt that a program should be immediately developed. The group was able to reach a compromise by agreeing that data would be collected for a

month regarding the problem.

Despite the resident's high functioning level, there was no discussion of altering his placement. The social worker's participation in the program was very low (1%).

The resident participated in the meeting and was asked to contribute to the development of the program plan. Steve was late in coming to the meeting. Apparently the team leader failed to bring the resident to the meeting, but did so upon the suggestion of the advocate. He seemed to be standing in a rather uncomfortable position almost in the middle of the floor.

It seemed that the meeting was conducted in a rather inefficient manner. The majority of comments (66%) were made by three of the twenty staff members including the team leader, teacher and music teacher (see Form #4, p. 173). This resulted in distraction and frequent "off-task" behavior by the remaining 17 members. The seating arrangement contributed in part to this problem.

Observation #5

Resident Profile

Ann was a 24 year old female who had resided at the center for 23 years. She had been diagnosed as severely retarded with an I.Q. of 23. Her condition was attributed

to cerebral malformation due to hydrocephalus and cerebral palsy.

Due to Ann's physical condition, she lacked minimal self-sustaining skills. Her individual program focused primarily on the development of receptive and expressive language skills and socialization skills. Other programs were designed at maintaining Ann's current health and physical status.

Physical Setting

The meeting took place in a well ventilated conference room adjacent to the residents' living quarters. The location of this meeting was the same as that of observation #3. The seating arrangement is shown in Figure 13. As with Observation #3, there were some members seated such that they did not have direct eye contact with other members, thus reducing opportunities for effective communication during the meeting.

General Observations

The meeting was very similar to Observation #3. The same number of staff attended both meetings. As shown in Table 3, with the exception of the psychologist who attended Observation #3 and the speech therapist who attended Observation #5, the same staff were represented at both meetings. The meeting lasted almost the same

amount of time. Also, the number of average responses were very similar.

As shown in Table 9 (p. 69) Teams #3 and #5 were very similar in the amount of discussion devoted to the assessment content category. Also, neither teams made any response in the placement alternative category. It was interesting to note that while Team #3 devoted 42% of its discussion to the program planning category, Team #5 devoted a similar percentage of the program implementation category. The team members in Observation #5 made informational type comments with regard to the implementation of the program. The team leader dominated the discussion with relatively few comments from other members. Less than 6% of the total responses were made by the PT aide, recreator, and social worker. Unlike the developmental aide in Observation #3, the aide in this meeting made no comments throughout the meeting.

In summary, the team leader conducted the meeting in an efficient and controlled manner. There was little interchange of information among the team members. Each member gave his or her report regarding the current status of Ann's condition with few suggestions or recommendations for change (see Form #4, p. 175). Most of the questions came from the team leader seeking information from the team members.

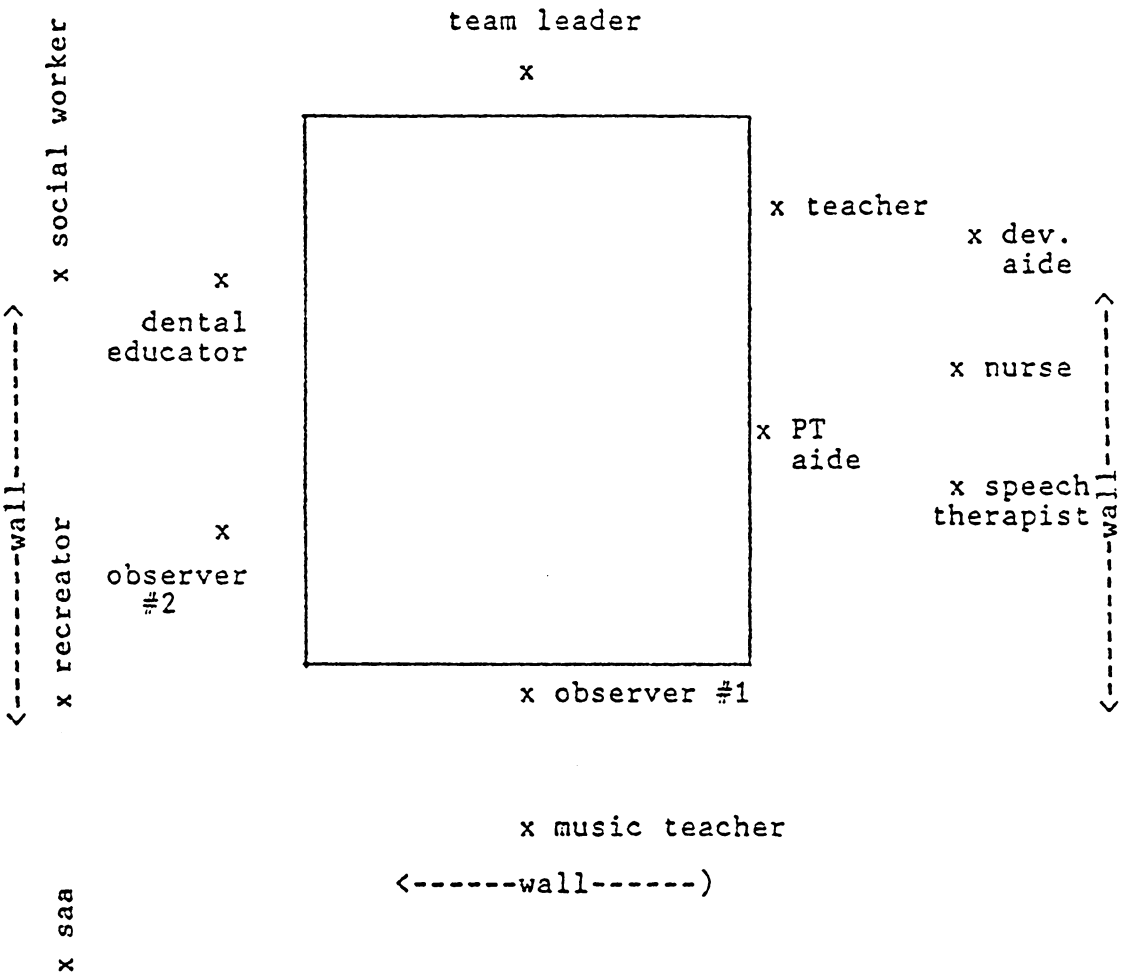

Figure 13. Seating Arrangement in Observation #5

Observation #6

Resident Profile

Gloria was a 45 year old female who has resided at the facility for 15 years. While Gloria was diagnosed as having an I.Q. of only 17, her functioning skill level appeared to be higher than that of an individual classified as profoundly retarded. She possessed all of her self-help skills and has good fine motor coordination. Unlike many other residents, she was able to verbally express herself. Gloria's training program included development of pre-vocational skills and physical therapy. She was employed at the facility as a part time worker and had received excellent performance ratings. Gloria sometimes abused herself physically and was given a psychotropic medication to help her control this maladaptive behavior. Gloria had frequent contact with her sisters.

Physical Setting

The meeting was held in the dayhall of the residential living area. The members were seated in a circular fashion so that everyone could be seen by other members. The seating arrangement is shown in Figure 14.

General Observations

This meeting was somewhat unique in that the resident and members of the family also attended the meeting.

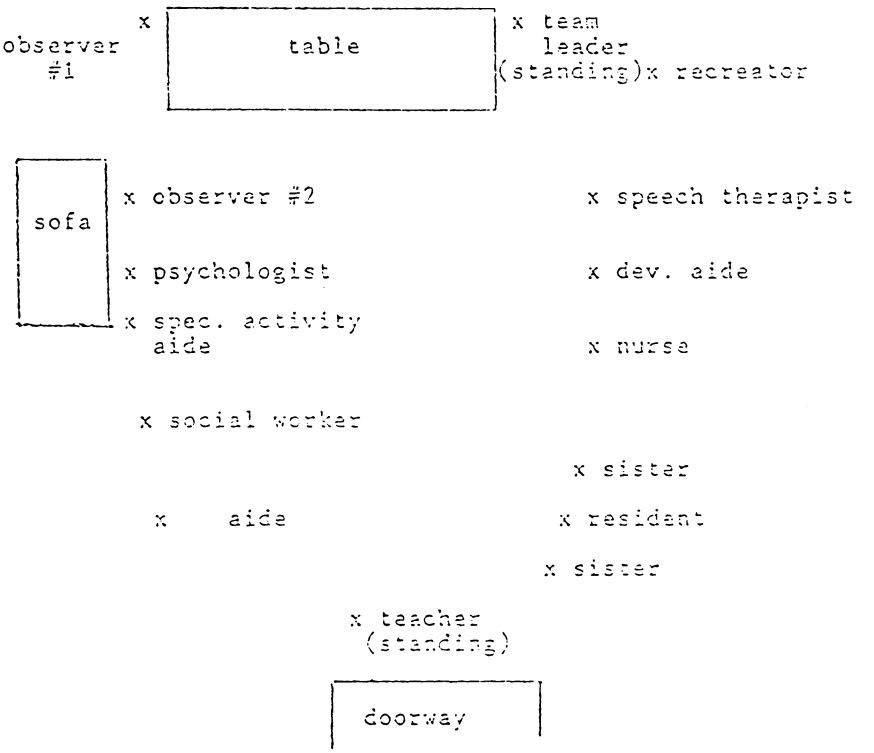

Figure 14. Seating Arrangement for Observation #6

There was an active exchange of information between Gloria's two sisters and the team members. The psychologist and the sisters discussed at length how they (the sisters) could help the team in modifying Gloria's self abusive behavior.

The team leader made a conscientious effort to get Gloria involved in the review of the program plan. Gloria was asked if there was anyway in which the team could provide her with more assistance. She was also questioned regarding the institutional food and her current living quarters. Gloria and her sisters seemed to be satisfied with the current arrangements.

The team leader, as seen in prior observations, dominated the discussion throughout the meeting contributing approximately one-third (32%) of all comments (see Form #4, p. 177). The leader was actively involved in the discussion in all four content areas. Throughout the meeting, the leader stood up while other members were seated. He conducted the meeting confidently and exerted a high degree of control over the meeting. As shown in Form #4 (p. 177) the team leader asked 63% of the questions. The questions were routine in nature, asking members for information. The leader's behavior did not stifle or subdue discussion by other team members. The members frequently responded in a spontaneous manner

throughout the meeting without being called upon by the team leader.

The majority of responses made at the meeting were informational type statements directed toward the implementation of Gloria's program plan. All members of the team with the exception of the speech therapist and the special activity aide made some contribution to this content category. The direct care staff representative made her only responses in this area.

As shown in Table 9 (p. 69), this team devoted an above average (15%) amount of the discussion to the placement alternative category. This discussion seemed to develop as a result of questions asked by Gloria's sisters. The exchange of information in this area took place between the sisters and the social worker (see Form #4, p. 177) regarding the possibility of Gloria being placed in an adult group home operated on the institutional grounds by the local community services board. Considering that Gloria resided in a living area with residents who are the most likely candidates for discharge, this finding is not surprising.

Observation #7

Resident Profile

John has lived at the facility for 35 of his 37 years. He was classified as profoundly retarded with an

I.Q. of 24. His condition was due to some unknown prenatal influence. While John possessed all of his self-help skills, he frequently exhibited aggressive behavior by hitting and kicking other residents and staff. To help John in controlling this inappropriate behavior, he received daily doses of loxitane, a behavior modifying drug.

John's training program focused upon increasing his personal hygiene skills including brushing his teeth, shaving and shampooing his hair. His parents visited him frequently taking him home for brief visits and outings in the community.

Physical Setting

The meeting took place in a small dayhall in the residential living area. There was one table next to the wall of the room. The team members sat on sofas and chairs around the room. The seating arrangement is shown in Figure 15. While the group sat in a manner such that everyone could see one another, the meeting was subject to frequent interruptions. On two occasions, the team leader had to leave the meeting to remove residents who wondered into the meeting. There were also numerous environmental interruptions including a telephone ringing and a custodial worker mopping the floor adjacent to the meeting room.

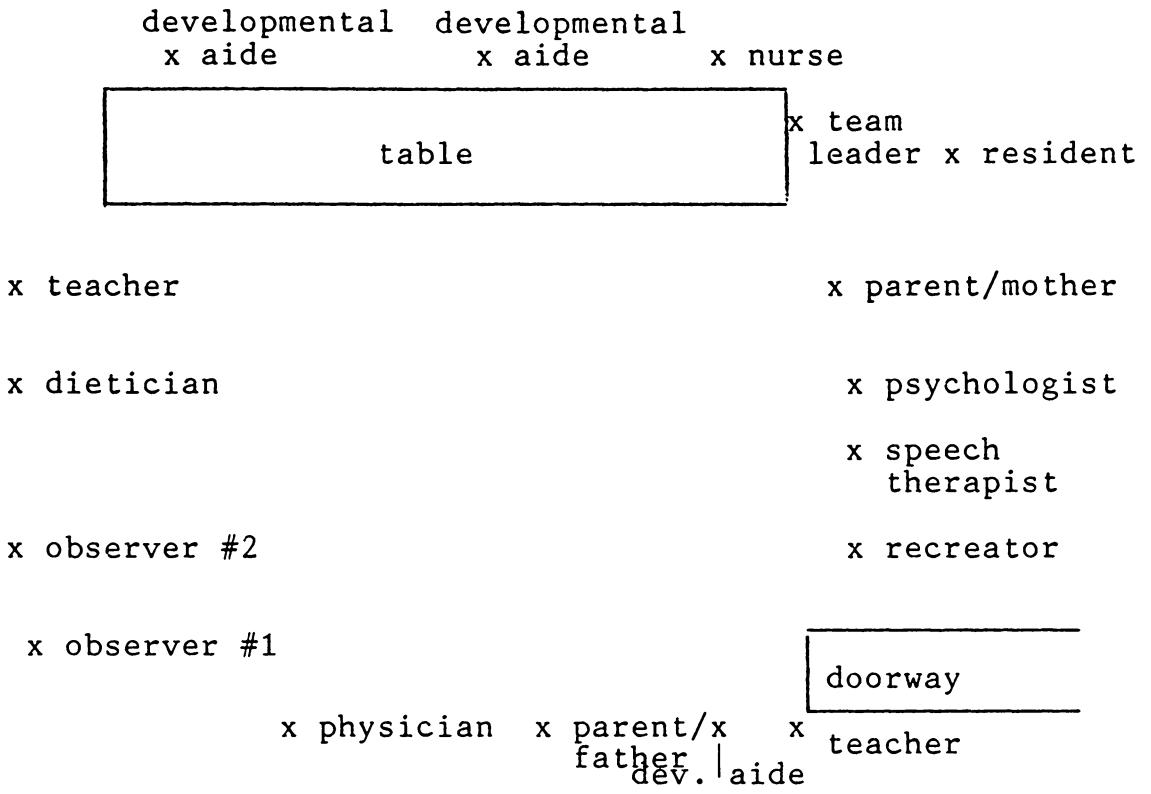

Figure 15. Seating Arrangement during Observation #7

General Observations

The same team leader who conducted Observation #6 also conducted Observation #7. He used very much the same style and format observed in the previous observation. This meeting was unique in that the resident and his parents were all in attendance. Over one-third of all the comments (36%) made at the meeting were made by John's parents (see Form #4, p. 179). The team leader was less actively involved in this meeting contributing only 16% of the total average responses, significantly below the 35% average response of team leaders as a whole (see Table 11, p. 78). The leader's role in this meeting was primarily that of chairing and conducting the meeting. The leader contributed very little to the program planning and the program implementation categories (see Form #4, p. 179). His primary contribution was that of asking other team members to give their input.

The percentage of responses made by each member in the four content areas is shown in Table 9 (p. 69). Only 13% of the total responses were directed to the program planning content area. The parents made the majority of the responses (65%) followed by the speech therapist (22%). The therapist suggested that John was ready to begin a new stage of language development which was of

interest to his parents.

John made no comments during the meeting. He sat quietly beside his mother. The team leader did not question John regarding his satisfaction with current program or any preference regarding decisions made about him by the ID team. This may have been due to his severely impaired language development.

The members frequently made comments in the areas of program implementation (33%). The parents, teacher and psychologist dominated this area of discussion. There was little discussion (4%) with regard to the placement alternative category.

Generally speaking, the team appeared to be effective in accomplishing its task, that of reviewing the resident's program plan. Several staff made no response throughout the entire meeting. Despite the presence of three direct care staff, only one made any remarks comprising a small 2% of the total average response. The recreator and one of the teachers made no comments during the meeting. While the staff nurses had been actively involved in other observations, it was interesting to note that the nurse in this meeting in which the physician was present made no comments. The physician gave an extensive update on John's condition that was of great interest to John's parents.

This meeting was highlighted by the attendance of John and his parents. Most of the interaction that took place was between the team members and the parents rather than among team members. The meeting was more of an information sharing meeting with little change in the program plan. The parents were very supportive of the team and made a closing remark about the excellent job they felt the staff had done in working with John.

Observation #8

Resident Profile

Ricky was an 18 year old male resident who had lived at the facility for the past six years. Ricky had been assessed as severely retarded with an I.Q. of 33. While the cause of his condition was unknown, it appeared to be related to a convulsive disorder for which he took phenobarbital and dilantin. Additionally, Ricky had a hearing loss and must wear corrective orthopedic shoes.

While Ricky possessed his basic self-help skills, he lacked personal hygiene skills such as knowing how to shampoo his hair and shave his face. As part of his IEP, the staff worked with Ricky on simple pre-academic skills. He frequently displayed maladaptive behaviors such as hitting and scratching other residents and staff. His family had frequent contact with Ricky and the staff.

Physical Setting

The meeting was held in a rather large room that was previously a dayhall and had been converted to a meeting and in-service training room. The meeting room provided a quiet location for the meeting isolated from the routine noise of the living area. There were no environmental interruptions during the meeting other than one announcement over the intercom. The seating arrangement during the meeting is shown in Figure 16.

General Observations

The meeting began rather abruptly with the team leader calling upon the members to give their summaries regarding Ricky's status. He did not review Ricky's problem or strength list.

The discussion was dominated by the teacher (26%) and the team leader (36%). (See Form #4, p. 180). The teacher contributed significantly to each of the four content areas. He provided a detailed overview of Ricky's IEP. He reviewed each of the resident's objectives and cited progress in each area. Despite his informative report, no questions were asked by the other members. For the most part, the other members appeared somewhat disinterested. The team leader questioned whether or not the resident had 5½ hours of instruction listed on his IEP. While the teacher noted

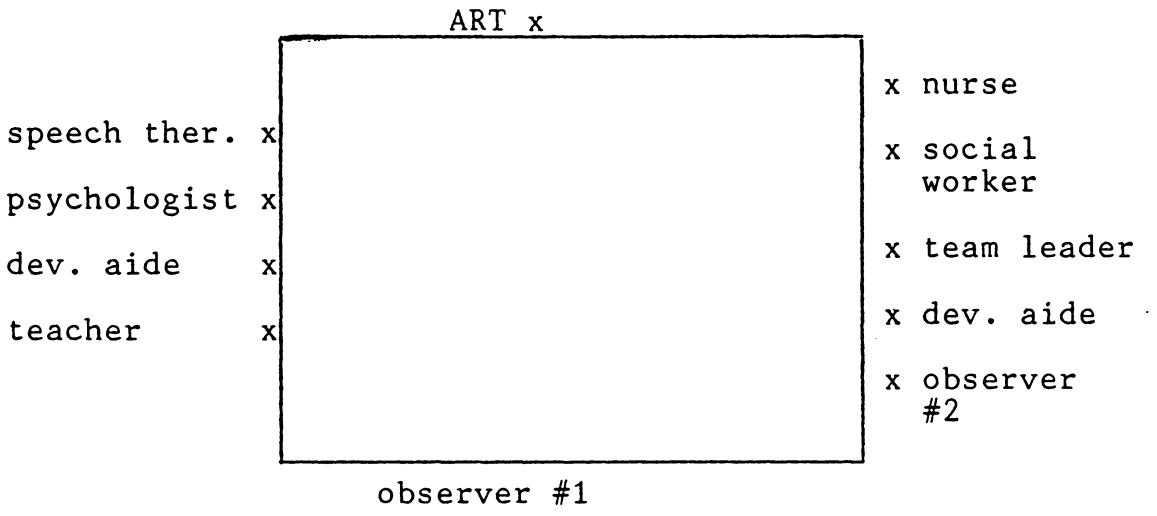

Figure 16. Seating Arrangement during Observation #8

that Ricky's IEP did not include 5½ hours of instruction, he was reluctant to write a new goal. However, at the team leader's insistance, another goal was added that showed 5½ hours of instruction on paper.

The psychologist read test scores from the psychological evaluation recently administered to Ricky. She quickly read the data failing to explain any implications of the test scores. She noted that Ricky had made no progress in achieving his behavioral goals. Despite this report that Ricky's maladaptive behaviors had not decreased, no team member questioned the psychologist or made any recommendations for modifying the program. The exception to this was a question by the team leader about extending the resident's objective for his behavioral problem.

The social worker, nurse and speech therapist read reports regarding their assessment of Ricky's current status. Again there were few questions relating to the substance of the program. Any questions asked were of a technical nature referring to the mechanics of the program. While two developmental aides attended the meeting, neither one made any comments throughout the meeting.

Generally speaking, the meeting was conducted in a very mundane, mechanical manner. While the team accomplished its task, there was a noticeable lack of interaction among the team members.

The team leader did little to facilitate an active exchange among the team members. It seemed that the meeting was conducted more in a multidisciplinary format with each discipline giving his/her report with little input from other members.

Also, one questions the lack of participation of two developmental aide staff who work with Ricky, a resident with a serious behavioral problem, on a daily basis. They made no comments and there were no attempts to get them involved in the discussion.

Observation #9

Resident Profile

Mark was a 21 year old resident who was profoundly retarded. His I.Q. was not available in the psychological data base. Mark was diagnosed as having Down's Syndrome. He had been institutionalized for 19 of his 21 years. His record revealed no additional handicapping conditions other than mental retardation.

Mark's education and training program emphasized the development of self-help and motor skills. He received 5½ hours of programming each day in accordance with Public Law 94-142.

Physical Setting

Observation #9 was conducted in a large dining

room. The meeting was relatively free from environmental distractions. There were food service staff also meeting in the same room.

The seating arrangement is shown in Figure 17.

General Observations

The meeting was characterized by the lowest number of responses made during any team meeting (40.5) as shown in Table 4 (p. 50). The meeting was attended by nine staff members and lasted 15 minutes. The same team leader who conducted Observation #8 also conducted #9. This team leader was substituting for the regular leader who was absent from work.

Prior to the beginning of the meeting, the social worker directed a question to the teacher regarding the resident's placement in educational programming. The teacher responded to the question in a very negative manner outwardly expressing feelings of anger regarding the resident's placement and the team. The team leader as well as other members chose to ignore the teacher's comments. No one attempted to address the teacher's obvious concerns. The team members may have chosen to ignore these comments due to the presence of the observers.

Similar to Observation #8, there was limited interaction among the team members. Very few questions were asked other than those of a technical nature by any

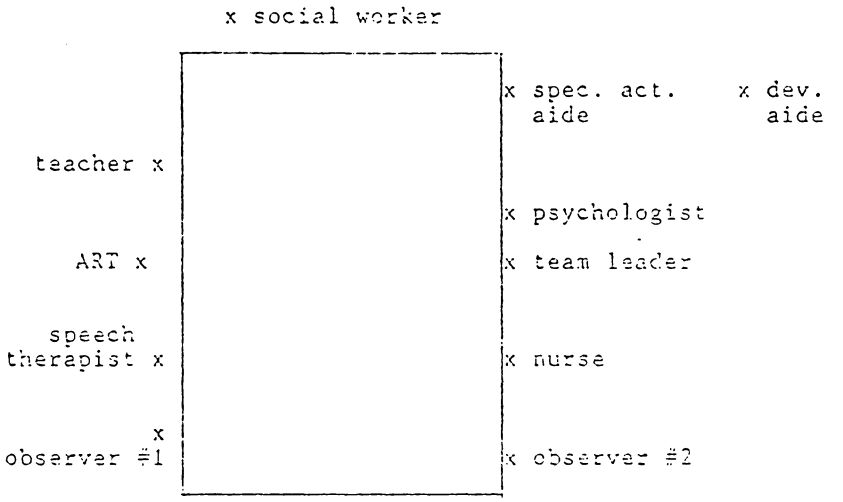

Figure 17. Seating Arrangement during Observation #9

team members. There were no comments made by the developmental aide or the ART during the meeting. Prior to the meeting, the team leader asked the developmental aide if ". . .she would mind sitting in on the meeting." It appeared that the aide had no prior notice regarding the meeting. She sat apart from the other members during the meeting. Also, it was interesting to note that there were no direct care staff from first shift at the meeting. As Mark was a school age resident, it seemed unusual that no direct care staff were present as they were responsible for part of his educational program.

The speech therapist was the most active member in the meeting. She gave a detailed report regarding Mark's speech program and had several recommendations regarding the implementation of the program.

The meeting was generally characterized by limited interaction among the team members. The teacher's negative comments at the beginning of the meeting seemed to dampen the atmosphere during the meeting. The members behaved in a mundane, mechanical manner directed toward reading their individual program summaries with little active interest displayed in programs written by other team members.

Observation #10

Resident Profile

George was a 31 year old resident who had resided

at the institution for the past 21 years. He was classified as severely mentally retarded with an I.Q. of 34. George was diagnosed as having encephalopathy due to unknown causes. He was epileptic and received daily doses of phenobarbital.

George frequently displayed aggressive behavior by throwing temper tantrums when he did not get his way. His training program focused on decreasing his maladaptive behavior, learning basic self-help, prevocational and leisure skills. George seldom had any contact with members of his family.

Physical Setting

The meeting took place in one of the bedrooms on a residential living area. There was a small table placed in the center of the room as shown in Figure 18. The physical setting was not conducive to effective communication among the team members. There were not enough chairs for all members so some members had to sit on the residents' beds. Several members were faced with their backs to the other members.

General Observations

The meeting was characterized by a high level of leader control. As shown on Form #4, p. 182, the team leader made 45% of all the comments made during the

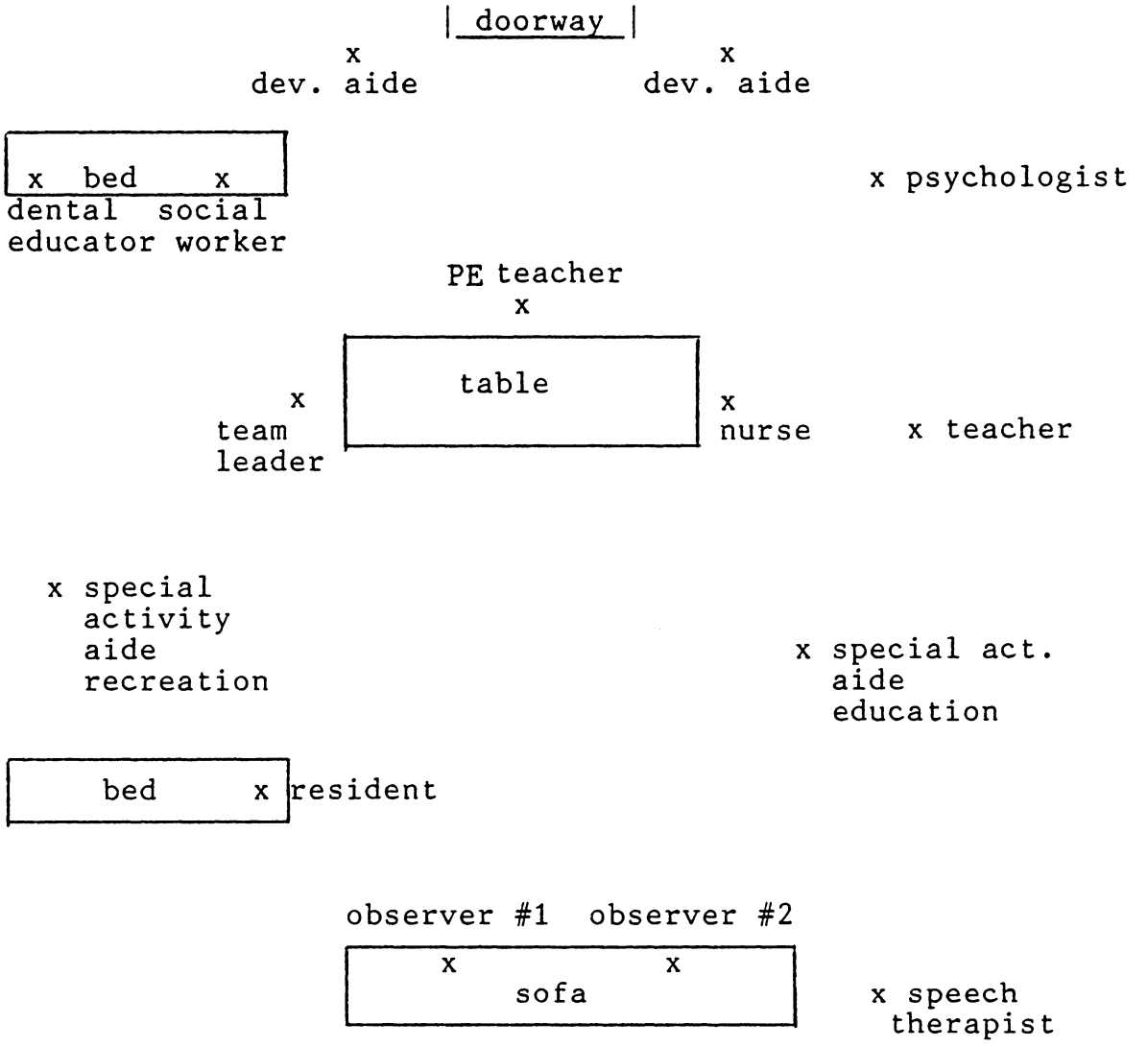

Figure 18. Seating Arrangement during Observation #10

meeting. He also asked 98% of all questions during the meeting. The team leader carefully reviewed the resident's problem and strength list. During the meeting, he specifically asked each member to comment on various aspects of George's program plan. With George as the exception, all members of the team made some contribution to the review of the program plan. During the meeting, George sat on the bed staring out the window showing no interest in the meeting.

As shown on Form #4 (p. 182), the developmental aides contributed 13% of all the comments made during the meeting. This percentage represents the highest level of participation on the part of any developmental aide. These two aide staff represented first and second shifts. As expected, the developmental aides made their contributions in the area of program implementation. They frequently commented regarding George's behavioral problems. On the other hand, the psychologist who was responsible for writing the behavioral programs contributed a small 2% of the total average responses. This was not surprising as the psychologist was a new employee at the center who had only been employed for approximately three weeks.

During the meeting, the special activity aide for education made more comments regarding George's education

program than did his teacher (see Form #4, p. 182). While the special activity aide worked under the supervision of the teacher, clearly she dominated the discussion regarding the resident's education program.

Of the total number of responses made at the meeting, 41% and 42% respectively were devoted to the areas of assessment and program implementation. Little attention was given to modifying the program plan itself. The only statements directed toward the placement alternatives category were those asked by the team leader regarding the appropriateness of George's continued placement in an institutional environment. Similar to other meetings, the members primarily made informational type statements (see Form #4 (p. 182). There were few questions asked during the meeting.

In summary, the meeting was conducted in a very efficient, business like manner. The members seemed to behave in somewhat of a "stilted" manner and appeared to be somewhat uncomfortable with the presence of two observers. The leader exerted a high degree of control over the group. However, every member made some contribution to the meeting. In this manner, there was an active exchange of information among the team members.

Observation #11

Resident Profile

Wesley was 37 years old and diagnosed as having an I.Q. of 28. He has resided at the institution for 29 years. Due to the intensity of his aggressive behavior, Wesley was placed on a behavioral unit. His current training program focuses on the development of self-help skills, language skills and leisure time skills. Wesley has no contact with his family.

Physical Setting

Observation #11 took place in a kitchen activity area on the unit. During the team meeting, there were two staff members preparing for a picnic. There was no partition between the area where the staff was conducting the meeting and the kitchen area. The team did not appear to be distracted by the activity going on in the adjacent area. The seating arrangement is described in Figure 19. The meeting had originally been scheduled to be held in a conference room on the building; however, another meeting was already in progress at the time the review meeting was to be held.

General Observations

The meeting lasted for only 12 minutes, making it the shortest of the 12 meetings observed. There were only

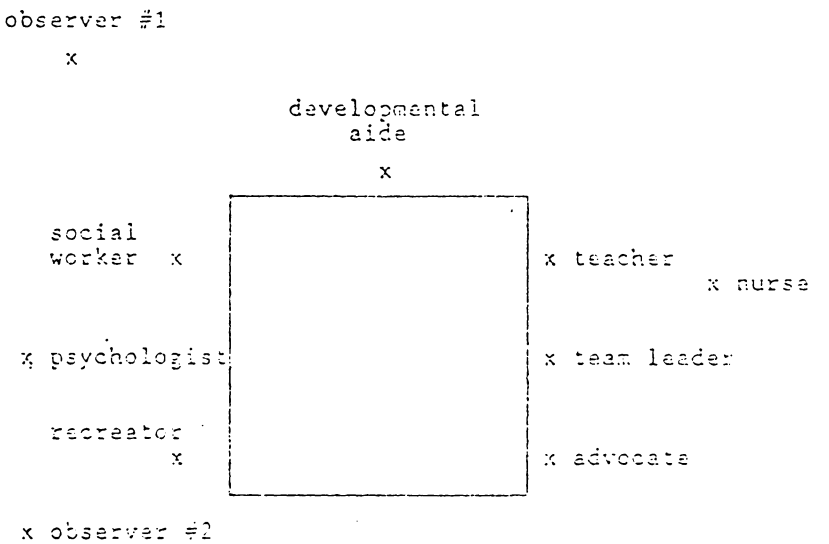

Figure 19. Seating Arrangement during Observation #11

eight staff present at the meeting. It is not surprising that there were also a relatively small number of responses made by the members (50.5).

The team leader began the meeting by reviewing Wesley's strengths. As shown on Form #4 (p. 184), the team leader dominated the discussion contributing approximately 60% of all responses made during the meeting. There were few responses made by any other team member other than the teacher. The discussion centered mainly on the assessment and program implementation content categories.

In general, the meeting was characterized by a lack of substantive content. Two members, including the teacher and special activity aide, stated that Wesley's current objectives had been deferred. For example, the team leader stated that, "Wesley lacks grooming skills," and the teacher responded by saying "new problems and objectives." A similar statement was made by the recreator when the team leader noted that Wesley ". . . lacks leisure time skills." It seemed unusual that no other team member, including the team leader, asked what the new plans and objectives were going to be. The team leader read a report from the speech therapist who was not in attendance at the meeting. Comments were made regarding Wesley's behavioral program by the psychologist.

Again, no questions were asked by other team members, even though Wesley was placed on this unit which was considered to be a more restrictive placement than placement on any of the other units. The nurse who arrived approximately five minutes late read a report regarding Wesley's health condition. The team leader did review an "accessibility statement" which the other team leaders had not reviewed. The team leader asked whether Wesley should have direct access to certain personal items such as toothpaste, shampoo, toilet paper.

In summary, this meeting appeared to be indicative of underlying attitude and/or motivational problems on the part of the staff. The staff did not adequately review Wesley's program plan. In two areas, including education and recreation, the other team members were not even informed of the content of the objectives, yet the review was considered complete at the end of the 12-minute meeting.

Observation #12

Resident Profile

John was a 40 year old multihandicapped individual who has resided at the center for 18 years. He was diagnosed as having an I.Q. of 29. John was nonambulatory, had a visual impairment and was also epileptic. John also

frequently displayed aggressive behavior by pushing, hitting others and slamming doors.

The resident's training program focused on the development of self-help skills, leisure time activities, following simple commands, speech and language skills and gross motor skills. John has no contact with his family.

Physical Setting

The meeting took place in a corner of a large dining room on a residential building. The meeting was relatively free from environmental distractions. However, there were staff from food operations on the other side of the dining room. The acoustics in the meeting room were poor, and it was difficult to always hear the members. The seating arrangement is shown in Figure 20.

General Observations

The team leader displayed a high level of enthusiasm that had not been observed in other meetings. While the team leader clearly dominated the meeting as seen in Form #4 (p. 185), there was some response from all of the other team members with the exception of the OT aide supervisor. The developmental aides, nurse, and the recreator actively participated in the meeting. Over 2/3 of all the comments made at the meeting were directed toward the assessment (37%) and program planning (35%) categories.

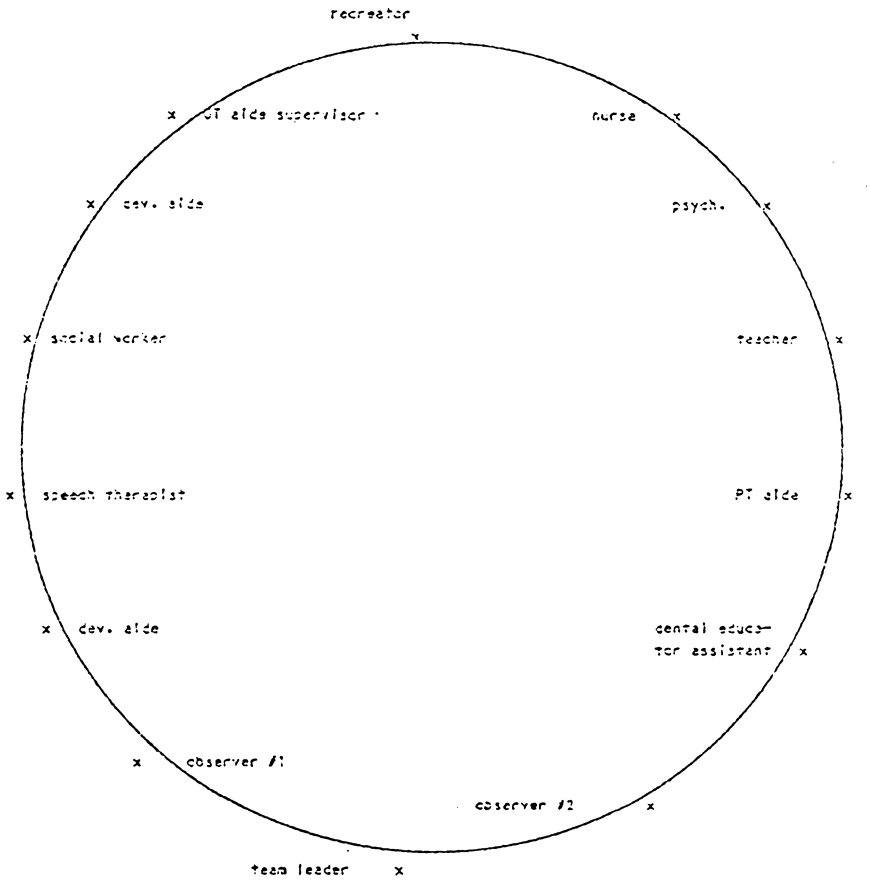

FIGURE 20. Seating Arrangement during Observation #12

The direct care staff, as shown in other meetings, provided the most input in the area of program implementation.

The team leader conducted the meeting in a very efficient and thorough manner. She read the resident's problem list, strength list, the ID Team Format Sheet and the Accessibility Sheet. While the leader exhibited a high degree of control over the group, the members appeared somewhat apprehensive about the presence of the observers. Although the team did not question information presented by other members, there was an active exchange of information sharing among the team members about the resident.

APPENDIX D

DESCRIPTION OF THE FACILITY

Description of the Facility

The facility in which this study was conducted is one of the largest facilities for the mentally retarded in the United States, serving a population of approximately 1,700 residents with about 2,450 employees. Opening in 1911 as a colony for epileptics, the mission of the center is to provide quality training and health care programs to the residents. All services are provided in accordance with the Standards for Services for Mentally Retarded and Other Developmentally Disabled Persons.

Operating under the unit system of management, the facility is divided into ten program areas. Each area has a center director/unit manager responsible for residents and staff assigned to the area. Residents are placed on the areas based on such factors as age, skill level, associated handicapping conditions, medical condition and adaptive behavior skills. Habilitation, medical and health services are provided to each resident at the center through the mediation of a specifically designated interdisciplinary (ID) team. The teams are responsible for identifying the resident's needs and designing programs to meet the needs. All recommendations made by the team are subject to review by the center director/unit manager. The teams are responsible for seeking input from all shifts in designing programs.

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AN EXPLORATORY STUDY OF ROLE BEHAVIOR WITHIN INTERDISCIPLINARY TEAMS IN A RESIDENTIAL FACILITY FOR THE MENTALLY RETARDED

by

Carolyn Jean Robinson

(ABSTRACT)

Twelve interdisciplinary (ID) teams in a residential facility for the mentally retarded were observed while conducting annual reviews of resident program plans. Observers used predetermined recording rules to code the responses of the ID team members into one of the following four content areas: (1) assessment; (2) program planning; (3) program implementation; and (4) placement alternatives. Additionally, the observers coded whether the statements made were: (1) questions; (2) informational type statements; or (3) recommendations or decision-making type statements.

Following the observations, the observers also rated the teams on the following nine variables associated with group behavior: (1) group effectiveness; (2) leader approachability; (3) mutual influence; (4) personal involvement and participation; (5) intragroup trust versus intragroup competition; (6) worth of the meeting;

(7) submission to versus rebellion against the leader; (8) leader control; and (9) role and idea conformity.

The observational data revealed that the ID teams spent most of their time discussing assessment related issues and the least amount of time discussing placement alternatives for the residents. The members seldom crossed territorial boundaries to give feedback to other members in areas outside of their discipline. Seldom did the members question information or propose any changes to information presented by others. In general, the purpose of the meetings seemed to be to review an already developed plan.

Professional staff, including nurses, social workers, teachers, and psychologists, participated more frequently in the meetings than did para-professional staff. The professionals usually contributed concrete data including written assessment reports and implementation data. The para-professional staff's comments were usually informational in nature.

Findings from this study raised concerns regarding the implementation of the interdisciplinary service delivery model in residential centers. While it is assumed that all members of the teams do participate in the meetings, the findings from this study do not support this assumption. Future research is needed to more broadly examine

participation in team meetings in PRFs across the nation. Additionally, alternative methods must be developed for increasing staff participation and assessing the quality of decisions reached by ID teams.