An evaluative analysis of the practice of teamwork in Health and Personal Social Services

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SUMMARY

This report describes the practice of teamwork as expressed in case conferences for care of the elderly and evaluates the effectiveness of case conferences in their contribution to care.

The study involved the observation of more than two hundred case conferences in sixteen locations throughout the West Midlands, in which one thousand seven hundred and three participants were involved. Related investigation of service outcomes involved an addiditional ninetysix patients who were interviewed in their homes.

The purpose of the study was to determine whether the practice of teamwork and decision-making in case conferences is a productive and cost effective method of working.

Preliminary exploration revealed the extent to which the team approach is part of the organisational culture and which, it is asserted, serves to perpetuate the mythical value of team working.

The study has demonstrated an active subscription to the case conference approach, yet has revealed many weaknesses. Not least of which is clear evidence that certain team members are inhibited in their contribution. Further, that the decisional process in case conferences has little consequence to care outcome. Where outcomes are examined there is evidence of service inadequacy.

This work presents a challenge to professionals to confront their working practices with honesty and with vision, in the quest for the best and most cost effective service to patients.

Key Words

Case conference
Teamwork
Outcome assessment
Care of the Elderly

"Intelligent and energetic people are forced to become ineffective by systems and methods which defeat and frustrate their best efforts to get on with their jobs. "

H.R.H. Duke of Edinburgh

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i The term 'patient' is used generically to represent all users of health and welfare services. It is acknowledged that in welfare services the term client is preferred.

ii Where necessary the male gender is also used in the generic manner.

Purpose

To evaluate the effectiveness of 'teamwork' as expressed in case conferences for care of the elderly. To review the individual contributions of team members. To consider their contribution in relation to care outcomes. To consider the cost effectiveness of the case conference approach to decision making.

Preface

Evolution and Ethos of Teamwork

The organisation and delivery of health and welfare services is an extremely complex business. Specialisation among the caring professions may be viewed as a means of coping with the ever widening boundaries created by developments in the sciences and technology.

As the advancement of knowledge forces diversification within the caring professions so it becomes increasingly difficult to organise and provide services without involving many different disciplines even for one episode of care. Thus teamwork emerges.

Teamwork pervades almost every aspect of the organisation and delivery of health and welfare services. Much has been written about its contribution to organisational effectiveness. In the report of the Royal Commission on the National Health Service 'teamwork' is recommended as:

> "a means of improving organisational effectiveness and raising the standard of service to patients". (1)

Care professionals themselves are reported to perceive teamwork

as a valuable and necessary way of working. Rarely is the team concept questioned. In Parsloe's major inquiry into the work of social services departments, she reports:-

> "that no one interviewed in the field studies questioned the area team as the basic component in the organisation of social services..... Most social workers found it congenial to work in a team and relied to a considerable extent on other team members for support" (2).

This preference is further supported in the evidence of the Personal Social Services Council investigation into collaboration in community care. (3)

Changes in structure, management style and care philosophy have particularly dominated the public sector during the past decade. Effectiveness and efficiency have become key terms of the era. The Health Service has moved from a 'consensus' to a 'general' management approach and from hospital based to community focused care. (4), (5), (6), (7), (8) (9). Social services from a relatively embryonic state to maturity, having been subjected to major organisational reviews on route. (10), (11), (12).

It could be asserted that the desire and continued support for the team approach is merely a natural response to the experience of major organisational change. Schon has expressed this as 'dynamic conservatism' - the individual's desire for familiarity and recognisable support in a changing environment. (13)

Throughout the changes and development service demands have been met, care progressed and teamwork has prevailed. Through legislative means, through professional desire or in response to demands presented by multiple pathologies, whatever the motivator 'teamwork' lives on; often unquestioned, frequently without design or objective, apparently because instinctively it is believed to be right.

This work seeks to question that myth.

PART I

Descriptive Study

An evaluative analysis of the practice of teamwork
in Health and Personal Social Services

CHAPTER I

Introduction, origins of the study

Introduction

Origins of the study

Many arguments supporting the interprofessional teamwork approach to care make sense and are inherently attractive but the paucity of scientifically admissible evidence is striking. In spite of the lack of evidence, the pervasive and generally unquestioned myth prevails, that teamwork is inherently good.

There appears to be a widely held belief that the practice of teamwork is not only an effective way of organising activity but that it is actually beneficial to patient care. Teamwork is acknowledged as an efficient and effective mechanism by which service needs and intentions can be clarified and decisions made. (op.cit, 1 & 3.)

The author's interest was first aroused in respect of the apparent dichotomy between the effectiveness of teamwork at differing levels of service. Personal experience in health care planning provoked questioning of the effectiveness of the collaborative mechanisms created through statutory provision such as the joint working or joint planning arrangements between health and social services. This allied to recognition of the unsubstantiated ethos of teamwork presented a particularly interesting area for study.

From preliminary investigation, two things emerged. Firstly, that a number of agencies were already involved in review of the statutory provision for joint working, at both operational and strategic level, not least of these being the D.H.S.S., which has since reported on several aspects of collaboration (14) (op.cit, 7). Secondly, that the richest source of material presented at operational level, where the effects of custom and

practice meet with the influences of statutory provision and where care outcomes consequent on this interface, seemed just as unquestioned as the inherent belief in teamwork itself.

Indeed much of the 'cultural' behaviours which nurture teamwork at operational level remain with staff throughout their careers; such behaviours are carried on through career paths to senior positions wherein officers influence policy by their own experience and thus 'teamwork' prevails.

To explore this phenomenon it was deemed necessary to identify a research population where there was the maximum multi-disciplinary team involvement and least statutory influence, thus allowing observation of teamwork and its outcome, to be relatively untarnished by influences other than the team's own effectiveness.

A suitable population appeared to exist in Case Conferences for child abuse. Several of these were observed, whereupon it became evident that contributors acted according to tightly prescribed often statutorily controlled regimen. The ability to influence decision, as an individual, was very limited. Therefore it would not have been possible to monitor, as proposed, the influence of the individual on teamwork and on practice. For a future study potential does exist therein to explore the control mechanisms of decision and possibly their influence on team practice, but this was not fitting the envisaged purpose of the present study.

An alternative, and what proved to be satisfactory medium, presented in Case Conferences for care of the elderly. In this forum, workers from a wide range of care agencies are drawn together (largely due to multipathologies presenting in the elderly) to purposefully decide upon care activities and review the outcome of care. There are few statutory provisions

to be met. Where stringent statutory requirements exist (e.g. Section 47. National Assistance Act 1947/51), such meetings were excluded from observation. (Appendix 1.)

As in the first encounter, a number of conferences were observed in order to confirm their suitability and that the research was purposeful and necessary. Any doubt was dismissed by one particular event - a Health Visitor when leaving a case conference commented:-

> "Good, I'm glad that's over, now I can go and see the secretary to find out what I really need to know about the patient, and get on with my work"

The Health Visitor had contributed very little during the two hours she had attended the case conference; behaviour which she shared with the majority of participants from a range of professional disciplines. It appeared that the proceedings were dominated by one individual. This led one to question the purpose, value and cost of such a meeting in relation to the benefits to patients or staff.

When asked to comment on 'teamwork', staff attending one case conference independently gave positive responses to its general value. Asked to consider the value of case conferences in relation to their contribution to care, they were less certain. Comments ranged from "a total waste of working time" - to "we could get so much more done more quickly without meeting together".

From the author's working experience, assumptions were made as to the possibility of the patient's perspective differing from that of the carers. It was considered inappropriate to approach patients at this juncture, without due observation of ethical

practice, verification of protocol through the ethical committee systems existing in both Health and Local Authorities. This was undertaken formally at a later stage.

It was considered that there existed sufficient evidence to warrant formal investigation and to assert that the outcome might make a valuable contribution to knowledge not least by confirming or refuting the myth that is summed up in the hypothesis:-

> **Teamwork as practiced in case conferences makes a very limited contribution to the outcome of care, and does not respect the need for efficiency and effectiveness.**

Before proceeding to the methodology it was considered a valuable discipline to clarify the perception of 'teamwork' by recourse to available literature, and to acknowledge by a brief resume some of the areas which support and perpetuate the practice of teamwork in health, in social services and in collaboration between agencies. This is contained in chapters two and three.

Having provided an overview of the structure and mechanisms for teamwork, a methodology is developed in chapter 4, which permits the exploration of teamwork in practice, the analysis of which follows, and is concluded with a small scale study of outcomes based on interview, survey of needs and provision of services in the community.

CHAPTER II

Perceptions of Teamwork

- from the literature

Chapter II

Literature Review -

this was addressed to three areas:

a) the theoretical concept of teamwork,

b) the practice of teamwork in health and personal social services,

c) research methods.

Background material on the theoretical concept was readily available. Found mainly in the behavioural and psychological reviews from the early 1960's to the present time. This is referred to throughout the thesis.

Material relating particularly to health and social services was less easy to find. A computer search was initiated using the following terms:-

Welfare/Social Services; Health/Services; Care Agencies/Child; Care/Day; Care; Centres Health/Social; Care Delivery/Team; Teamwork; Case; Conference; Review/Health; Team; Conference; Clinical; Team/management; Multi-disciplinary combined; Group; Dynamic; Professional Participation.

Fiftyeight references were obtained in the search of which only four were relevant. Personal contact was then made to governing bodies of care agencies involved in the dissemination of information eg. *CCETSWA, BASW, Royal Colleges, Kings Fund. Staff at these agencies were most helpful. It was sad to discover much unpublished or uncirculated work from which all carers could benefit. A better cataloging and sharing of literature for health and social services would be valuable.

For completeness the computer bibliography is contained in Appendix 2.

Research Methods -

The sources of most benefit were Fox, Polit and Hungler, Bales, and Lalean, these complemented the formal research methodology course undertaken by all doctoral students at the University of Aston. (15), (16), (17), (18).

*

CCETSWA	-	Council for Education and Training in Social Work
BASW	-	British Association for Social Work
Royal Colleges	-	Chartered Colleges for Medical Specialisms
Kings Fund	-	Centre for Research and Development in Health Service Organisation (Royal Charter)

I

Perceptions of Teamwork - from the literature

Goldschmidt describes social interaction as "the very stuff of human life". He acknowledges that individuals in all societies move through life in terms of a continuous series of social interactions. It is the context of such encounters which, he claims, shape both the society and the individual. (19).

The intention here is not to enter into an involved anthropological debate, but merely to reflect on this premis as it may influence our disposition to group or team behaviour.

The inevitability of interaction in our existence may help to explain our penchant for working in teams or groups and our positive feelings about them.

Most discussion about teams and team function is found in the sociological and behavioural literature of the 1950's and 1960's and is not commonly oriented to the function of health or welfare teams. One of the more relevant literature reviews pertinent to health care, is that undertaken by Marshall, though this has little to do with the actual effects of teamwork on care practice. (20).

Some forms of 'Audit' have purported to evaluate the outcome of team activity, such as that described by Marsh in his evaluation of the change between triparte and multi-disciplinary team working in obstetric care. (21) Bozzone, comparing treatment teams to departmental working in a paediatric psychiatry unit in America reported significant differences in factors such as length of stay and the disposition of patients. There was however no conclusive evidence from which to ascribe the difference to 'teams' as an alternative form of work organisation. (22)

Christensen and Hingle, isolated 'teamness' as a variable in a study in which they report the effect of interprofessional nursing teams on health outcomes. (23) In their study they compare individual care given by a nurse covering a geographical area, with a team concept in which nursing skills were matched to the needs of a family. No significant difference was shown in terms of health status or outcome although the patients perceptions did differ. Such work, although inconclusive in respect of the effectiveness of teamwork, is relevant in the context of current health care thinking in the United Kingdom, where consideration is being given to the development of Neighbourhood Nursing teams. (24)

A cautionary note is offered by Kane, to those who would pursue an analysis of teamwork. (25) In her comprehensive monograph on interprofessional teamwork she meticulously reviews the philosophy and practice of teams. Summarising a vast collection of evidence on team composition and function, she concludes that the major and most common pitfalls which render evaluation meaningless, relate to the idiosyncratic nature of teams and their members.

The awareness gained from such literature has led the author to further study the various perceptions and definitions of teams and teamwork from which to identify certain characteristics presenting in the research population. Idiosyncratic behaviours are less easy to contain but an attempt has been made through selection of an appropriate research instrument, to specifically denote the behaviour of individuals within teams, thus acknowledging not denying their influence in the assessment of outcomes.

2. Definitions of Teams and Teamwork

The Oxford dictionary defines the word 'team' as:-

'a set of persons working together'

In common with Payne, the author finds this definition inadequate. Payne, chooses to use the description 'work group' to describe the situation where people are brought into relationships one with another by virtue of the fact that they work together to enhance the work that they are doing. (26)

Woodcock, defines a team as:-

"Individuals working together to accomplish more than they could alone." (27)

From the basic assumption that - a group is more than the sum of its parts - it is natural to assume that people working together will create more than those same people working on their own could achieve. Such an assertion may help to explain the mythical value afforded teamwork practice. There may be a relationship with the need to achieve and the potential for achievement offered by team working.

Other writers expand on this theme, as follows:-

- "A team is a group of people, each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to communicate, collaborate and consolidate knowledge from which plans are made, actions taken and future decisions influenced". Brill (28)

- "Ideally team working involves the definition of common goals and the development of a plan to which each member makes a different but complementary contribution towards the achievement of the teams aims." Hunt (29)

- "Teams are collections of people who must rely on group collaboration if each member is to experience the optimum success and goal achievement." Dyer (30)

Using the main elements of these definitions one is able to adequately describe the sort of collaborative team perceived as the subject of this research. It is a team which purports to have common goals and its members, whilst they retain personal and individual responsibilities, divide their work so as to maximise activities and ensure that they achieve those goals. The definition can be extended to 'teamwork' as the process of achievement; that is to say, what team members do in order to achieve their goals, acknowledging that the work may be undertaken by an individual, with appropriate skills, working for

and on behalf of the team. Collaborative teamwork requires a process for deciding on goals, a process for helping members fit in their personal skills and responsibilities and a process for dividing up and distributing the work - in the context of this research - the case conference.

There are of course a number of influences which determine the rate at which a team develops to the stage of defining and meeting goals. These include, the development of the individual team member, the goals of the agency concerned and of course with 'management' in its broadest sense. Not overlooking one of the influences mentioned in the introduction which was the influence of statute and policy upon the organisation as a whole and upon care practice in particular.

There are several schools of thought on the particular way in which teams develop. Tuckman and Brill envisage a rational or structured approach, which can be likened to group formation and the processes of **'forming'** (getting together), **'storming'** (fighting over territory in the group), **'norming'** (coming to general agreement on how the group should function), and **'performing'** (getting on with the work). Brill uses different words to those of Tuckman described above. Brill uses the terms orientation, accommodation, negotiation and operation. (31) and (op. cit, 28).

Woodcock, asserts that teams would often remain in an undeveloped stage were it not for outside influences, e.g. statutory obligations to be met, which force them through stages which he terms - experimenting, consolidating and finally maturity, often achieved by a somewhat incremental process. (op. cit, 27).

Payne, reviews alternative ideas which he refers to as the 'contingency' perspective. His view is that teams do develop sometimes through definable stages, but more commonly in response to pressures of some form. In his book he uses the example of

the transitional processes of a community team which changed in response to changes in the community it served. (32) Payne, also refers to the changes of individual team members in response to changes in their perception of other team members' roles.

Dominance within a team is a contentious issue. Horsley, suggests that dominance of one member works against team decisions and thus effectiveness. (33) Horwitz identifies both 'leader - centred' and what he describes as 'co-ordinative' teams, the former being leader dominant, the latter less so. The dominated team having a much greater control upon activity may well operate more purposefully and thus achieve more. (34) This was possibly the thinking adopted by 'Griffiths' when he introduced the concept of General Management into the National Health Service consensus team approach, in 1983. (op.cit. 6) However, the observations concluded herein do not entirely support Horwitz's philosophy.

There is a danger in over generalising from the behavioural literature, to the health and welfare perspective. The very hierarchical nature of these organisations often militates against any truly homogeneous team formation. In particular the battlefield of professional-vs-semi-professional persons is particularly prevalent in the public sector: Doctors being very much the archetypal profession, social work being in a very embryonic semi-professional state. Such factors may strongly influence team development.

Working harmoniously in a team depends so much on individual personalities - on a willingness to listen to the other members which requires a climate of trust and understanding. The now famous 'Hawthorne' studies describe very favourably the strong team approach where individuals adhere to common standards and loyalty within the team - in their example, working as a team

against management's best interests. (35) This of course was one particular type of team approach uncommon to the public sector. The nature of teamwork in the public sector is more the result of diversification or specialisation than of homogeneity of function. Webb, and Hobdell, suggest that different types of teams can be categorised using characteristics such as how heterogeneous or homogenous the group's skills or tasks are. Payne adapts Webb and Hobdells taxonomy to address health and welfare situations, as shown in figure 1. Overleaf. (36)

Webb and Hobdell, suggest that teamwork is intended to overcome specialisation by improving co-ordination and by using the advantages of labour. Specialisation, is concerned with skills and how they might be best integrated into a set of roles that a worker can carry out. The division of labour is concerned with the tasks to be done and differentiating between them in a sensible way so that they can be given out to the different specialist workers. The teamwork subject in this research falls into the category described as a complex heterogeneous team, typical of that formed as a consequence of specialisation. The effectiveness of teamwork in such consequences remains to be tested. Two external influences may determine the degree of success experienced by such a team. Firstly, the primary organisation may not share or understand the teams objectives, which can include, as Thomas and Warburton point out, different timescales and values between organisations and between individuals and teams within organisations. This can lead to conflict and lack of achievement. (37) Secondly, the existence and influence of formal or statutory relationships. Both of these factors exist within the research population. Where possible statutory influence has been minimised. The degree to which team objectives are shared or indeed 'teamwork' itself is

Figure 1

Taxonomy of Teams

Tasks (i.e. jobs the team must do)	Skills or roles (ie abilities of team members available to do jobs)	
	Homogeneous (members have similar abilities)	Heterogeneous (members have different abilities)
Homogeneous (jobs are rather similar)	Collegial team e.g. family practitioner team	Apprenticeship team e.g. social services team with different grades of staff
Heterongeneous (many varied jobs to be done)	Specialised collegial team e.g. SSD team with intake/long-term or social care/family-care specialisation	Complex team e.g. health centre team

Source: adapted from Webb and Hobdell (1980) (op. cit. 36)

valued within the structures is less easy to identify. Where the management system itself is unstable, it is less likely to establish objectives for other levels of the service. The next chapter attempts to portray the turbulence in the system which may influence the degree to which operational activity is monitored or directed.

CHAPTER III

Formalised Teamwork

1 In Health

1.2 In Social Services

1.3 In Collaboration

CHAPTER III

Formalised Teamwork

1. In Health

Teamwork in Management

One of the major thrusts towards formal teamwork came in the National Health Service Management re-organisation of 1974. (op.cit.,4). The primary aim of the re-organisation was to provide a fully integrated, patient centred Health Service in which every aspect of health care could be provided by members of health care professions integrally involved in planning and management at all levels.

Prior to 1974, the National Health Service had lacked a cohesive planning strategy involving all disciplines. Decision making was, for the most part, a matter for members of Health Authorities or committees with considerable influence being exercised by the 'administrator' in his capacity as Secretary to the Authority.

Team management and consensus decision making were seen in 1974 as being the solution to the problem of integrating a multifacited, increasingly specialised organisation. As suggested earlier, support for the team approach may be in-bred - the solution therefore being less than objective.

Five key principles were identified:-

a) The health-care professions should be integrally involved in planning and management at all levels. This involvement must be achieved without infringing the clinical autonomy of medical and dental consultants and general practitioners and without interfering with the professional standards of the health-care professions or inhibiting the exercise of professional judgement by members of those professions.

b) Responsibilities must be clearly defined and allocated. This applies both to the responsibilities of Regional Health Authorities and Area Health Authorities and the relationships between them and to the responsibilities of officers of Regional Health Authorities and Area Health Authorities and their decision-making discretion. It should be clearly established for what duties an officer will be accountable and to whom.

c) There should be maximum decentralisation and delegation of decision-making, but within policies established at National, Regional and Area levels.

d) Higher organisation must be designed to provide policies within which local services can be managed effectively. Higher levels of management should therefore agree objectives with lower levels as the basis for delegating authority and for monitoring perfomrance.

e) Delegation downwards should be matched with accountability upwards." (38) also (op. cit. 4)

Thus District Management Team members were jointly responsible and bound by team decisions.

The District Management Team was described in the re-organisation document as:

> "a group of equals, no member being managerially superior to another .... sharing jointly responsibility .... ensuring that interdisciplinary issues are resolved within the team. In resolving such issues the team will act as a consensus forming group i.e. no decisions can be taken that over-ride the opposition of a team member". (op.cit., 4).

In retrospect, it was somewhat remarkable that the Government of the day was prepared to take the risk of entrusting the future management of such a massive enterprise as the British National Health Service to such a relatively untried and untested management practice. It was at the time a source of considerable puzzlement to observers outside the National Health Service, as to how effective decision making could be possible adopting such an approach. Even now, team management operated on a consensus basis, is observed with some wonderment.

One of the major difficulties was that multi-disciplinary team members were by definition from diverse backgrounds - having differing responsibilities and perceptions including perceptions of what the Health Service is for. Nevertheless teams emerged as required at various levels to foster the new style of management thinking in both operational and strategic management. A

daunting task for everyone not least for the chief officers, whose responsibility it became to recommend policy and practice to fellow members of the District Management Team who were primarily professional equals and each of whom previously operated with a high degree of autonomy, in a relatively specialised field.

An example would be that of the Treasurer whose principal responsibility became that of advice and co-ordination of Teams of Officers on all financial aspects of the 'Teams' work. This included assisting with the allocation of resources, preparation of planning guidelines and the provision of information to 'Teams' on financial performance. The challenge was not only in convincing a relatively uninformed group as to appropriate financial strategy but also in being able to accept their criticism of such recommendations - this was rarely an issue with the previous experienced finance sub-committee arrangement of Health Authorities.

Energies were very much concentrated on making the management team work - the principles of objective setting for delegation was a secondary consideration - operational teams struggled on, often uninfluenced by the change.

There was an emphasis at the time on the need for multi-disciplinary training. Ironically, for all the emphasis on 'teamwork', most of the available training addressed itself to management techniques rather than behavioural aspects such as team building. The use of 'T Groups' and team training was a rare exception. Overall officers were ill equipped with the skills and knowledge required to undertake and operate in their new roles.

Working harmoniously in team management depends so much on individual personalities - on a willingness to listen to the other members of the team, this requires trust and understanding. In the early days of the 1974 re-organisation members of management teams often had no appointed support staff to their new role and found themselves in difficulty, trying to contain their professional function and their team function effectively. They had little time to prepare and read papers for team meetings, thus decisions were made or worse still delayed in a state of ignorance. Without a firm knowledge base it was difficult for any of them to endear the others' trust and confidence. One of the major issues was each officer's coming to understand the perceptions and experience of the other - to say nothing of the structures and anomalies which operated within each profession.

As the years passed officers learned to overcome their problems by the development of support staff roles and by learning to delegate within their specialist function.

Officers who experienced these times say that they learned a great deal about each other and about the Health Service in the widest possible sense. A treasurer once wrote:

> "I feel on reflection that I have gained a much greater understanding on health service problems through team membership than I could have hoped to achieve otherwise - to return now to operate exclusively in the more technical world of National Health Service accounting would be be unattractive". (39)

D. Wild

In the years between 1972 and 1982 progress was un-doubtedly made, in relation to integration of the management mechanisms. Planning and policy making became interwoven with the quest for cost effectiveness and budgetary controls. On the one hand there was greater recognition and understanding of the need for cost controls, whilst financial management began to adopt a much broader perspective, recognising more fully health care demands and priorities from the perspective of clinical practice. A team spirit emerged, albeit still very introspective and limited in its vision and influence over basic operational activity and objectives.

There developed an increasing tide of criticism levelled at the National Health Service consensus team approach. Observers claimed that in multi-disciplinary decision-making, tough decisions were avoided and that in a profit making environment much more unpleasant decisions would need to be taken and with greater speed. A further re-organisation emerged (Health Circular HC(82)2) as a response to such criticism, hoping to salvage the best of consensus whilst seeking to sharpen up decision-making and achieve a service more responsive to the community it served. (40)

Unlike the previous 'funded' re-organisation, the 1982 model was implemented within a ten percent reduction in management costs. The soul searching went on to determine which discipline could absorb the cuts and there were inevitably casualties - many experienced and knowledgeable staff were lost. Teamwork was shaken but survived. A tier of management was removed - the 'Area' tier which often served four or five Health Districts; each District became self-sufficient, in effect a Single District Area. Unit teams of a senior Nurse, Doctor and Administrator were established, to whom much more responsibility was delegated. A unit was commonly synonymous with a group of like specialities e.g. elderly care, acute services or primary care. Certain

difficulties did arise, for example, where there was a single nurse representative at unit level representing specialties contained in that unit but for which he/she was not professionally accountable e.g. midwifery in an acute (general hospital services) unit.

Despite the hopes that the new service would be more effective with a simplified management structure, it seemed that even before the wounds were healed from the 1982 experience, judgement was passed that the required efficiency had not been achieved. The problem was identified as being the team management approach - the solution 'General Management' expounded in the document Health Circular (HC(83)13) commonly known as the 'Griffiths' report. (op. cit. 6).

To those working in the service the judgement seemed harsh. Unit teams had begun to come to terms with the increased responsibility and in dividing accountability not to District but through unit officers. Operational planning was evolving, unit priorities were being determined which themselves reflected better the District Strategy - or long-term plan - but one difficulty remained - effective teamwork, as described in Chapter I, requires the definition of common goals and the development of a plan to which each member makes a different but complementary contribution towards achievement of the team's aims. The team situation created by the structural arrangements of the National Health Service, was hardly conducive to such ideals. Rarely was a team totally in control of its own destiny. All too frequently team decision taking was pre-empted by Government edict - which made a nonsense of setting priorities and the planning system in general. Some would say that this is the inevitable consequence of being a service funded through general taxation. Interestingly, Government intervention is equally likely to impinge upon the "General Management" function as it has upon "Team Management", presenting similar difficulties for planning

and achievement of targets. Examples are already emerging in relation to spending targets and the continued thrust towards care in the community which is not always the cheapest or indeed the most caring option for service delivery. "Griffiths" style management does not entirely do away with the team concept, but aims to ensure, through the designation of one responsible individual, the achievement of efficient and effective decision and action - in effect sharpening the process of decision taking.

Much research has been undertaken with regard to management team development, by organisations such as the Kings Fund and the Health Service Management Centres. Whilst it has not been directly acknowledged in the "Griffiths" strategy, one can hope that Unit General Managers will learn and retain the better aspects of team management, described in such research as the HSMC (Birmingham) investigation into Unit Management Teams (41) or the Kings Fund report from Workshops on Unit Management (42).

2. In Social Services

Personal Social Services development in the United Kingdom owes less to the poor law reforms, to which it is often accredited, and more to the changes experienced by a post-war society. Titmuss has succinctly documented his observation of changes in our society following the Second World War. These include, the equalising effect which the war had on all classes in society, the demands of physical fitness required to endure the war and its aftermath, and changing attitudes to social problems. (43)

Of particular significance were the changing attitudes. Social problems such as unemployment or handicap came to be seen in their social context, rather than as problems of the individual.

The result of these changes was an emphasis on caring within the community and dealing with problems where they arose, rather than withdrawing the individual to some form of institutional care.

In response to these changes, Social Work teams emerged in the 1950s and 1960s operating within one of three distinctly separate types of social work. Social Workers were employed in hospitals, clinics and prisons, and as a consequence most medical and psychiatric social workers were to be found within large medical institutions. Secondly, mental welfare officers, where they generally worked with medical practitioners - as a consequence of which, this group lacked any clear professional identity. Thirdly, child care officers who were also employed by local authorities but, unlike welfare officers, had a strong professional identity. This last group being the one with which today's social workers readily identify. Whereas much of the social work practice emanated from care of the mentally ill, there were at this time, increasing demands for support of the long term chronic sick and disabled, the burden of their care

falling increasingly upon social services, neighbourhoods and families, from which a movement built up which called for radical changes in welfare service. There were two schools of thought at the time, one which called for a family service to be created by enlarging the existing childrens' departments. The other, which followed the recommendations of the committees chaired by Ingelby and Younghusband, which felt the 'family service' notion to be too narrowly conceived and called for the integration of all social services into a single department. (44)

Finally, Social Services departments of local authorities in England and Wales came gradually into existence in 1970 and 1971, following the recommendations of the Seebohm Report of 1968. (op.cit. 10). Although the recommendations of 'Seebohm' ambitiously portrayed plans for a fully comprehensive social services, the subsequent legislation was far more stilted. It did, however, include provision for:-

a. the appointment of special committees in each local authority, to be concerned wholly and solely with social service matters.

b. the appointment of a Director of Social Services, again, wholly and solely concerned with social services. (NB. No joint appointments of Medical Officer of Health/Director of Social Services would be accepted - thus Directors would be immediately and solely accountable to Social Services' committees).

c. the appointment of Directors to be subject to the Secretary of State's scrutiny on appointment and veto.

In essence, the legislation gathered under one roof the personal social services carried out in health, welfare and children's departments. It did not, unfortunately, refer to social work carried out in education, housing and hospitals, although it did require the latter to be transferred to the employ of local authorities; neither did it include arrangements for the probation service.

Directors of Social Services found themselves at the head of departments employing many hundreds, or in the case of the largest departments, some thousands, of staff. These include child care officers, welfare workers and mental health workers; the staff of various homes and hostels for children, the old, the mentally disturbed and the handicapped; the staff of various day centres and nurseries: large numbers of home helps and large numbers of supporting administrative and clerical staff. To help co-ordinate and manage this diverse empire, a new range of assistant directors and advisors were appointed to head up administrative teams. A teamwork approach was a natural response to the challenge of creating order within such complexity. Despite the fact that collectively the integration of services brought a considerable wealth of practical knowledge and experience together, only a small proportion of staff had any formal qualification in social work - in 1974 the Council for Education and Training in Social Work (CETSWA) reported that only 40% of field workers were qualified and only 4% of residential staff had any type of formal training.

Since the early seventies, the task of providing education and training in the various aspects of social work has been taken in hand, firstly, by the provision of a certificated course and, more recently, at Diploma, Degree and Post Graduate level, all of this being monitored by the Council for Education and Training in Social Work administration, which in 1984 established a central inspectorate for the evaluation of working practices, including aspects of general and specialist training.

The most recent development in education is the consideration being given to joint training initiatives between health and social services, at least at basic programme level. The potential which this offers, for fostering good teamwork, is an exciting prospect.

The nature of social work, its tasks and function being particularly diverse, means that its management requires a structure which not only allows for effective co-ordination of the different components but one which is sensitive to the need for a high degree of autonomy in service delivery.

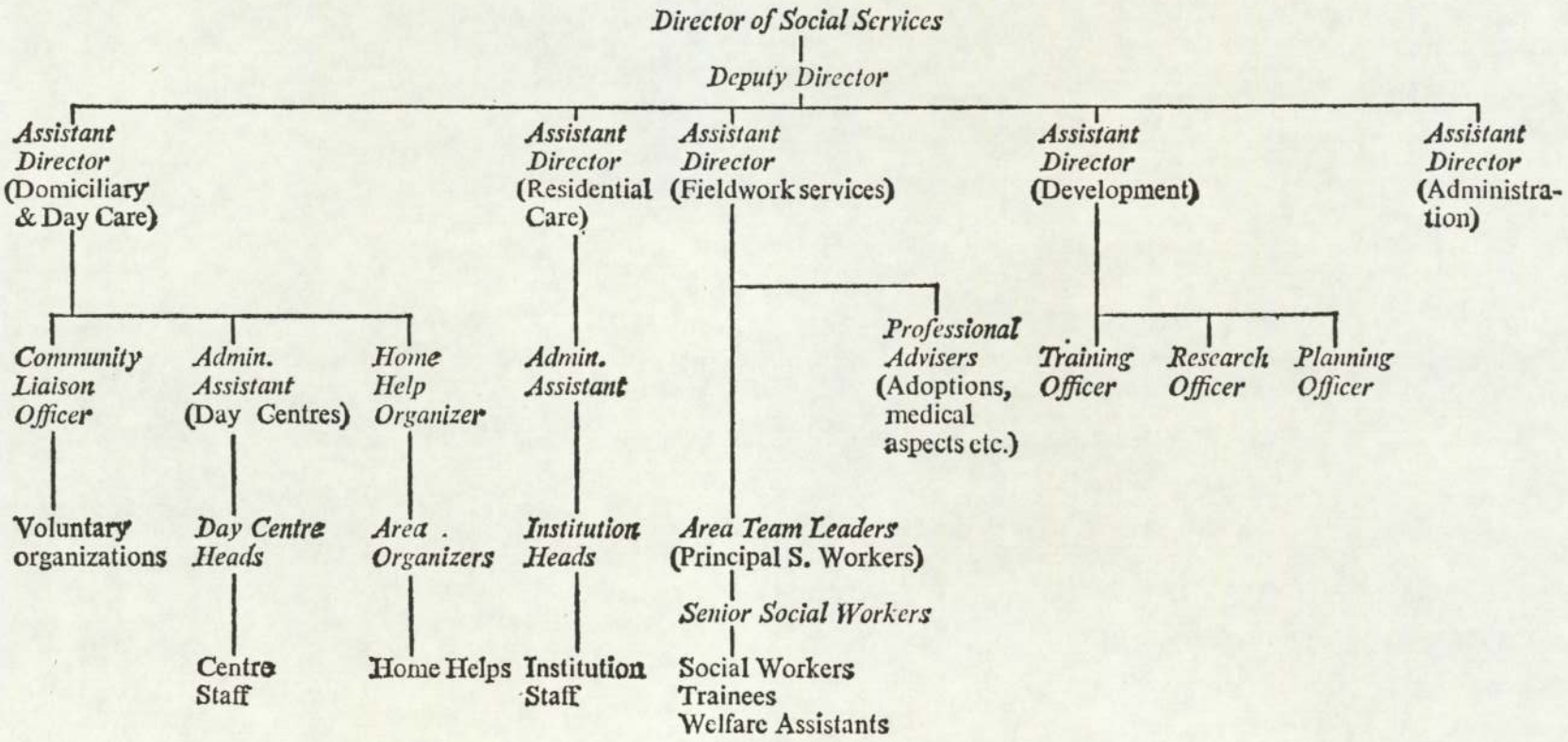
The most common structure adopted by large social work agencies is a modified hierarchical approach. In such a structure natural teams can be identified as evident in Fig. 2. (page 48).

This approach is not without its problems. The identified team leader - linkpin - will have to relate to two groups whose perspective may conflict with one another. Secondly, it is the structure which tends to define the leader, who may not be the best suited to that role. Collaboration and communication between teams in the hierarchy can be difficult, where conflicting management styles are adopted; this is particularly noticeable between autocratic and democratic leadership.

The orientation of the social work teams differs from authority to authority. Some will be of a functional orientation - child welfare - mental health etc., others will be generic teams defined on a geographic basis. Supervision within teams is a contentious issue related to the basic propriety of the supervision of fieldworkers. There are frequent claims for the needs of 'due professional independence'. In reality rather than explicit autonomy, professional social workers usually operate

Figure 2

Organization of a Social Service Department



Source - City of Birmingham
Social Services Department

within limits of 'delegated discretion'. Within the internal social work structure 'delegate discretion' may well suffice. Where social workers function in a multi professional setting this can conflict with others who practise autonomously such as doctors, who often become frustrated with the sanctions operated within social work. This issue is effectively explored by Butrym and Horder (45).

In contrast to health care, teamwork is more explicit in the organisational framework of social services. One could contend that this is a consequence of social services being a sub-section of Local Government and were it a centrally controlled agency it's design would differ.

Two, somewhat overlapping divisions can be made within social services organisation. Firstly, into teams which are mainly working with individuals, families and groups of clients formed for the purpose of social work intervention (social work teams) and those which are responsible for work with naturally occurring groups in the community (community work teams). Secondly, into teams which exist in primary settings, where social work may or may not be the main purpose of the agency.

The social work team category and primary setting category include most of the major social service agencies; the area teams of social service departments, teams in all kinds of residential and day care centres, and most teams in probation and after care, and many teams in the voluntary sector which have a client orientation. Such teams have advantages for the development of teamwork. The main purpose of the organisation (and the main direction of its activities) is social service, so expectations from outside the team should be similar to the desires of the team members, or at least easily brought into line. Moreover, social work teams and primary setting teams are dealing with a

work group whose prime staff are social workers and other staff are mainly ancillary to social workers or of inferior status, so that inter-disciplinary and status issues are less problematic. (This is not the case as described within health care).

Importantly the lack of inter-disciplinary struggles within the social work setting renders staff ill-prepared to cope with the very sensitive inter-disciplinary /inter-professional issues which emerge in the joint health and social care team. Similarly social workers who are 'senior' within their own organisation at every level in the hierarchy may find their inflicted subordinate status within the health care domain, hard to bear. Where social workers are influential within their own teams, external constraints, such as those imposed by the courts on the probation and after care setting, by Local Government on Social Service departments and by finance and voluntary agencies, can seem more intractable because they cannot be dealt with inside the team.

Greater difficulties for teamwork are to be found in the community work team, or a team with some community work element as in the secondary setting team, similar to that mentioned earlier in the relationship with the health care team. The primary organisation may not share similar status principles or the system of organisation may not be appropriate. A more common and difficult problem arises where the primary organisation does not share or understand their objectives. Thomas and Warburton, in his study of community workers in social services departments identified all of these traits. Staff neither shared nor attempted to understand or support their community work colleagues, they shared neither values nor objectives, and much frustration was caused by their operating on different timescales of their work. (op. cit. 37). Community work often suffers a similar conflict of interests with the public it serves. Powerful groups in society often have differing values and objectives which do not meet with those of the community work team.

In the care context problems are faced in residential homes, particularly for the elderly, where the individual's quest for privacy and independent living often is confronted by the operational consequence of communal activity.

Payne queries whether, as there is no clear dividing line between the community work team and the public it works with, can it really claim to be a team?. (op. cit., 26).

Where such conflict exists the question must arise - should the principles of the individual work group be adhered to and they retain a separate identity?, or should they merge to form a multi-disciplinary group? If the latter, they may be viewed, as Hey suggests -

> "part of a looser network of workers rather than a team". (46).

The significance of this background to the present study emerges in both its behavioural and organisational context. Despite the assertion of both health and social workers that their major concern is with the patient, the character and organisation of each group differs so greatly that it can contribute to breakdown in effective working (op.cit. 36). Whilst this is often associated with the fundamental differences of control by central or local government, professional differences also play a part.

Social work as an emergent profession commands less readily the general respect afforded the long established medical profession (47) - this leads to disharmony (48),(49). The organisational

isolation from the health service, emanating from the 'Seebohm' approach detracts from natural commitment to shared ideals and common goals. Further, it requires the imposition of ancillary mechanisms to effect collaboration. Isolation has been furthered by successive changes in health care organisation, in particular those of geographical boundaries.

Concentration upon organisational issues in both health and welfare services one may assert, has by default supported the unquestioned acceptance of adequacy in other areas. Thus custom and practice prevails however bad or unproven that practice.

In conclusion there are many issues which arise from this, such as those concerned with the value of professional status; the implications for the organisation and potential for re-organisation. One could rehearse the debates for local and centralised controls or coterminosity of boundaries. The constraints upon this study limit the opportunity to consider these in detail. Certain of the broader issues are considered in the following section, recognising that this can in no way do justice to the full debate. This study concentrates particularly on the issue of outcome, the degree to which patient's needs are identified and met through teamwork. The issues raised here are simply to give a contextual framework to the study, its limitations are recognised.

3. In Collaboration

The purpose of this section is to provide some background to the organisational context of collaborative teamwork in health and personal social services, and to review certain factors which influence inter-agency teamwork in practice.

It is hoped that with this insight observations of the teamwork situation can be viewed from the broadest possible perspective and any conclusions made with vision and reality.

In the documentation introducing the objective of the 1974 Health Service Reorganisation it is stated:-

> "Management plays only a subsidiary part, but the way in which the service is organised and the processes used in directing resources can help or hinder the people who play the primary part". (op. cit., 4.)

Hicks quotes Chester I Barnard as saying:-

> "An organisation is a system of co-operative human activities". (50).

No element of an organisation can exist in isolation. The complexity of health and social services organisations often detracts from individuals coming to terms with elements of the organisation outside their immediate area of practice. To be truely effective, such barriers must be overcome. For this reason it is seen as important to ensure that teamwork practice is seen in its context within its organisation, but also recognising the influence of the organisation on individual effectiveness within and outside the team.

Teamwork and Collaboration

The need for effective collaboration arises from both organisational and human necessity. The organisation seeks collaboration, primarily, to ensure efficient use of resources and to avoid duplication in service. Human necessity is more complex. It involves behavioural aspects of work and wellbeing of those within the organisation described concisely by Warr and Wall. (51). More importantly, it concerns the patient and the need for the professionals to address themselves to the patient as an individual, as a family member and as a member of the society in which he lives. It is this recognition which determines most succinctly the coalition between health and personal social services. The degree, to which such a coalition is successful, is in the hands of the professional carers and those who organise, plan and manage the services.

Ideologies - Harmony and Conflict

The origins of health care and social work lie, for the most part in humanitarian ethics derived from religion, and empirical observation sifted by experience. This gives them an important shared base.

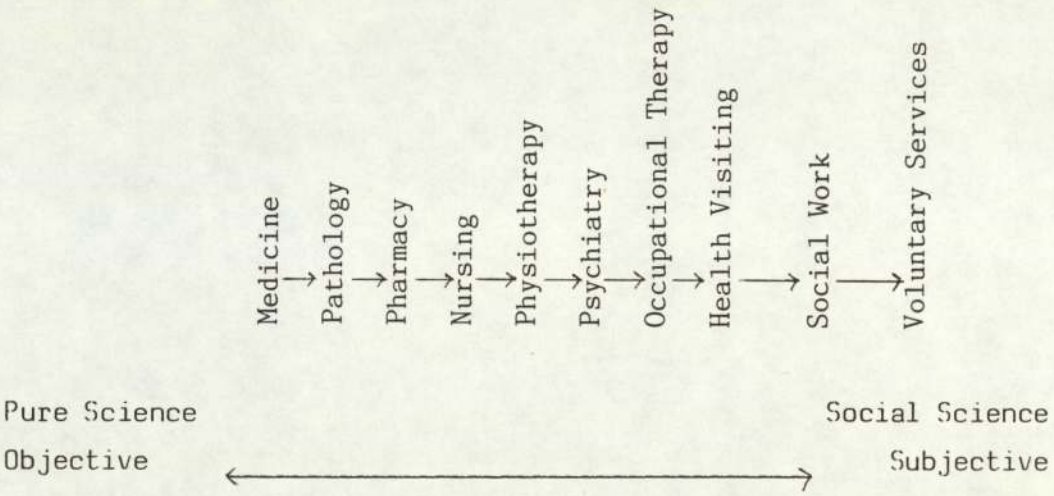
The major difference between medicine and social work rests on the use of science, that is, the extent of the adaption of a rigorous intellectual approach based on the demand that ideas be capable of proof and verification.

Medicine can be viewed as lying at one end of a continuum, having developed over the past three centuries to a high degree of scientific respectability. This contrasts dramatically with the relatively new profession of social work, which is based largely in social science and relies heavily on subjective assessment - the other end of the continuum.

Nursing and the paramedical profession, enter at various stages along the continuum according to their technical orientation and scientific base. Fig. 3. Nursing which has been particularly dominated by medicine - is now developing its own natural body of technical research based knowledge and as a result the medical domination is becoming less apparent.

Continuum of Professionalism

Fig. 3



Garrard argues that it is the difference in status of the knowledge base in the two extremes which has been a major factor in the problems of communication and collaboration between the health and social services. (52). Butrym and Horder describe this in terms of 'The Medical Model' and the 'Social Assessment Model'. They describe the Medical Model as follows:-

> "Under the influence of the physical and pathological sciences an effective but narrow approach has come to

dominate much of medical consultation, aimed above all at achieving a 'diagnosis' which can be stated in one or two words, classified, related to morbidity changes which can be demonstrated in life or after death by objective tasks and which points the ways of management aimed at cure". (op.cit. 45).

- this is 'the medical model'.

The social assessment model, in contrast, shows a striking lack of precision which serves only to reinforce the dominance of the medical model. For many years such diversity has influenced attitudes and perceptions, practical experience has served to reinforce these. In more recent times the influence of psychological, economic and social aspects of health and disease have become more widely acknowledged among the health care professions. This appears to have created a more receptive attitude between the disciplines, in particular between medicine and social work. Ironically one could argue that the past problem of indifference, derived from separate concerns and perspectives may be replaced by the problem of rivalry resulting from much shared ground. To some extent this has happened already between social work and health visiting. Whether or not this extends further will depend on the degree of realisation by all concerned that their contributions are complementary and that the effectiveness of their help to patients will increasingly depend on their success in establishing effective collaboration. To do this, there will have to be considerable adaptions. All groups involved will have to become more ready to give and receive in a relationship of mutual respect, trust and sharing - a true team.

There is no easy way to achieving successful collaboration between the professions. It can only come about gradually from the experience of working together and thus learning at first hand each other's strengths and limitations, and what benefits can accrue to patients from such teamwork. An important feature is a shared 'service orientation' which puts the needs of the patient before any vested interests of a personal or professional nature. Ethics and codes of practice would support this. Joint opportunities for study are also important. Discussions have taken place with regard to integrating elements of social work and nurse training, similarly between medicine and nursing. There is great potential to be exploited in shared learning, not least from an economic perspective. The desirability of integrated training is confirmed by Hannay's study of community health. Based on his research evidence Hannay speculates that:-

> "if medical and social symptoms were viewed as a continuous spectrum of maladaption, then the services concerned would best be conceived as a coherent entity". (53)

Organisational Perspective

The issue of integrating the services to form a coherent entity is not new. Before the introduction of the National Health Service in 1948 most hospitals, and a number of other health services, were provided by local authorities. After the inception of the National Health Service the arrangement was reversed but still attracted attention. The possibility of transferring the hospital service to local authorities was reconsidered and rejected by the Guilleband Committee in 1956, although Sir John Maude, a member of the Committee, held reservations and stated that personally he looked forward to the day when a reorganised Local Government would assume

responsibility for a unified National Health Service. (54). Thirteen years later, the Royal Commission on Local Government, England, envisaged the transfer of the National Health Service to a reorganised Local Government. (55). The Government of the day rejected this recommentation. Mr. R.H.S. Crossman's Green Paper, published in 1970, which preceded National Health Service reorganisation, concluded:-

> "that the unified National Health Service cannot be directly or indirectly controlled by local authorities, and that special area health authorities must be established to administer it". (56).

Despite the fact that local authority control had been rejected more than once, evidence submitted to the Royal Commission on the National Health Service continued to support it. The evidence both for transfer of the National Health Service to local government and of social services to the National Health Service was considered most carefully. In the first case they quoted comment from the 1970 Green Paper.

> "First, the professions believe that only a service administered by special bodies on which the professions are represented can provide a proper assurance of clinical freedom. Secondly, independent financial resources available to local authorities are not sufficient to enable them to take over responsibility for the whole health service". (op.cit., 56).

The British Medical Association giving evidence, were in support of transferring the Personal Social Services to the National Health Service; their statement read:-

"The administration of the health and personal social services should be functionally re-integrated. This is particularly important in those areas - care of the elderly, the mentally ill, handicapped and those requiring after care - where health and social workers are dealing with the same person". (op.cit., 1).

The Royal College of Nursing and National Union of Public Employees supported this view and it was noted that there was a precedent for it in Northern Ireland, where since 1973 the services had been integrated.

An alternative proposition was the transfer of client groups, to one or other body, whichever the more appropriate.* Problems of definition and multiple pathology made this untenable. In conclusion, the Royal Commission chose to endorse the Personal Social Services Council views and finally recommended that:-

a) before any collaboration begins, its purpose, form and resource implications should be identified with the different agencies and professions involved.

b) the Northern Ireland development should be encouraged.

c) there should be more emphasis on the education and continuing training of health and social work professionals on the importance of inter-professional collaboration.

d) there should be no radical change in the responsibilities of health or personal social services.

(op.cit. 1 pp.268)

* This possibility is currently being reviewed by Sir Roy Griffiths, his report to the Government is due in Spring 1988.

These are of course only four out of the one hundred or so recommendations made by the Royal Commission. They were among the many issues taken up by the Government, some of which were adopted in their thinking published in the consultative document on restructuring entitled "Patients First". There was much emphasis in the document, on the need for closer working between Health and Local Authority departments. In his leader Patrick Jenkins wrote:-

> "The National Health Service is only one part of our welfare service. Families may need help from the services of local government - the social services, education and housing. We attach high importance to the National Health Service working together with these services, but we have come to the conclusion that this does not necessarily mean that they need to do this within common administrative boundaries. What is necessary, and what will, we know, be readily forthcoming, is the will to work together". (57).

Coterminosity of boundaries was acknowledged as desirable; emphasis was placed on liaison by designated individuals, such as school nurses, and provision was made for there to be four local authority representatives on each District Health Authority. Importance was placed on the need for effective collaboration and authorities were required to detail proposals for ensuring this within the restructuring not least in the administration of joint financed projects. A joint consultative committee structure was to be retained with improvement in terms of reference and greater emphasis on co-ordination.

Many observers believed that the 'Patients First' proposals would impede collaboration and perpetuate the worst aspects of existing team working and an unfavourable press developed. (58) (59).

Eventually the DHSS acknowledged this possibility, which was supported by a variety of anecdotal evidence. (60). Smith, for example, writing in the Health and Social Services Journal claimed evidence that joint planning had virtually come to a standstill. (61).

The DHSS commissioned an investigation which was conducted jointly by the Centre of Social Policy Research - Loughborough and the National Association of Health Authorities. The first report published in 1986, outlines the arrangements which health and local authorities have, in practice, developed to meet the structural context for collaboration. (62). It reviews collaboration at member level, officer level and in joint finance. The survey data does not support the assumption that complex structures increase barriers to joint planning. It notes for example the continued progress in certain joint finance initiatives. It does however report a marked slowing up of the system, particularly in respect of 'Care in the Community'. The survey made observation on the response to joint arrangements where coterminosity of boundaries existed and where it did not. The evidence received confirmed the view that coterminosity was not necessarily associated with a better record of collaboration. It recognised that variations in structure was only one of a wide range of variables which affected the degree and quality of inter-authority planning. They gave examples such as differences in service stocks, financial resources, professional viewpoints, personality factors, need and expressed demand, all of which it was considered may act as barriers to - or opportunities for - collaborative working. They suggest:

> "It is the interaction of these factors alongside formal structures which determines policy outcome". (op. cit, 62).

It is at this point that the main interface between formal collaborative working and the working described as teamwork in the context of this research is both at its most intimate and yet dichotomous, each being influenced by the same factors, yet the present review of teamwork identifying a lack of tangible sense of direction shared with commitment by all participants - an absence of collective policy outcome.

One might suggest that a lack of coherent policy, stated objectives or some intended purpose provides the perfect medium for self-motivated leaders to emerge. It is difficult to understand why then the leaders emerging in this study are always of the same discipline. Could it be that experience, custom and practice has far greater influence on our behaviour than for example our goal objectives?. This is reason enough to explore further. If the influence of experience is so strong practice will be difficult to improve and to change.

Importantly at a time when the services are awaiting the outcome of yet another review (the Griffiths evaluation of Primary Care and Local Authority services) it is wholly appropriate to bring to the fore issues which have previously gone on unnoticed in the turmoil of change - yet issues which are fundamental to service operation - such is the subject of this research.

PART II

Research Projects

CHAPTER IV

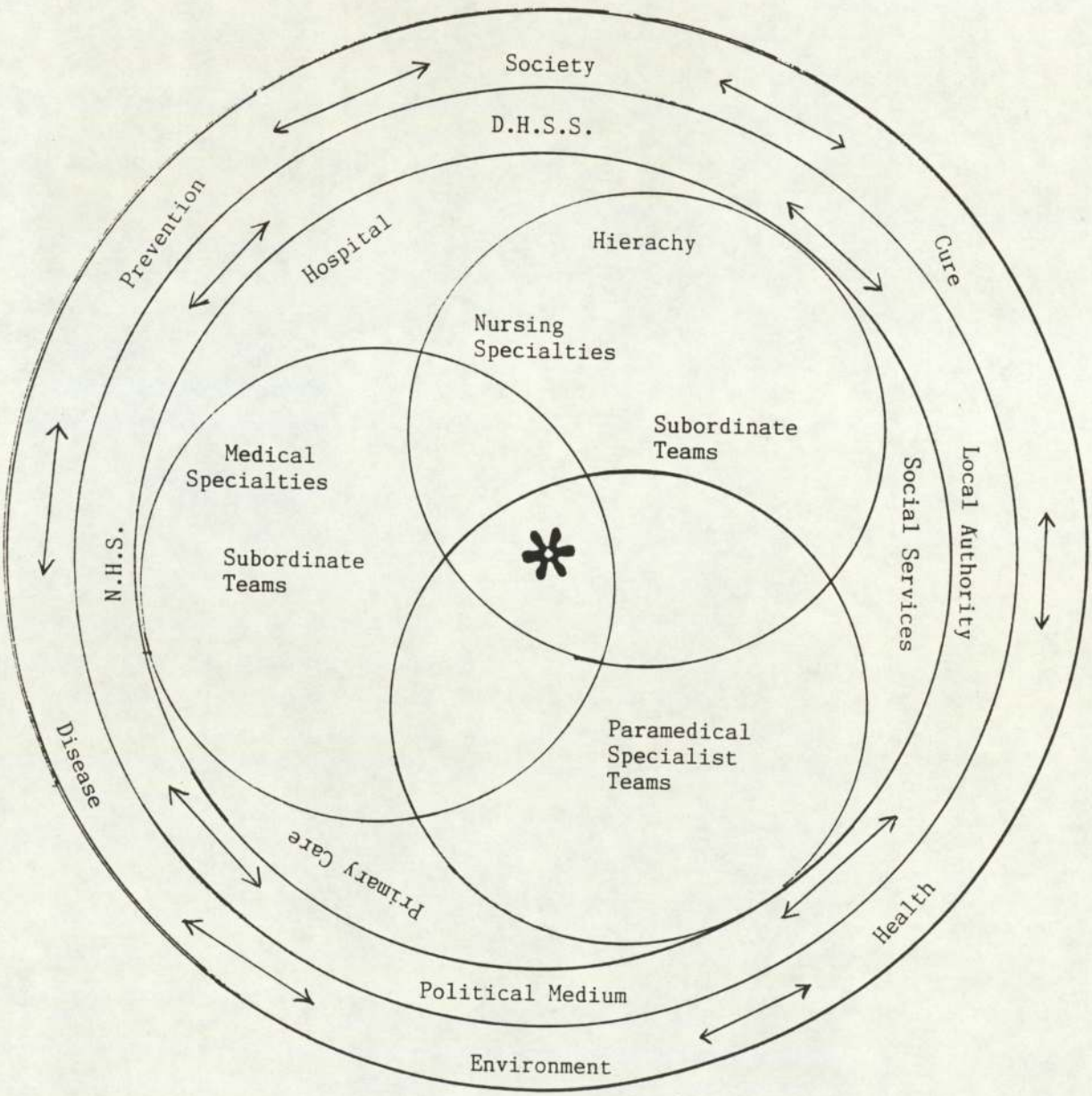
Research project -

Section I	Development and Methodology i
Section II	An Observational Study of Teamwork
Section III	Development and Methodology ii
Section IV	A Study of Outcomes

Teamwork Model

The previous chapters contribute to the description of a model which is devised to portray the nature and complexity of teamwork among the caring agencies.

Fig 4.



The Patient/Client

The model was contrived as a reflection of the description of teamwork elicited from the literature and from personal experience of working in health and welfare teams. It seeks to portray the multifarious composition of the team, which must be responsive to the influences of nature the outcome of disease process, the means available for prevention or cure, societial and epidemiological factors, the prevailing Political/political and economic climate, the individuals operating therein, and the environment in which teamwork takes place. The patient remaining central throughout.

Observation of teamwork and different types of teams indicates that the greatest barriers to effective teamwork are not ignorance, uncertainty about roles or the way in which teams are structured, but rather those due to professionals perception of the world and of the balance of power between professional groups and between professionals and their patients/clients. Webb, suggests that this is a fundamental issue which gives rise to questions about the importance of teamwork as only one of the many ways of improving the provision of care. (63).

Spitzer and Roberts pose twelve questions about teams in the health services, which they distill into one:-

> "are people better off when they are cared for by teams rather than by individuals"? (64).

The model of teamwork presented attempts to encapsulate the whole array of sensitivities which influence teamwork and its outcome.

From observation of the activity generated it is hoped that, if only in a limited context, scientifically admissible evidence will be produced, which goes some way to answering Spitzer and Roberts' question. In doing so identifying a substantial challenge to custom and practice.

During the process of study the model has acted as a reference point, a discipline to ensure that:

a) the work was comprehensive, and

b) that whatever change in direction was taken the overall frame of reference was constant.

The model served as a basis to construct the research design, in such a way as to examine each aspect of the 'teamwork' scenario confronted by the research hypothesis.

Research Hypothesis -

this is derived to reflect the circumstances considered in Section One and to address the stated research purpose.

Teamwork as practiced in case conferences, makes a limited contribution to the outcome of care and does not respect the need for efficiency and effectiveness.

Main Assumptions

At this stage it is felt necessary to share assumptions explicity, not only in the research activity, but in determining an appropriate methodology. Firstly assumptions are made as to a common understanding of the terms - team and case conference.

1) Team

The conceptual definition of 'teams and teamwork' is explored in Chapter III. The functional definition assumed for the study ascribes largeley to the general concept. One must state, however, that care practitioners may not share the concept and may not view the 'case conference' as a team situation, although may well identify themselves as members of other 'teams'. It is not considered that this in any way detracts from the research purpose or outcome. The individuals perception of teamwork is recorded independently of the interaction study on case conferences. It is the nature of interaction which is observed not the degree to which personal perceptions or prejudices influence the individuals contribution. It is acknowledged that certain members of case conferences identify less readily with the activity of the case conference team, as a whole - this issue is explored in the analysis . For the purpose of research the case conference is assumed to meet the customary definitions of a 'team'.

> "Individuals working together to achieve more than they could alone".
>
> Woodcock (op.cit. 27).

2) Case Conference

A 'case conference' in the present context is as in common practice a multi-disciplinary meeting called for the purpose of reviewing, progress evaluating previous activities and determining action for one or more patients.

As previously asserted, case conferences for care of the elderly are a rich source of multi-disciplinary, multi-agency collaboration. Multiple pathologies among the elderly determine the need for the widest range of services enlisted for their care and well-being.

Case conferences in this study commonly take place in a venue outside the hospital ward, at an appointed often regular time and place. The patient may or may not be present. In this enquiry case conferences differed from 'ward rounds' undertaken at a patients bedside, for the purpose of the clinical evaluation of progress. Case conferences are commonly initiated by the same individual on each occasion, often the consultant in charge. The range of professions involved is marginally variable. This is a factor identified in the observation.

In order that the research hypothesis be considered it is assumed that there is a relationship between the action taken and the cost which it incurrs. It is recognised, however, that rarely do practitioners directly consider the relationship of costs and practice in this manner. Further, that the 'value' ascribed to activity and outcome is largeley subjective and may be viewed differently by each contributer. It was therefore not the

intention to rigerously assert the relationship between activity and costs, but to identify their order of magnitude from which to draw conclusions.

A further assumption is made in that it is the collective measure of activity which contributes to outcome, that is 'teamwork' as expressed by the interaction of the individuals concerned. This must be distinguished from the care action of an individual acting outside the team process. For example, if it is decided at case conference to discharge a patient from hospital - this is the outcome of 'teamwork', the action must include mobilising the resources to enable the discharge, for the team action to be considered effective e.g. delegating the discharge procedure to a named individual or asking for a 'home assessment' by staff. If however the decision to discharge is distinct from other activity, this is not effective teamwork, for example - the team may agree a discharge to sheltered housing, for an elderly person. The ward sister, based on her knowledge and experience, and in discussion with the social services staff may determine that the discharge cannot be effected until the patient becomes mobile - the sister may then initiate a programme of mobility training - the training is not the 'teams' action. If it was not a task specifically identified and delegated by the team, or that mobility training was not an explicit pre-requisite of discharge considered by 'the team' - then the effect cannot be attributed to teamwork.

Prior to developing the methodology to address 'team' function, much time was spent in debate on these issues and a great deal of anecdotal evidence amassed. This supported these assumptions as being a reasonable reflection of practice. A further issue was similarly explored, this being -

> **do established teams fail to directly address selected topics because experience gives them confidence in 'the system' which will automatically refer to the issue?**

For example, when taking a discharge decision does the team assume that in doing so a procedure is initiated which will ensure that the patient is able to return home safely? As a generalisation, the response from Doctors was that they had every confidence in their ward team to take any action necessary. The response by social workers and ward sisters was that far too much was 'taken for granted' that the problems of discharge were insufficiently considered, often to the detriment of care.

It would have been easy at the stage to be drawn into a study of discharge procedures. Evidence would suggest that this would be a useful area for further study. In the present context it is valued as supporting material only.

Practical Issues

1) Academic Authority

An outline proposal was submitted to three Universities for consideration as admission to Doctoral programmes. In each case a good deal of interest was shown and each offered enrolment and a degree of supervision. However, Aston University was the only University able to offer guidance in respect of all aspects of the proposition i.e. social welfare, health, management and economics, within one faculty. Registration was therefore taken up as a part-time Doctoral student in the Management Faculty, under the main supervision of R.W. Cale. Lecturer in Health Services Management with joint supervision by J. Skinner, Lecturer in Social Policy and Social Work.

2) Funding

Employers - Sandwell Health Authority, and latterly Kidderminster and District Health Authority, agreed support in terms of meeting the time requirements, use of computer and allied resources.

A DHSS nursing research studentship award was granted, providing funding (on a part-time basis) to meet University fees and limited expenses for a period of three years. The remaining fees and expenses have been self-financed.

The value and support of the Health Authorities and of the DHSS is greatly appreciated. A brief personal evaluation of the nursing studentship scheme is provided in appendices 3 and 4 and together with a copy of the acceptance and conditions of support.

3. Access

The original concept was to compare and contrast team activity in two Health Districts diametrically opposite in character and conurbation:

- one urban
- one rural

Access was granted, the research protocol having been approved by both District Management Teams and local ethical committees.

After the commencement of research activities, access to one authority was withdrawn and certain restrictions placed on information in the other. In each case the reason given was the implementation of 'General Management' (in accordance with Health Circular HC(84)13 (op.cit. 6.) The rationale offered was to respect the intentions of newly appointed general managers who wished to examine services, free of outside influences. Despite what some might view as the futility of such actions, one had to respect their wishes. This posed a dilemma - to continue, to start afresh, or to abandon the project.

Following discussion with academic supervisors, it was agreed to continue; to utilise the information already obtained and to seek new additional sources for observation.

It was decided to observe randomly selected case conferences relating to the elderly. It was no longer feasible to make comparisons of the influence of environmental characteristics between Districts, variables would have been too numerous. Most health Districts have a relatively unique identity according to the range of services provided and the prescribed boundaries which are not always coterminous with one Local Authority, hence in some instances case conferences may have representation from one or more Social Services or Housing Departments.

In retrospect this does not appear to have been detrimental to the study. From the wider range of districts observed, there seem few disparities in the case conference approach.

Indeed there is sufficient evidence to assert that there is no significant difference attributable to the activity environment. An area worthy of further investigation.

In the original population, access had been granted to detailed financial information, to provide for a cost benefit analysis of the activities observed. The revised population involved a larger number of authorities, not all would permit access to financial information in detail. It would, therefore, be incorrect to infer in the research title the presence of cost benefit analysis, in the purest sense of the term, costings have been derived by general application of standard cost index e.g. National salary scales. A submission was therefore made for a change of title.

4. Change in Title

Original title:-

"An evaluative analysis of the practice of Teamwork in Health and Personal Social Services - Costs and Benefit".

Revision - approved by the University - High Degrees Committee May 1986:-

to exclude the words "Costs and Benefit".

a discussion.

Unlike commissioned work, research which is self-initiated, in theory has few boundaries. In practice the boundaries are common to both, they include:-

a) research knowledge and ability

b) academic support

c) finance

d) human/physical resources

e) personal motivation, self discipline and endurance

f) access to a suitable research population

g) knowledge of subject and access to information

each of these has influenced the progress of this study, as follows:-

a) Research knowledge and ability -

Here one must differentiate between a general knowledge and application of research and the in-depth academic discipline. The former has been gained by the researcher in the professional work situation, ranging from involvement in large scale studies, to the supervision of small projects.

Health care being a dynamic discipline the experience has been wide ranging. The theoretical knowledge has been gained from membership of the 'Doctoral Programme' through both the taught methodology course and subsequent discussion groups. Much of what has been learned has been applied to developing the methodology for this study, for example, the use of observational methods and alternative approaches to the use of questionnaires.

b) Academic support -

In addition to the taught programme the benefits of the multi-disciplinary approach to supervision have enabled the researcher to undertake elements of this study outside professional expertise. This has benefitted the outcome by ensuring that exploration and interpretation of the subject was accomplished with intelligence and insight.

c) Finance -

As reported, it is believed that the outcome of the study has benefitted from the regime of academic discipline. Importantly it is hoped that the findings will be better received in acknowledgement of such discipline. This would not have been possible were it not for the financial support of the grant of a D.H.S.S. Nursing Research Studentship, which supplement the researcher's own resources.

There are inevitably boundaries past which both personal and public finance cannot extend. For example, limitations were imposed upon the breadth of the study in terms of travel. Ideally a national study is to be recommended, rather than that which reflects merely practice within the

parameters of the West Midlands. Availability of finance influenced the methods of study employed, both positively and negatively. It was possible to train and use observers sufficient to validate the approach in the area of observation, but financial and other factors constrained the potential for in-depth interviews, questionnaires and case studies on a large scale.

d) Human/Physical resources -

For anyone attempting research whilst in full-time employment, the pressures on personal i.e. research time, are exacting. Flexibility within the professional environment has been a valuable resource to the study, particularly in the formative period. The issue of research 'time' must be carefully considered. Whilst an extended period of study is allowed for part-time students, experience would suggest that it is inadequate merely to compute whole-time with part-time equivalent hours/years; several factors must be acknowledged. Firstly, the timespan between periods of research activity is often protracted in part-time study, an extended revision period is required each time the research is actioned unlike full-time research, which is a continuous process. This was particularly noticeable during the data collection, data analysis and reporting. Secondly, consideration must be given to the influence of 'change' on the environment of study. Change within the public sector, particularly health and welfare services, has created the need for the earliest possible completion, not least to ensure that the outcome of the study is relevant to the organisation of services, as practiced at the time of reporting.

e) Motivation, self discipline and endurance -

Essential qualities in any researcher, their resource was challenged dispassionately during the course of this study. Predominantly by the effects of organisational change, for example, having gained access to the selected organisations and started the observation and interview process, permission was withdrawn from two locations, pending the appointment and restructuring of services in accordance with the 'General Management' philosophy (op.cit., 6). This action followed another protracted period of delay whilst licence was sought from the publishers, of 'Bales' interaction instrument used in the observational study. Neither of these was considered in the original study plan.

f) Access -

Access to a suitable research population is inhibited by ones own position in an organisation, particularly where the observer may seem intimidating either to that organisation or its members. Geography also influences access where resourcing imposes constraints upon travel.

Whilst permission for access to Social Services provision was in principle immediately forthcoming, the complexity imposed by the Directors Research Protocol Committee created a delay of six months. This mechanism of review seemed particularly cumbersome and unnecessary and was viewed as a source of embarrassment by the Directors themselves.

g) Knowledge of the subject and access to information -

Not only does knowledge of the subject help to legitimize access, in many cases it directs the researcher through what in terms of the public sector is a maze of bureaucracy within bureaucracy. In spite of an intimate knowledge of one element of the organisation, it is common as in the researchers experience, to have very limited knowledge of the other components of the service. It can be an extremely time consuming exercise to derive sufficient insight to acquire necessary basic information. In the context of this research the academic supervision, resources within the work organisation and the researchers own experience, contributed substantially to success.

Selection of Research Method

Selection of the observational method did not come naturally to the researcher. Having had some previous research experience, the natural tendency was to use previously tried and tested methods with which one is familiar. Previous experience had involved questionnaire and interview techniques, which had proved successful, the temptation was, therefore, to apply such a method to this research problem. Upon closer scrutiny however, the inadequacies of such an approach became evident. The need was to observe the situation as a whole process rather than to selectively examine different issues in isolation.

Observational Method - a critique

Observation is a method commonly employed for complex research situations which are best viewed as complete entities and which are difficult to measure either as a whole or separately. Despite having wide application in the social sciences observational technique is not without its critics, who contest that it is inherently biased by both the observer and the observed. Further, that it is not ethical to make judgements on observation and where observations are recorded they may vary from observer to observer. Weick, has gone so far as to create an inventory of observational biases. (65).

The most obvious problem to be overcome using observational techniques in field studies is the effect which the observers

presence may have on the situation which is being observed. Lalean quotes Blau and Scott's summary of this problem:

> "How can the investigator observe and inquire about social conduct without in the process completely altering that which he wishes to study". (op.cit., 25).

Lalean suggests that the researcher minimises the disturbance created by explaining at the outset, who he is, who the sponsoring organisation is, and in general terms, the aim and method of study. This, it is acknowledged, can only be vaguely stated as precise knowledge of the research topic would inevitably influence the behaviour of those being observed.

The writer acknowledged the experience of 'Lalean' as of particular importance. There were marked similarities in the populations being observed, in terms of the social, cultural and physical, environment and experience of the individuals. In this study it was possible to keep the explanation consistent for each set of observations, an advantage over the work in which Lalean tempered her explanation according to the subject (patient or nurse). This one could argue made the subject alert to and possibly responsive to differing stimuli in the observation, thus distorting the response and outcome.

Byerly among others, has conducted studies to assess the effect which the presence of 'observation' has on a given situation. It was found that when an outside observer did not interfere with or manipulate work routines, there was little noticeable attention paid to the observation. One could contend that twenty years on, observation in the work place has become much more common place, as has the acceptance and conduct of research. No less so than in the arena of public services. This, it could be argued, would limit until barely negligible any influence which 'observation' may have on a given situation. (66).

In contrast to Lalean's supposition, the possibility of getting an "observer effect" which would result in increased job performance was considered equally negligible. The nature of this research population and the individual activities of its members detracts from collective energies being positively compelled to the groups activity. Each actors workload is not substantially conditioned by the case conference. Indeed, in many instances, the case conference was considered by members to be of little consequence to their professional activities, one is quoted as saying of case conferences "a pleasant, informal but totally valueless forum".

The potentials and criticisms of observation as a method have been instrumental in the selection of an appropriate research tool.

Main Research Tool

Interaction Process Analysis - an observation technique.

Interaction Process Analysis is a term not exclusive to the now famous work of Bales, but one which was adopted to designate a body of methods developed in the 1930's and 1940's for the observation small groups.

Small groups which are amenable to study in the fashion of Bales are described by him as being:-

> "groups from two to twenty in number, formed for group therapy, for counselling, planning, training programme and experimental teaching procedures". (op.cit., 24).

Bales identifies numerous groups upon which his method has been applied, including policy forming committees, boards and panels, diagnostic councils in clinical work, problem solving groups, families, playgroups, gangs and cliques, social and recreational clubs, teams and workgroups.

The appeal of this particular approach is many fold. Significantly, it is a well tried and tested method, which has gained much acclaim from respected research authors, such as Pollit and Hongler, (op.cit., 23). Fox (op.cit., 22). It is recognised as a method which is free from integral values, but respectful of scientific procedure and ethics. In his book, Bales describes in detail,

the revision and retesting which went on for more than ten years, to determine the approach, as it is known today. (op.cit., 24.)

The system has been designed explicitly for the observation of interaction, that is the process content of the chosen interaction as distinguished from topical content or subject matter. This is of particular importance in the context of this study as it would be totally inappropriate to indulge in observation of content which may well include the imposition of clinical judgement, for which the author is not qualified.

Characteristics of Method

In Bales' approach the observer assumes that all small groups or teams are similar in that they involve a plurality of persons with certain generalised common tasks or problems. The tasks arise out of their relation to an outer situation and through their own social and emotional relationships with each other. It also assumes that each act of each individual in the group can be analysed with regard to its bearing on these problems.

The Method

The method involves a set of 'categories' which are intended to be inclusive in the sense that every act observed can be classified in one positively defined category. The method is continuous in that all acts are observed as they occur in sequence. No observed acts in a given period are omitted except by error.

One particular regulator suggested by Bales, is that it is necessary for the observer to adopt the point of view of a general group member, thus enabling him to categorise information in terms of its significance to other members of the group. In this respect it was determined that all observers used in the study should be of a similar professional background and one which is complimentary to those of the participants in the case conferences. The last point proved important, recognising the frequent use of jargon and exclusive medical terminology which prevailed among the subjects. It was, however, not considered appropriate to be judgemental as to the significance of contributions.

Bales' approach intended that sequential recording would support detailed analysis of the interaction form. That is the degree to which the presence of socioemotional responses for example detract from the task of the group. For this purpose Bales interprets the relationships between categories in a distinct fashion, fully described in Chapter 2 of this book. (op.cit., 17). This aspect was not considered to be of particular significance to this study and was therefore omitted. What remains is the interaction categories themselves. Bales work substantiates the hypothesis that any observational form of human interaction in the group situation can be associated to one of the categories without expansion or need for further explanation.

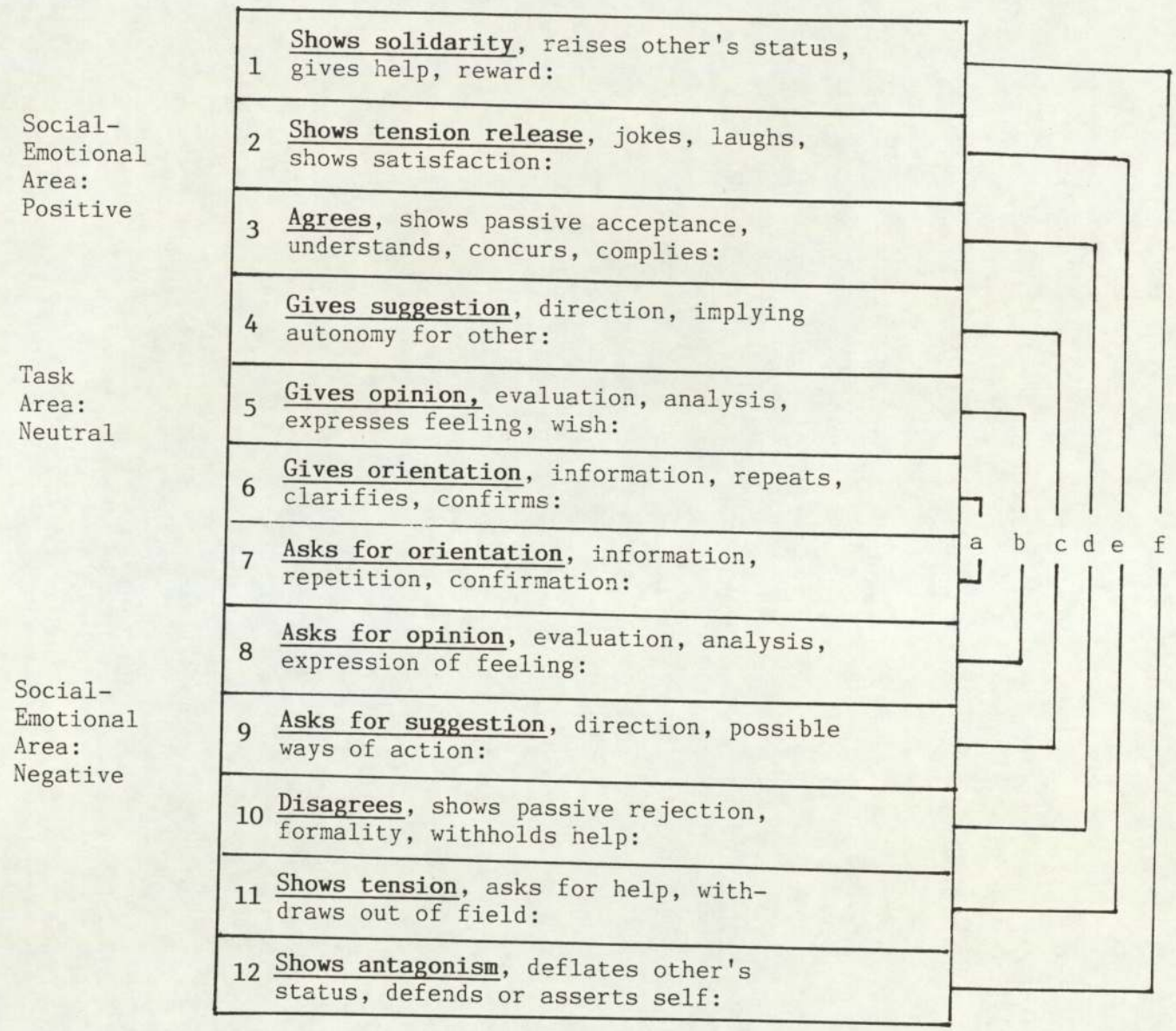
The Interaction Categories - an overview

The twelve major scoring categories are those identified in the central column of the chart - fig. 5. Bales provides a detailed interpretation of these in his book, and goes on to express the perceived relationships - in brief these are as follows:-

FIG. 5

Categories of Interaction

The system of categories used in observation and their major relations



KEY:

a Problems of Communication
b Problems of evaluation
c Problems of Control
d Problems of Decision
e Problems of Tension Reduction
f Problems of Reintegration

From: R.F. Bales Interaction Process Analysis
Addison Wesley 1951. p.9 and 89.

The middle area of the system, sections B & C are regarded as constituting an area of "Task Problems", while the terminal sections, A & D, constitute an area of social emotional problems. In the ideal situation there would be alternating emphasis between the two, when attention is given to the task, strains are created in the social and emotional relations of the group, and attention is turned to the solution of these problems. Whilst this happens the 'task' is not getting done, and attention would be expected to turn again to the task area.

The degree of detail in the analysis prescribed by Bales is far in excess of that required for this research. In the present context, the categories are used to describe the level and nature of interaction between participants. It is not possible to effect the mode or category of the interaction by introducing secondary leaders or controlling the socioemotive area, as in some of the experimental activities commissioned by Bales. This work very deliberately addresses real world situations very much as an observer, not perhaps as would a behavioural consultant, invited to analyse and support or counsel a particular team. The measure of interplay between the section is, therefore, assessed on aggregate rather than sequentially. However, the actual categories are retained in tact and are acknowledged as being fully demonstrative of any interaction which might be observed.

Copyright -

A legal search for copyright licence was not undertaken, however the Publishers of Bales Interaction Process Analysis were contacted, with a view to seeking permission to extrapolate items from the work. appendix 6. The Publishers did not respond. In view of the age of the document and recognising that no explicit alterations were to be made - other than by ommission, it was considered acceptable to proceed. (This action was sanctioned by the D.H.S.S.). see appendix 7.

Research Instrument

1. In Data Collection

The prime element of the research being observation, an instrument was required which would enable observers to identify all necessary components of the case conference situation in an easily recordable, readily useable format.

To design the data collection instrument, ten case conferences were observed and the different activities presenting were recorded. This information was then analysed against the statement of research purpose to ensure that the data items collected were applicable. A form was designed which included the Bales' 'categories' of interaction, a coding for participants and an amount of descriptive data added to reflect the activities observed in the conferences. Fig.6.

2. In Preparation for Analysis -

At the time when Interaction Process Analysis was first practiced computer technology was underdeveloped. To some extent the absence of technology limited potential and slowed the process of analysis. In adopting modern computer technology one is able to be more imaginative in approach and less restricted by human resources. This opportunity promoted the departure from Bales' original format, and it is suggested served to improve the validity of observation as a method because the recording mechanism was less intrusive.

Observation Schedule FIG. 6

1	Observer	6	Number of Cases Presented
2	Date	7	Total Participants
3	Venue	8	Patients Present Y N Relatives Present Y N
4	Time	9	Briefing Paper Circulated 2 wk 1 wk Day 0
5	Initiator	10	Cases Actioned

			a Consultant	b Senior Registrar	c Other Doctor	d Psychologist	e Sister	f Other Nurse	g Community Liaison	h Health Visitor	i Hospital Social Worker	j Social Worker	k Home Help Supervisor	l Occupational Therapist	m Physiotherapist	n Speech Therapist	o Patient	p Relation
1	Shows solidarity	raises other's status gives help, reward:																
2	Shows tension release	jokes, laughs, shows satisfaction:																
3	Agrees	shows passive acceptance, understands, concurs, complies:																
4	Gives suggestion	direction, implying autonomy for other:																
5	Gives opinion	evaluation, analysis, expresses feeling, wish:																
6	Gives orientation	information, repeats, clarifies, confirms:																
7	Asks for orientation	information, repetition, confirmation:																
8	Asks for opinion	evaluation, analysis, expression of feeling																
9	Asks for suggestion	direction, possible ways of action:																
10	Disagrees	shows passive rejection, formality, withholds help:																
11	Shows tension	asks for help, withdraws out of field:																
12	Shows antagonism	deflates other's status, defends or asserts self:																

Data analysis -

Bales acknowledged that users of his technique may wish to create their own methods. He supported two approaches which were specifically designed for his work. The first was a type of coding machine, which he used during the observation to record activities and which subsequently aggregated responses according to a pre-determined selection of categories. The second method was a system of punch cards, holes were made to represent different coded responses. By using a vibrating box groups of cards with similar codes would be extracted.

Each of these approaches was rejected in this study, primarily because they have been superceeded by computer technology. Such technology creates the potential for much more sensitive analysis. Computers provide for the handling of larger quantities of data and respond more quickly than either of the systems described above. One must also question whether the use of apparatus during observations in any way distracts or influences the participants. The first of Bales' instruments is reported to be noisy in operation.

Having decided upon computer assisted analysis it was necessary to determine whether suitable software was available, or if the writing of a special suite of programmes could be justified. The most appropriate of the ready made systems was S.P.S.S. 'Statistical Package for the Social Scientist'. (67). This was not readily accessible and would have been labour intensive in terms of coding and inputing data; a system of queuing for access to S.P.S.S. operates in the University - this militates against access by part-time students. A Televideo microcomputer system and programming resources were readily available, this presented the opportunity for the design of software for commercial use as part of a total package for the analysis of small groups. Copyright permitting this will be persued independently of the study, having first tested the capability within this project.

Validation of method

It is very difficult to be assured that the observed population are not manipulating the observation in some way. Or that knowingly observed they behave, albeit subconsciously in a different manner, often to endear the observer. Validation of such behaviour would always be contested and this is acknowledged. The likelihood of bias was limited by observers:-

a) undergoing careful training concluded by reliability assessment;

b) not participating in debate;

c) not making sound recordings;

d) by being present during the entire conference;

e) presenting regularly at conferences.

Information from the first month of observations at each venue, was discarded, this was considered a suitable period in which the observed could become accustomed to the presence of an observer. Although the subject matter of each conference differed, such that it was not possible to directly compare responses between conferences to derive a level of significant similarity. It is suggested that after the initial observations the presence of an observer did not influence the population. This is supported by evidence in the records in appendix 9, where one can see a marked similarity in response and action throughout all conferences at any one venue.

Validation/Pilot

A small pilot study was conducted for the purpose of:-

a) testing the observation schedule,

b) assessing inter-rater reliability.

Observers

Although the bulk of observations was undertaken by the author, four other observers were used, to accommodate workload and more importantly act as a validator.

The total number of observations completed by each observer in the main study was as follows:-

Table 1 Observer Activity

Observer	1	133	66.5%	(The Author)
	2	37	18.5%	
	3	18	9.0%	
	4	7	3.5%	
	5	5	2.5%	

Training of Observers

The author introduced the observers to the observation schedule (op.cit., fig.6) and gave an outline of the purpose of the research and their contribution.

Video recordings of case conferences were used to assess inter-rater reliability. On each of eight occasions all observers simultaneously assessed the same video recording of a case conference using the observation schedule. The time span for observation increased from 15 minutes to one hour. (Video recordings were loaned by the Department of Geriatric Medicine - University of Birmingham).

The author (observer 1) assumed her response as the control, monitoring the similarity and accuracy of observation against this. The results were as follows:-

Pilot
Observation

Table 2 — Validation

Observer			1	2	3	4	5
Time	Episode	Tape	%	%	%	%	%
15	1	1	100	80	73	89	92
15	2	2	100	88	89	93	92
15	3	2	100	94	93	95	94
15	4	1	100	97	96	97	98
15	5	1	100	98	96	100	98
1 hr	6	1	100	100	98	99	100
1 hr	7	2	100	100	100	98	100
1 hr	8	1	100	99	98	99	100

Table 3 — Validity Test

	Chi	Mean	Sd	
1	5.101383	86.8	10.52	p 0.2
2	0.965368	92.4	4.72	p 0.5
3	0.3235294	95.2	2.77	p 0.975
4	0.094	97.6	1.517	p 0.995
5	0.1138	98.4	1.673	p 0.995
6	0.0322	99.4	0.89	p 0.995
7	0.03213	99.6	0.894	p 0.995
8	0.02823	99.2	0.837	p 0.995

As can be seen observers quickly demonstrated a high degree of reliability between observations.

At the commencement of the study proper, two observers attended each conference and recorded a selection of conferences which were compared in the same way, to ensure continued reliability. Information from these initial observations and subsequent random tests of this form, were discarded from the final analysis.

Sample Population - factors influencing selection.

As discussed previously, case conferences for care of the elderly provide the richest source of multi-disciplinary activity. Their care commonly involves medical, nursing and paramedical staff and a wide range of Local Authority agencies.

Case conferences for the elderly commonly take place in one of three locations, in social services departments; General Practice (Health Centres and Doctors' surgeries) and in hospitals. The first venue was excluded as these rarely include health personnel other than Doctors and are commonly regulated by Statutory provision eg section 47.NAA (op. cit, page 9). Appendix 1. In General Practice primary care staff, social workers, health visitors and community nurses are involved, but rarely are hospital or voluntary agencies represented. In hospital situations all disciplines are involved and representatives of the community team, social services and voluntary agencies are regular participants. This was considered therefore to be the more appropriate forum for observation and this was reflected as a pre-condition within the sampling frame.

Sampling Frame - criteria for selection of population.

1. that the conferences be hospital based and relate to elderly care in a general hospital;

2. that the case conference be multi-disciplinary - to include participation of health and local authority agencies;

3. that the conferences be routine practice no less frequent than bi-monthly;

4. that core observations be contained within the same time period in one year.

5) that the population be drawn from within a 40 mile radius of Birmingham.

The geographical contraint was necessary in order to ensure that it was possible to include all available case conferences as emerged in the sampling frame. Failure to limit boundaries would have meant that certain conferences would have been excluded because the observer was not able to reach the location. This would have invalidated the random selection process. Financial constraint further imposed limitations upon the distance travelled and use of overnight accommodation.

Identification of Population

Potential sources were identified within the geographical boundary by reference to the Hospital Year Book 86). Contact was made by telephone (usually to the Director of Elderly Care Nursing) to ascertain the existence and frequency of case conferences which met with the criteria outlined in the sample frame, and to identify an appropriate point of contact 16 separate locations were identified. (68).

Sample Selection

This was derived by the following random selection methods:-

Case Conferences

1. Within the defined area all available case conference locations by health Districts were identified, which met with the prescribed criteria. Each health District was numbered and a selection of 10 made from a table of random numbers; these provided the pilot group used to test the data collection mechanism.

2. In consultation with each District, an estimate was made of the potential number of conferences to be held in one year period.

   Total 1850

3. Each 'potential' conference was allocated a number, 250 of which were selected for observation, referring again to the table of random numbers.

   N.B. The case conferences previously observed were allocated a number and included within the appropriate allocation for their particular District. By including them in the random selection of observations, objectivity was retained. Those not selected by the random table were discarded.

4. Access was formally requested for the observations. In respect of two Districts, access was refused. A further selection was made from the random table until the total of 250 case conferences was achieved.

Upon examination it appeared that the conferences were relatively evenly distributed between Districts in the geographical range.

Ethics

Examination and approval by local ethical committees varied between locations, suffice to say that in each case approval for observation was formally granted. The participants at the case conferences received a brief explanation and ethical assurance appendix 9, titled Research Agreement.

Delays were experienced in gaining ethical approval within Social Services, where a protocol is reviewed by an executive committee of Directors, who consider such issues within the agenda of routine management meetings.

Section II

Chapter Five

Analysis of Conference Data

Chapter V

Analysis of Case Conference Data

The volume and potential of the information generated by the observations is immense. It's value and significance will inevitably differ according to the users perception, experience and purpose. The analysis presented here seeks only to address those aspects significant to the research hypothesis.

> **Teamwork as practiced in case conferences makes a limited contribution to the outcome of care and does not respect the need for efficiency and effectiveness.**

The full record of observation is published as appendix 9, to enable readers to use the results for their own purposes. A computer record is also held by the author. It is strongly recommended that anyone wishing to pursue their own analysis of the data refer to Bales original work, particularly Chapter 5, where analysis and interpretation are fully discussed. In particular pages 141 to 147 deal with the 'interaction relationship' in which the reactive qualities are assessed by reference to an index of difficulty. This is not of specific relevance to this study, it would provide a useful tool to apply to the data in a future study. (op.cit., 24).

Excluding the pilot and validation studies, 200 conferences were observed by 5 observers in 16 different locations involving 1703 participants. Following completion of all observations at each venue, informal discussion took place between the conference participants and the researcher. The purpose was threefold; firstly to extend gratitude for allowing the observation, secondly to provide initial feedback outlining the use of the material and thirdly to identify any issues which may be outside the researchers observation. Such disclosure was not formally recorded and is recognised as subjective, although one should not minimise the value of experienced perception which in most cases could be described as a 'professional judgement'. To the extent that any medical clinical judgement is accepted as valid, one may argue that 'professional judgement' in any discipline is objective. Recognising that this is a contentious issue, information gleened in this way is only used in discussion and is not claimed to be part of the empirical data.

For simplicity the order of analysis will follow the construction of the observation schedule (Fig. 6 repeated page 90/103). As a consequence there will be two distinct sections. Firstly, that which relates to organisational aspects of the conferences. Secondly, the functional element - the interaction event.

Observation Schedule

FIG. 6

1	Observer	6	Number of Cases Presented
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4	Time	9	Briefing Paper Circulated 2 wk 1 wk Day 0
5	Initiator	10	Cases Actioned

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1	Shows solidarity	raises other's status gives help, reward:																
2	Shows tension release	jokes, laughs, shows satisfaction:																
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5	Gives opinion	evaluation, analysis, expresses feeling, wish:																
6	Gives orientation	information, repeats, clarifies, confirms:																
7	Asks for orientation	information, repetition, confirmation:																
8	Asks for opinion	evaluation, analysis, expression of feeling																
9	Asks for suggestion	direction, possible ways of action:																
10	Disagrees	shows passive rejection, formality, withholds help:																
11	Shows tension	asks for help, withdraws out of field:																
12	Shows antagonism	deflates other's status, defends or asserts self:																

Section One - Organisational Aspects

Analysis -

Each of the ten organisational aspects are considered individually, presented firstly as an activity, followed by discussion of the significant features.

1. Observer -

The validity of observer activity is considered on pages 93 - 95.

2. Date of Conference

Activity -

At each venue there was regularity of date, time and place.

Discussion -

The regularity of conferences was a matter of convenience for all concerned. In support of this practice participants emphasised the value in terms of scheduling work activity. It was suggested that awareness of conference dates enabled participants to store questions and information in the knowledge of a forthcoming opportunity for discussion. This was considered beneficial to the overall control of workload and thus offered a time saving. In practice

this was not supported, often the demands of the work situation pre-empted the outcome of questions or discussion, patient needs were more immediate. In the conference analysis this issue is also considered, it would appear that questioning and discussion are constrained in the conference situation. Participants also drew attention to the fact that by regular scheduling of conferences certain individuals were precluded from attendance due to other regular commitments. This often meant that participants were representative rather than being those directly involved with the patients care or treatment.

It could be suggested that with regular participation familiarity would reduce inhibition or conversely that complacency and lack of attentiveness may result. Whilst neither of these arguments is substantiated, it must be noted that evidence from the observation strongly suggests a high degree of inhibition among non-medical participants.

3. Venue

Activity -

96% of case conferences were held on hospital sites, the remainder at health centres. No use of Social Services premises was made. Three types of accommodation were used - offices, seminar rooms or hospital ward patients day rooms.

3. Venue (continued)

Discussion

One could suggest that:

- the type of accommodation influenced the duration and quality of the conferences

- that the nature of the accommodation influenced the decision to invite patients or relatives

- that the level of intimacy conditioned responses

or that ownership of the venue conditioned reactions among the participants eg. meeting in a consultant's office in some way authorised the consultant to take the lead role.

Participants frequently made comment regarding the accommodation, usually in an apologetic manner. In general discussion a preference for seminar type accommodation was frequently expressed.

From the observations there appears to be no significant relationship between:-

a) the venue and the interaction processes;

b) the venue and the duration of conferences, see pages 107 and 108.

4. Time

Activity -

Time was measured in minutes from the opening of the first case to the closing of the last case. There was commonly a pre and post conference period best described as 'social interaction' where several conversations, often insignificant to the purpose of the meeting, were exchanged at the same time. No record of this type of interaction was made, nor was the timespan included in the final calculation.

Appendix 10 provides an analysis of conferences by time and a cost, at 1986 pay scales, attributed to each staff member. This is also discussed on page 195 at the end of this section.

Mean duration of conferences by initiator.

Table 4

Consultant	Registrar	Sister	Community Liaison	Psychologist	Social Work
84.96	65.7	24.4	39.4	30	45
mean		mean			
75.33 minutes		34.7 minutes			

The consultant figures overall are skewed by the figures of one newly appointed consultant whose mean time = 43.75 minutes. Excluding this from the total consultant timing raises their mean to 89.125 minutes.

4. Time (continued)

Discussion

The mean duration of consultant led conferences was double that of the collective mean of all other disciplines. (This is discussed further in the context of cases actioned).

It must be noted that in addition to the obvious doubling of the time factor against cost, further additional costs were incurred because consultants' regularly brought their junior medical team to conferences. Where conferences were not consultant initiated, junior staff were rarely present. Another significant factor is that senior medical staff salaries are more than twice that of other staff groups, thus costs were markedly increased by their presence. Time was often a factor in determining the amount of consideration given to any particular case.

Towards the end of the longer meetings cases were often given cursory treatment e.g. "any problem with Mr. Smith, Brown, Jones, Sister - no, good, we're finished then".

5. Initiator -

Action -

Case conferences were selected for inclusion in the research, without prior knowledge as to the discipline of conference initiators.

The distribution was found to be as follows:-

Distribution — Table 5

Consultant	Senior Registrar	Psychologist	Sister	Community Liaison	Social Worker
151	21	1	17	9	1

Discussion

The predominence of consultants' is to be expected in a hospital situation. Of those conferences selected the social worker and psychologist initiated conferences both occurred as a result of the consultant's absence. It is known that outside hospital, in child care situations, health visitors, social workers and psychologists often initiate case conferences, acting in a statutory capacity as 'key worker'. There is no knowledge of other paramedical disciplines taking the lead role, with the exception of those initiated by various nursing disciplines.

In all cases observed the initiator not only called the conference together, but also assumed chairmanship.

Whilst there were no formal processes of designation, staff commonly spoke of "his" case conference, deferring some form of 'ownership' to consultants.

In hospital practice this is also the case - Doctors being 'clinically responsible' for patients confirs automatically the status of patient care manager and advocate, almost by default - certainly without known challenge.

6. Number of Cases Presented per conference

Table 6

Activity -

	By Initiator - for all conferences					
	Consultant	Senior Registrar	Sister	Community Liaison	Psychologist	Social Worker
Mean	26.7	20.6	22.8	11.6	4	4
Range	30-3	26-8	25-3	20-6		

Discussion -

The number of cases presented would appear to reflect habit and individual preference. In many instances the number of cases was simply the total ward occupancy. Anecdotal evidence described situations where sisters' selected patients whom intuition and experience suggested were "suitable for consideration". One consultant saw women and men on alternate weeks, irrespective of need. Another situation was described where no incontinent patient would be considered for discharge from hospital, whether or not they were otherwise mentally or physically well, therefore their case was not the subject of conference.

(It is common practice in certain Social Services accommodation for the elderly and some private residential homes to refuse admission of patients who are incontinent. This may have had some bearing on the consultant behaviour).

On no occasion was time considered to be an influencing factor in determining the number of cases actually presented. Many staff spoke of their concern that insufficient time and consideration was given. Several participants commented that "the case conference was an unnecessary ritual", "a time waster". Observers reported that where fewer cases were presented more 'in depth' consideration was given and participants were more satisfied with the outcome - this is of course a subjective view. See also item 1.7

On 43 occasions, consultants' conducted a ward round on the day of a conference, 29 of which were post case conference rounds. The frequency of consultant ward rounds with patients who were also the subject of case conference ranged from daily to weekly; whilst these were primarily for clinical evaluation, it was reported that they frequently duplicated and often overode conference decision.

7. Total Number of Participants

Table 7

Activity -

Total Participants	1703
	Mean
Consultant initiated	10.79
Registrar	7.9
Others	5.5

Discussion

Consultants invariably had junior medical staff in attendance at case conferences. This is an acknowledged contribution to medical training. Notably other staff groups rarely had students in attendance - despite the obvious contribution which student and junior ward nursing staff make to direct patient care, with their unique knowledge of the patient. Rarely were students present nor did they provide formal reports for the meetings.

The actual contribution of each participant is considered under the analysis of interaction, discussed in the next section.

At each individual venue the participants on each occasion were generally unchanged. As discussed under item 1.2, familiarity among participants may have an influence upon the outcome of their meeting.

8. Patient/Relative Present

Table 8

Activity -

Initiator-Consultant		Registrar	Sister	Others
Patient	14	3		Nil
Relative	10		1	

Discussion -

There was no routine involvement of either patients or relatives. Of the eleven relatives in attendance, two had initiated the involvement themselves. Seven were invited to address particular problems which had been identified at earlier meetings. On all occasions a specific action arose from the ensuing discussion - Eight resulting in patients being discharged.

In discussion no consultant objected to either relatives or patients being present, although some did express the opinion that where relatives or patients were in attendance, proceedings were constrained. The following comments were made:-

> "They don't understand what's going on."
>
> "You have to be so careful about what you say in front of the relatives."
>
> "I prefer to see patients separately to explain what is happening otherwise conferences take all day."

Two consultants claimed that patients and relatives were always welcome, although no action was taken to effect an invitation. Ward sisters expressed the opinion that it would be outside their jurisdiction to invite people. Asked to consider the record of patient and relative involvement, all participants were surprised at the low level. Their perceptions were of a much more regular and frequent involvement.

The degree to which patients and or relatives should be involved is an issue for consideration worthy of specific research. The attitude that patients did not own their care decision, was prevalent. Consideration may be given to the degree to which this attitude may influence outcome. It would appear that where patients and or relatives become involved a decision and action is concluded sooner. Observation would suggest that where a patient or relatives are involved:

a) there is always a positive outcome (action)

b) referral to a future conference is less common

The material collected did not lend itself to directly address this issue.

9. Briefing Paper Circulated

Table 9

Activity -

2 weeks	1 week	Day of Meeting	No Papers
2	15	40	143

Initiator	Consultant	Registrar	Sisters	Other
Total conferences	150	21	17	12
Papers circulated	54	0	0	3

9. Briefing Paper Circulated (continued)

Discussion -

Three consultants regularly circulated papers which accounted for 27 of the total recorded. A further two consultants circulated papers for at least two-thirds of their conferences, this amounted to 23 of the total recorded. The remainder were insignificant in number. The papers consisted primarily of lists of patients with detail of age, sex, length of hospital stay and current diagnosis. One consultant provided papers at every meeting, which in addition to the data described, also provided a clinical summary and proposed course of action. It is significant to note that this consultant took action on substantially more cases than any other initiator, see 1.10. The majority of these papers were circulated within the week prior to the conference. Participants expressed a preference for this method of working, reporting that they were able to investigate situations prior to the case conference, and arrive better informed. However, it should be noted from section 2. that there was no significant difference in the interaction behaviour among these participants. It was also reported that the circulation of papers in advance led in certain circumstances to cases not being considered, despite being suitable; several participants indicated that this adversly affected the length of stay for patients.

10. Cases Actioned

Table 10

Activity -

Initiator	Cases Actioned	Cases Presented	Total No. of Conferences	% Actioned
Consultant 1	58	73	17	79
Consultant 2	28	209	8	13
Consultant 3	37	203	7	6.4
Consultant 4	10	78	3	12.8
Consultant 5	98	635	23	15.4
Consultant 6	131	944	36	13.8
Consultant 7	139	955	35	14.5
Consultant 8	68	551	21	12.3
Registrar 1	7	113	6	6.19
Registrar 2	4	51	2	7.8
Registrar 3	16	241	13	6.6
Sister 1	2	6	2	33.3
Sister 2	37	323	15	11.4
Community Liaison	10	105	9	9.5
Others	8	11	3	75

Discussion -

It is not appropriate to compare the achievement of one initiator with another, in terms of outcome or cases actioned. In practice only medical staff may discharge patients and changes in regime frequently require medical authorisation. These factors may influence the outcome, therefore, conclusions drawn simply from

this observation, would be questionable. It is, however, notable that one consultant and one sister achieved a significantly larger number of actions than any other member of their peer grouping. It was commented that the approach of the consultant achieving greater action was more progressive and dynamic than other consultants. His case conferences were generally of short duration. The number of cases actioned significantly higher and in general the conferences ran more smoothly. Participants arrived better prepared by virtue of pre conference papers. However, evidence from the interaction process does not substantiate any change or influence which these factors may have brought about. The degree, frequency and nature of participation is common to many other conferences observed. It is notable that relatives and or patients were regular participants. The degree to which the interaction of the conference led to the outcome should be questioned - one could contend that the behaviour of the initiator was the soul subscriber to outcome.

Analysis Section 2

Observation Data

The analysis presented in this section represent a collation of the interaction responses recorded in Appendix 8. The data is expressed in two forms on pages 119 to 121 as summary tables of all questions -

Table 11 shows a table of aggregated responses for all participants by question. In absolute and percentage form for all conferences.

Table 12 shows a table of aggregated responses for all participants by question. In absolute and percentage form for conferences, initiated by consultants only.

Table 13 shows a table of aggregated responses for all participants by question. In absolute and percentage form for non consultant initiated conferences.

these summaries provide an overview of the interaction. There follows on pages 122 to 191 a graphical presentation of the same data question by question, together with the researchers interpretation of the findings, interspersed with comments made by conference participants.

Note - The term 'question' is used when referring to the individual interaction categories - this being considered more appropriate to the form of enquiry.

INTERACTION PROCESS - SUMMARY TABLE

TABLE 11

ALL CONFERENCES

	Shows solidarity	Shows tension release	Agrees	Gives suggestion	Gives opinion	Gives orientation	Asks for orientation	Asks for opinion	Asks for suggestion	Disagrees	Shows tension	Shows antagonism
Absolute	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
CONSULTANT	90	92	139	149	153	100	123	114	85	37	7	23
REGISTRAR	20	39	67	33	59	59	21	31	25	6	2	3
HOUSEMAN	10	13	21	13	16	20	11	13	16	3	0	1
PSYCHOLOGIST	13	24	40	19	35	27	10	18	19	9	1	4
SISTER	54	115	191	76	159	194	77	101	158	33	7	7
OTHER NURSE	0	15	20	5	14	12	10	5	6	2	0	0
COMM LIAISON	18	78	160	30	76	79	66	45	68	17	3	3
HEALTH VIS.	18	85	145	27	71	77	72	39	54	19	5	7
SOCIAL WORKER	19	64	97	27	70	60	65	35	49	20	3	7
HOSPITAL SW	3	34	72	19	38	35	51	21	22	12	3	9
HOME HELP SUP	6	35	89	3	13	25	43	13	49	8	2	0
O.T.	12	71	144	26	81	111	54	44	77	8	4	3
PHYSIOTHER.	19	84	160	35	111	135	78	56	120	25	5	3
SPEECH THER.	1	6	9	4	8	14	4	1	4	1	0	0
PT/REL	1	5	15	5	13	15	17	4	8	3	1	1
* SUBTOTAL *	284	760	1369	471	917	963	702	540	760	203	48	67
Percentages	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
CONSULTANT	31.7	12.1	10.2	31.6	16.7	10.4	17.5	21.1	11.2	18.2	14.6	34.3
REGISTRAR	7.0	5.1	4.9	7.0	6.4	6.1	3.0	5.7	3.3	3.0	4.2	4.5
HOUSEMAN	3.5	1.7	1.5	2.8	1.7	2.1	1.6	2.4	2.1	1.5	0	1.5
PSYCHOLOGIST	4.6	3.2	2.9	4.0	3.8	2.8	1.4	3.3	2.5	4.4	2.1	6.0
SISTER	19.0	15.1	14.0	16.1	17.3	20.1	11.0	18.7	20.8	16.3	14.6	10.4
OTHER NURSE	0	2.0	1.5	1.1	1.5	1.2	1.4	0.9	0.8	1.0	0	0
COMM LIAISON	6.3	10.3	11.7	6.4	8.3	8.2	9.4	8.3	8.9	8.4	6.3	4.5
HEALTH VIS.	6.3	11.2	10.6	5.7	7.7	8.0	10.3	7.2	7.1	9.4	10.4	4.5
SOCIAL WORKER	6.7	8.4	7.1	5.7	7.6	6.2	9.3	6.5	6.4	9.9	16.7	10.4
HOSPITAL SW	1.1	4.5	5.3	4.0	4.1	3.6	7.3	3.9	2.9	5.9	6.3	13.4
HOME HELP SUP	2.1	4.6	6.5	0.6	1.4	2.6	6.1	2.4	6.4	3.9	4.2	0
O.T.	4.2	9.3	10.5	5.5	8.8	11.5	7.7	8.1	10.1	3.9	8.3	4.5
PHYSIOTHER.	6.7	11.1	11.7	7.4	12.1	14.0	11.1	10.4	15.8	12.3	10.4	4.5
SPEECH THER.	0.4	0.8	0.7	0.8	0.9	1.5	0.6	0.2	0.5	0.5	0	0
PT/REL	0.4	0.7	1.1	1.1	1.4	1.6	2.4	0.7	1.1	1.5	2.1	1.5
* SUBTOTAL *	100	100	100	100	100	100	100	100	100	100	100	100

INTERACTION PROCESS - SUMMARY TABLE

TABLE 12

CONSULTANT INITIATED CONFERENCES

Absolute	Q1 Shows solidarity	Q2 Shows tension release	Q3 Agrees	Q4 Gives suggestion	Q5 Gives opinion	Q6 Gives orientation	Q7 Asks for orientation	Q8 Asks for opinion	Q9 Asks for suggestion	Q10 Disagrees	Q11 Shows tension	Q12 Shows antagonism
CONSULTANT	88	90	136	146	150	98	121	111	83	36	7	23
REGISTRAR	16	31	58	25	52	52	15	24	18	4	2	3
HOUSEMAN	4	6	8	6	6	13	4	3	7	1	0	0
PSYCHOLOGIST	11	19	35	14	29	25	5	14	15	9	1	4
SISTER	43	89	152	54	122	154	55	74	124	27	7	4
OTHER NURSE	0	15	20	4	12	11	9	4	6	1	0	0
COMM LIAISON	16	59	128	22	48	61	45	28	51	12	3	2
HEALTH VIS.	15	67	120	18	52	59	54	27	42	16	5	3
SOCIAL WORKER	15	48	73	18	46	37	42	20	32	18	7	6
HOSPITAL SW	3	29	66	17	33	30	44	19	19	11	3	8
HOME HELP SUP	4	32	84	2	12	23	40	12	45	7	2	0
O.T.	10	54	112	14	56	82	38	28	62	6	4	3
PHYSIOTHER.	15	62	122	25	78	101	59	37	92	23	4	3
SPEECH THER.	1	6	9	4	8	13	4	1	4	1	0	0
PT/REL	0	5	13	5	13	13	15	4	7	3	1	1
* SUBTOTAL *	241	612	1136	374	717	772	550	406	607	175	46	60

Percentages	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
CONSULTANT	36.5	14.7	12.0	39.0	20.9	12.7	22.0	27.3	13.7	20.6	15.2	38.3
REGISTRAR	6.6	5.1	5.1	6.7	7.3	6.7	2.7	5.9	3.0	2.3	4.3	5.0
HOUSEMAN	1.7	1.0	0.7	1.6	0.8	1.7	0.7	0.7	1.2	0.6	0	0
PSYCHOLOGIST	4.6	3.1	3.1	3.7	4.0	3.2	0.9	3.4	2.5	5.1	2.2	6.7
SISTER	17.8	14.5	13.4	14.4	17.0	19.9	10.0	18.2	20.4	15.4	15.2	6.7
OTHER NURSE	0	2.5	1.8	1.1	1.7	1.4	1.6	1.0	1.0	0.6	0	0
COMM LIAISON	6.6	9.6	11.3	5.9	6.7	7.9	8.2	6.9	8.4	6.9	6.5	3.3
HEALTH VIS.	6.2	10.9	10.6	4.8	7.3	7.6	9.8	6.7	6.9	9.1	10.9	5.0
SOCIAL WORKER	6.2	7.8	6.4	4.8	6.4	4.8	7.6	4.9	5.3	10.3	15.2	10.0
HOSPITAL SW	1.2	4.7	5.8	4.5	4.6	3.9	8.0	4.7	3.1	6.3	6.5	13.3
HOME HELP SUP	1.7	5.2	7.4	0.5	1.7	3.0	7.3	3.0	7.4	4.0	4.3	0
O.T.	4.1	8.8	9.9	3.7	7.8	10.6	6.9	6.9	10.2	3.4	8.7	5.0
PHYSIOTHER.	6.2	10.1	10.7	6.7	10.9	13.1	10.7	9.1	15.2	13.1	8.7	5.0
SPEECH THER.	0.4	1.0	0.8	1.1	1.1	1.7	0.7	0.2	0.7	0.6	0	0
PT/REL	0	0.8	1.1	1.3	1.8	1.7	2.7	1.0	1.2	1.7	2.2	1.7
* SUBTOTAL *	100	100	100	100	100	100	100	100	100	100	100	100

INTERACTION PROCESS - SUMMARY TABLE

TABLE 13

NON CONSULTANT INITIATED CONFERENCES

Absolute	Shows solidarity	Shows tension release	Agrees	Gives suggestion	Gives opinion	Gives orientation	Asks for orientation	Asks for opinion	Asks for suggestion	Disagrees	Shows tension	Shows antagonism
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
CONSULTANT	2	2	3	3	3	2	2	3	2	1	0	0
REGISTRAR	4	8	9	8	7	7	6	7	7	2	0	0
HOUSEMAN	6	7	13	7	10	7	7	10	9	2	0	1
PSYCHOLOGIST	2	5	5	5	6	2	5	4	4	0	0	0
SISTER	11	26	39	22	37	40	22	27	34	6	0	3
OTHER NURSE	0	0	0	1	2	1	1	1	0	1	0	0
COMM LIAISON	2	19	32	8	28	18	21	17	17	5	0	1
HEALTH VIS.	3	18	25	9	19	18	18	12	12	3	0	0
SOCIAL WORKER	4	16	24	9	24	23	23	15	17	2	1	1
HOSPITAL SW	0	5	6	2	5	5	7	2	3	1	0	1
HOME HELP SUP	2	3	5	1	1	2	3	1	4	1	0	0
O.T.	2	17	32	12	25	29	16	16	15	2	0	0
PHYSIOTHER.	4	22	38	10	33	34	19	19	28	2	1	0
SPEECH THER.	0	0	0	0	0	1	0	0	0	0	0	0
PT/REL	1	0	2	0	0	2	2	0	1	0	0	0
* SUBTOTAL *	43	148	233	97	200	191	152	134	153	28	2	7

Percentages	Shows solidarity	Shows tension release	Agrees	Gives suggestion	Gives opinion	Gives orientation	Asks for orientation	Asks for opinion	Asks for suggestion	Disagrees	Shows tension	Shows antagonism
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
CONSULTANT	4.7	1.4	1.3	3.1	1.5	1.0	1.3	2.2	1.3	3.6	0	0
REGISTRAR	9.3	5.4	3.9	8.2	3.5	3.7	3.9	5.2	4.6	7.1	0	0
HOUSEMAN	14.0	4.7	5.6	7.2	5.0	3.7	4.6	7.5	5.9	7.1	0	14.3
PSYCHOLOGIST	4.7	3.4	2.1	5.2	3.0	1.0	3.3	3.0	2.6	0	0	0
SISTER	25.6	17.6	16.7	22.7	18.5	20.9	14.5	20.1	22.2	21.4	0	42.9
OTHER NURSE	0	0	0	1.0	1.0	0.5	0.7	0.7	0	3.6	0	0
COMM LIAISON	4.7	12.8	13.7	8.2	14.0	9.4	13.8	12.7	11.1	17.9	0	14.3
HEALTH VIS.	7.0	12.2	10.7	9.3	9.5	9.4	11.8	9.0	7.8	10.7	0	0
SOCIAL WORKER	9.3	10.8	10.3	9.3	12.0	12.0	15.1	11.2	11.1	7.1	50.0	14.3
HOSPITAL SW	0	3.4	2.6	2.1	2.5	2.6	4.6	1.5	2.0	3.6	0	14.3
HOME HELP SUP	4.7	2.0	2.1	1.0	0.5	1.0	2.0	0.7	2.6	3.6	0	0
O.T.	4.7	11.5	13.7	12.4	12.5	15.2	10.5	11.9	9.8	7.1	0	0
PHYSIOTHER.	9.3	14.9	16.3	10.3	16.5	17.8	12.5	14.2	18.3	7.1	50.0	0
SPEECH THER.	0	0	0	0	0	0.5	0	0	0	0	0	0
PT/REL	2.3	0	0.9	0	0	1.0	1.3	0	0.7	0	0	0
* SUBTOTAL *	100	100	100	100	100	100	100	100	100	100	100	100

GRAPHICAL PRESENTATION OF INTERACTION FINDINGS

For ease of reference the graph pages are reversed to confront the dialogue.

Discussion

Question 1

Shows solidarity, raises other's status, gives help, reward.

The dominance of the Consultant in this interaction is clearly demonstrated. Commonly, question 1 type responses came early in the conference activity, often with introductory comments such as:-

> "I'm glad to see so many of you here".
>
> Consultant.

> "Welcome - sister has us all well organised this afternoon".
>
> Consultant.

This form of interaction accounted for only 2% of all responses, often it was used in the context of gaining control or exerting Chairmanship upon the proceedings, calling to order a period of general conversation.

Sisters' were the second largest contributor. Their contribution was made in one of three forms, either to gain control, to echo the sentiments expressed by a Consultant or to draw the Chairman's attention to a particular participant e.g. a new member of the group. It appeared that scant attention was paid by members to interaction occurring in this category. A muttered hello or nod was the most common behaviour.

Question 2

Shows tension release, jokes, laughs, shows satisfaction.

Such behaviour accounted for 10% of all responses. Common place at the beginning of a meeting and following a period of negative interaction. It is of note that where a boss : subordinate relationship exists between participants, the surbordinate responded less often. It is suggested that such response is a common trait unrelated to the nature of questioning. Local Authority staff, social workers, home help supervisors rarely contributed to conferences in this way, a behaviour repeated throughout most question types. One might speculate as to whether their hesitancy was due to the conference venue, commonly alien territory to these staff. A typical comment among staff at this stage was:

> "I can't be doing with all the pleasantries, I'd rather get on with the work".

Question 3

Agrees shows passive acceptance, understands, concurs, complies.

The most prevelant response, accounting for 19% of all responses. Less common among medical staff, but very common among staff of a nursing and paramedical background. It might be considered that this typifies the relationship between medical and other hospital staffs. In the present context this gives cause for concern, as evidence of compliance does not necessarily denote a positive, proactive contribution to the conference debate, and supports the evidence of 'consultant' dominance. (This is further explored in comparison of consultant and non-consultant initiated conferences). It is important to note that Local Authority staff groups contribute more frequently to this conformity than to other types of response. Again, it would appear that where boss : subordinate relationships exist, noteably sisters respond and other nurses withhold a response.

Commonly the nature of response in this area involved a good deal of non verbal communication, nods or show of hands and 'grunts of approval'. The verbal exchange was usually monosyllabic, which might be considered to exhibit acceptance of a 'course of least resistance'. This issue was taken up in post conference discussion - the researcher posed the question:

"My observation indicates a high degree of acceptance and understanding - is this an accurate reflection of your view of the proceedings?".

Comments were as follows:-

Consultant -

"Yes, one would expect approval for a course of action".
"Mine is the clinical decision with which I expect conformity".
"We are not here to disagree".
"We are a very positive group, we have developed our understanding over a number of years".

Sister -

"It's the consultants decision which counts".
"Sometimes I prefer a quiet life".
"I don't know enough to argue with clinical opinion".
"I know what he wants before the conference, I help him achieve it".
"I make my views known privately, he respects my opinion - the case conference is not the place".

Health Visitor -

"Unless I have known the patient prior to admission I am not usually in a position to argue".
"I trust that sister will put him right".

Community Liaison -

> "Time is too precious - we would be here all day if we debated everything and all gave our opinion".

Social Worker -

> "I bow to the professional opinion".
> "Whatever the outcome, it means work for one or other other of us".

Such comments were exceedingly common and often tempered with an air of hopelessness. Where enthusiasm for a view was expressed it was commonly for an isolated case rather than a generalisation.

One is led by such comments to seriously question the value of conferences to these individuals. Indeed, one should address the issue of negative contribution and whether this is a professionally responsible way to behave.

Question 4

Gives suggestion, direction, implying autonomy for others.

Clearly the consultant is dominant in this area, contributing more than 30% of all response. Ward sister, the second most active respondent, contributing 16% of the total response, usually did so by reference to changes in patient activity - often in a 'bargaining fashion':

> "If physiotherapist can get Mrs. X walking, then we will be able to start toilet training".

> "Mrs. Y is ready for the occupational therapist to do some dressing practice and then we can have a home assessment".

Medical response was very much an autocratic 'Chairmanship' process. To the outside observer it appeared that such confidence to generate conclusion would need to be based on a substantial knowledge of the care situation. Therefore one reflected that it was disappointing that should such knowledge exist, it was not overtly shared with the conference participants.

In total this activity amounted to less than 7% of all responses. This is disappointing, particularly when considered together with Question 5, as the two most activity provoking areas of response.

Question 5

Gives opinion, evaluation, analysis, express feeling, wish.

A moderate level response - 12.9%. There appeared to be a balance between the staff involved in day to day care. It was observed that the medical contribution was the more analytical in nature, making statements as to the plan of care intent and statement of outcome. Nursing response was more in the role of 'patient advocate' often nurses spoke of the patients preferred regime - even when patients were present and able to speak for themselves. The future recipients of care responsibility, e.g. community nurses, social workers, used the opportunity to make explicit the terms for discharge.

Comments were made such as:-

> "She would need to climb up two or three steps before coming out".
>
> "He would have to be continent".

Home help supervisors contributed in a similar fashion but referred more often to the "accountability" of discharge without setting criteria, apparently seeking some evidence of a professional mentor role to whom they could refer once patients were living at home.

Question 6

Gives orientation, information, repetition, confirmation.

The nature of the nursing workload naturally dictates that nurses will be the lead contributor to this form of response, followed by other key workers - occupational therapists and physiotherapists. The nature of material presented was current and descriptive of the patients progress. Where medical staff contributed at this stage information was of an historical, descriptive nature, more given to general orientation and introduction.

If one submits that the prime purpose of case conferences is to collectively determine solutions to meet jointly identified care needs, it is particularly disappointing to note the overall limited response in this category. The claimed purpose of case conferences being to share information and solve problems one is led once more to question the effectiveness of this medium of exchange.

Question 7

Asks for orientation, information, repetition, confirmation.

The interaction profile indicates a more even distribution of response among participants. Overall however, this constituted only 9% of total responses. Again boss : subordinate influences come into play.

In the terms of 'Bales', interaction in this area is described as 'Task area Neutral' as a consequence one might expect a greater degree of responsiveness as the outcome of involvement is not directly born by the respondent and particularly with regards question 7, outcomes may be viewed as 'beneficial' - an increased level of knowledge. Questioning participants in respect of this issue the following were typical of the comments made:

Consultant
(the most frequent contributor = 19%)

"Sister tells me a lot of what I need to know on the ward rounds - I don't need it repeated".

Sister

"Knowing the patient means a lot of the answers are obvious".

Health Visitor

> "I do ask some questions, but I don't want to make a fool of myself".

Social Worker

> ""I just say enough to let them know I'm still alive".

Home Help Supervisor

> "Its the only part of the meeting I become really involved in (6% of total response). But I get confused at all the medical words, sometimes I don't understand the answer I'm given".

Few participants expressed concern with regards the opportunity for this form of interaction. Many considered the patients records a much more reliable source of information - commonly forms of comment were as follows:-

> "You review so many patients each meeting its easy to confuse them - I check what I'm doing in the Kardex".

Liaison Nurse

"The nurses write everything up we discuss, so I use their records".

Physiotherapist

"Sister's the one to ask if you want to get a straight answer - I only come to get a chance to pin her down at the end and find out what's going on".

Social Worker

"This is what case conferences are all about - shared learning and understanding".

Consultant

The diversity of perceptions admirably supports the rationale for this study - acquiescence and tradition appear to condition activity far more than the evaluation of met and unmet needs.

Question 8

Asks for orientation, evaluation, analysis, expression of feeling.

Again an area dominated by the consultant and sister. Curiously their conversations frequently overtook the meeting as though no other participants were present. Whilst the nurse : doctor contribution commonly related to the direction of future care, the 6% - 8% response of other disciplines was usually related to concern regarding a lack of progress by the patient or attitudinal difficulties. Observers reported little analytical process to this type of exchange.

Collectively the evidence would suggest a lost opportunity - particularly as participants regularly admitted generating their informational and decisional bases outside the conference.

Question 9

Asks for suggestion, direction, possible ways of action.

The direct care staff, nurse, physiotherapist, occupational therapist, dominated this area of interaction. This again is surprising, recognising this to be one of the expressed purposes of case conference - to discuss and determine appropriate courses for care action.

Sisters contributed 21% of the total activity. Recognising that they have regular and frequent access to medical opinion and indeed to all other participants, it is surprising to see such a heavy involvement at this stage. In response to questioning this behaviour, it was suggested that sisters play a facilitator role in the process, rehearsing known decisions for the benefit of other participants. No other participant claimed to recognise this contribution, indeed several commented with surprise at the apparent level of knowledge of the sister which was not commensurate with her level of patient contact.

Community Liaison Nurses and Home Help supervisors did use this opportunity more fully than other opportunities, but in total this remained insignificant.

Question 10

Disagrees, shows passive rejection, formality, withholds held.

This constituted less than 3% of all responses, relatively evenly distributed among participants.

One could contest that this is indicative of the conformist nature of the conference activity, a supposition born out by comparison made with question three - the highest activity area showing 19% of all responses related to agreement and passive compliance.

It could be speculated that behaviours relating to disagreement are less obvious and thus not adequately recorded, however, the interater reliability of all questions shows a high correlation. Further, one could contest that physical signs of negative attitude are more obvious in flushing face, clenched hands, dolefull expression. Observers reported this to be the case for all negative responses.

Question 11

Shows tension, asks for help, withdraws out of field.

Behaviour in this category amounted to less than 1% of total responses. The main contributors being consultants, sisters and social workers. Whilst one could assume that such a low scoring negative zone would indicate that conferences were generally forums of confident amiable and positive action, one must also consider that whilst there were no outward signs of tension, either verbal or non verbal, this may have been concealed behaviour. It is not the purpose of this research to debate the relevant theories of psychology or to apply behaviourist perspectives to the observation.

Such theory may have application here as would the views of Levinson which regards role behaviour as mere epiphenomena, by-products of unconscious fantasies and defences.

Question 12

Shows antagonism, deflates others status, defends or asserts self.

Convincingly the consultants domain, accounting for 34% of responses in the category. As Bales asserts, this reaction marries with the behaviour in question one, where a similar dominant response was recorded.
Sisters too demonstrate a significant level of activity. What is particularly interesting is the contribution of social workers, particularly hospital social workers, among whom response under category 12 was at least double the level of response to any other question category.

Asked to comment on this observation, it was stated:

> "We have to stand our corner occasionally or they would walk all over us, I give as good as I get".

> "It is often the case that I work hard to effect a suitable discharge arrangement - not all families want granny at home you know - the process if often slow, getting grant applications, adaptations and the like - then they try to push a discharge through quickly - because they need the bed or something - it upsets everything and often creates more of a family problem than they ever know".

"I am fairly tolerant of all the clinical mumbo jumbo - who am I to judge?, but when they invade my area I have to protect the client".

"I don't know much about the actual care, but I do have to protect my families with, for example, very young children or teenagers doing exams. Having a disorientated relative at home can cause so much conflict - in the inner cities the housing just isn't conducive to multi-generation living - its a lot to do with their culture - caring for their elders - I have to be the peace-keeper between hospital and home, for families and professionals".

"My colleagues look for my support.

Consultants when questioned about their apparent 'dominance' in this area replied in the following tones:

"Its what you would expect".

They are my patients', I have to remain in control".

"Its what is expected of me".

I wouldn't have considered it to be that obvious - but I do realise I say more than most of the team".

"We are really a happy bunch, its not actual conflict, more a difference of perspective".

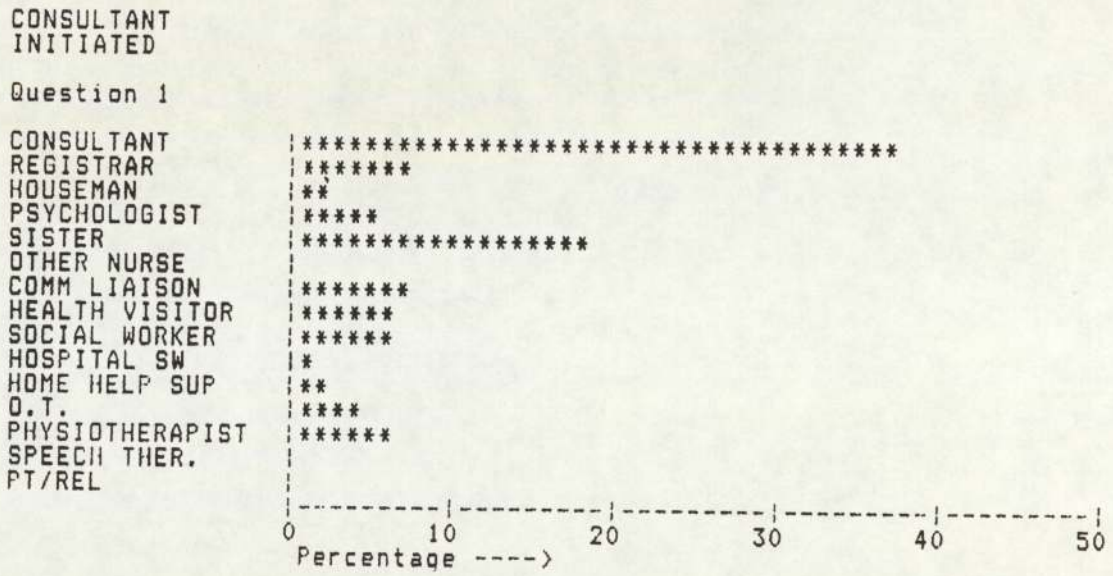
CONSULTANT INITIATED

Graphs and tables reflecting exclusively consultant initiated conferences are included here for completeness.

The dialogue referring to comparison between consultant initiated and non consultant initiated is reported within the subsequent section pages 166 to 190 which are directed to non consultant initiated conferences.

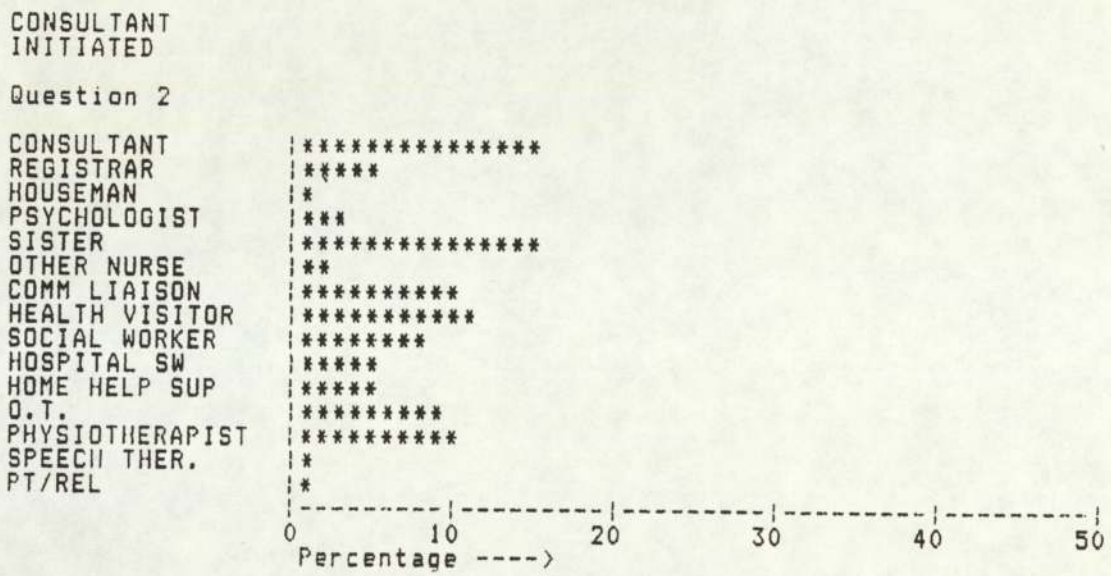
GRAPH 13

Shows solidarity, raises other's status, gives help, reward.



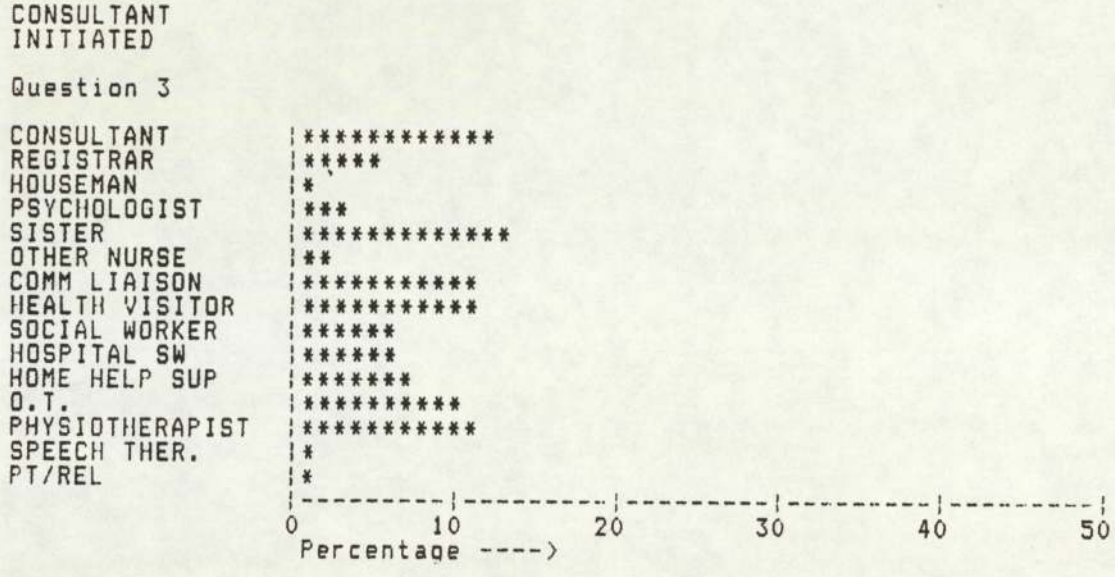
GRAPH 14

Shows tension release, jokes, laughs, shows satisfaction.

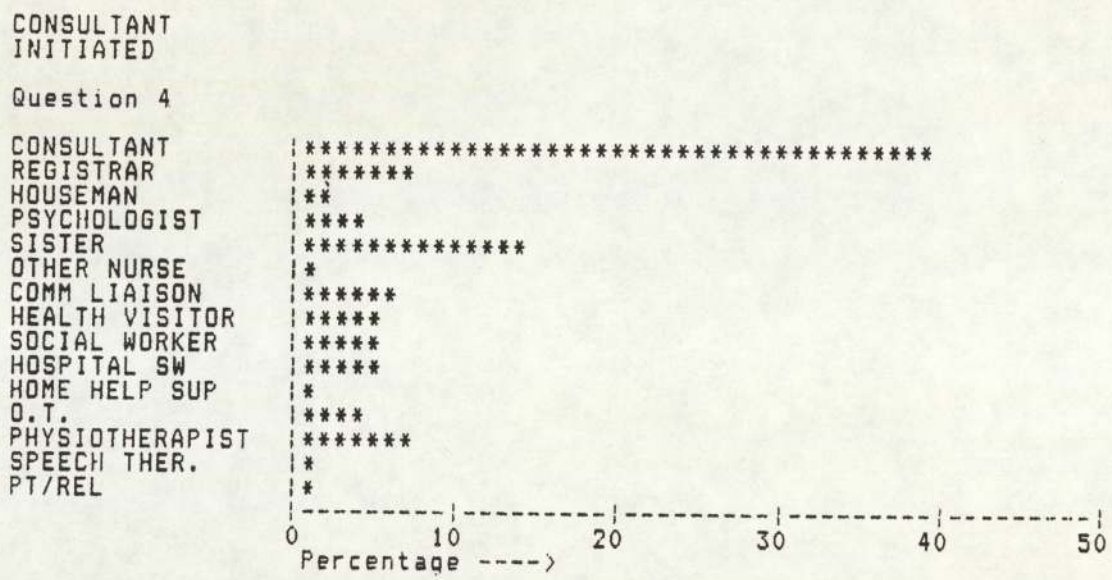


GRAPH 15

Agrees, shows passive acceptance, understands, concurs, complies.



Gives suggestion, direction, implying autonomy for others.

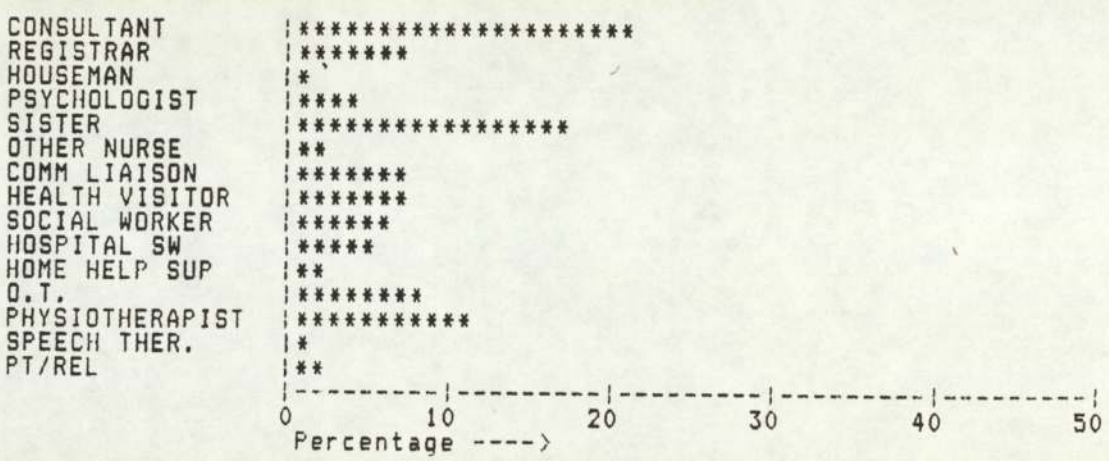


GRAPH 17

Gives opinion, evaluation, analysis, express feeling, wish.

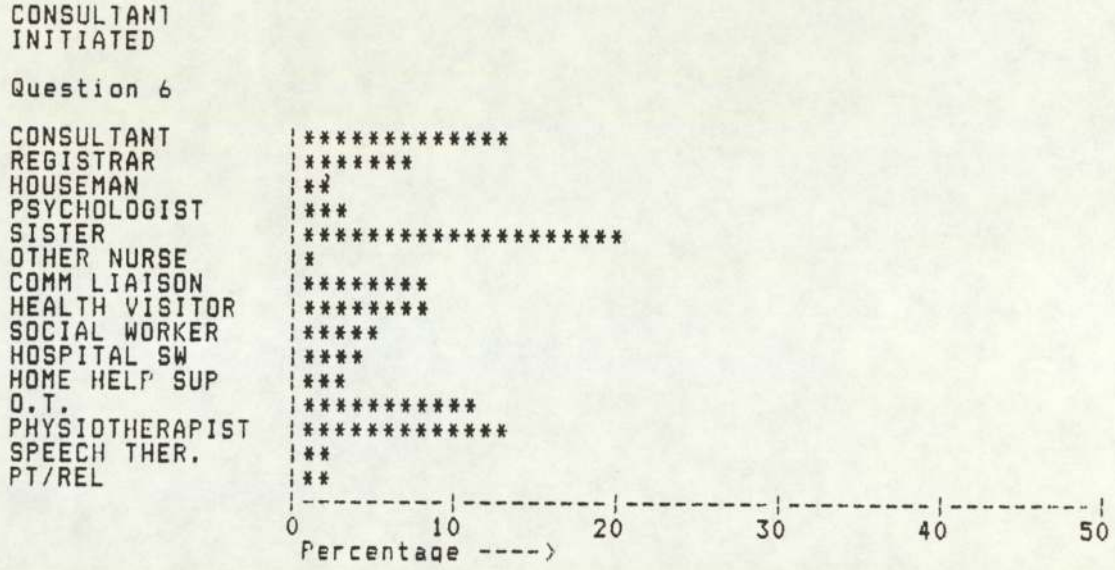
CONSULTANT
INITIATED

Question 5



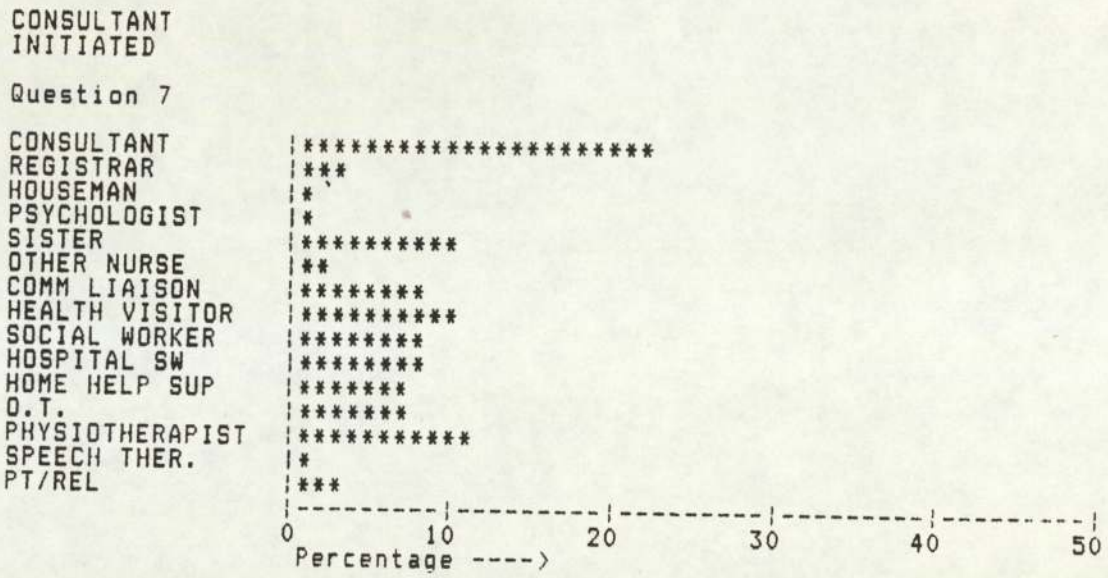
GRAPH 18

Gives orientation, information, repetition, confirmation.



GRAPH 19

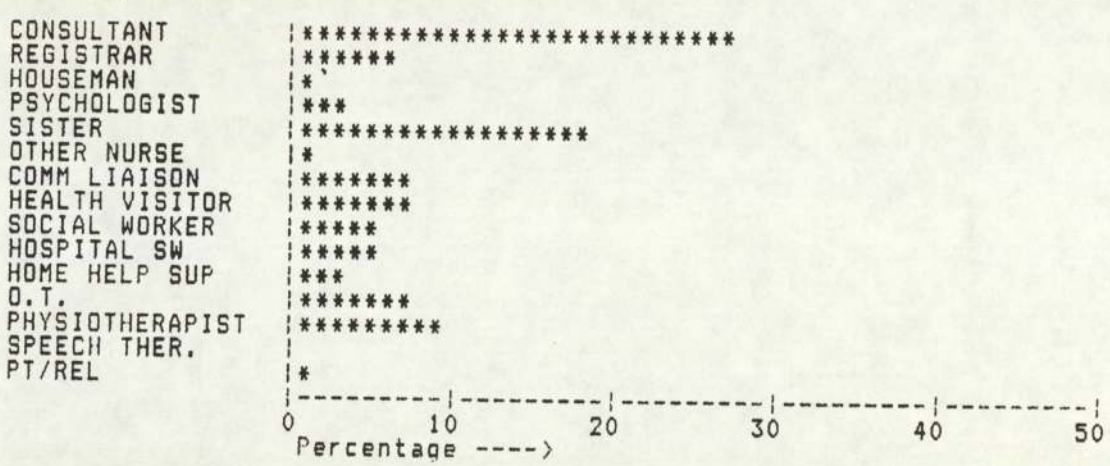
Asks for orientation, information, repetition, confirmation.



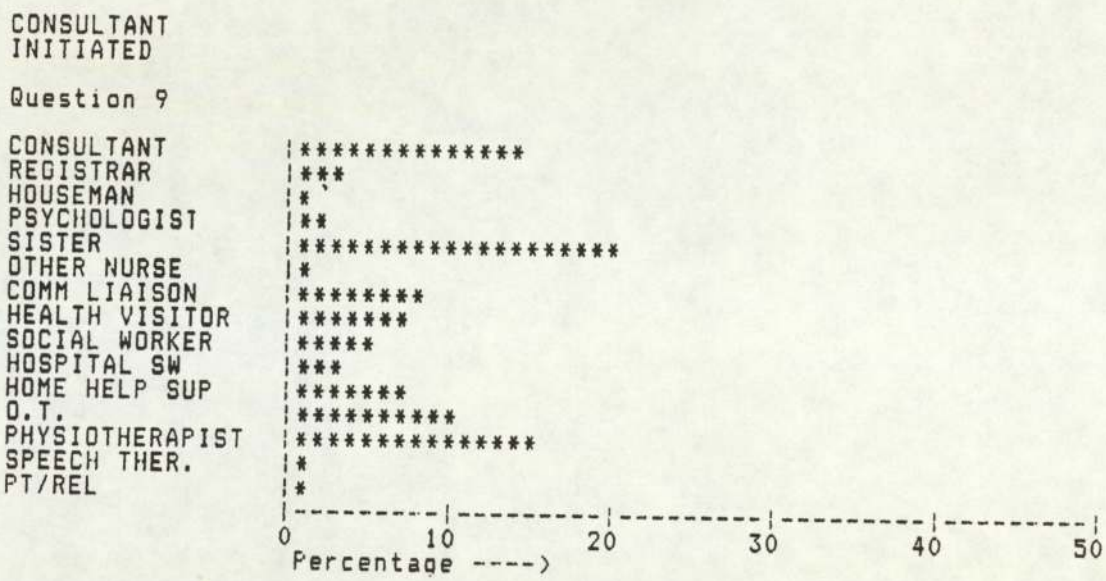
Asks for orientation, evaluation, analysis, expression of feeling.

CONSULTANT
INITIATED

Question 8

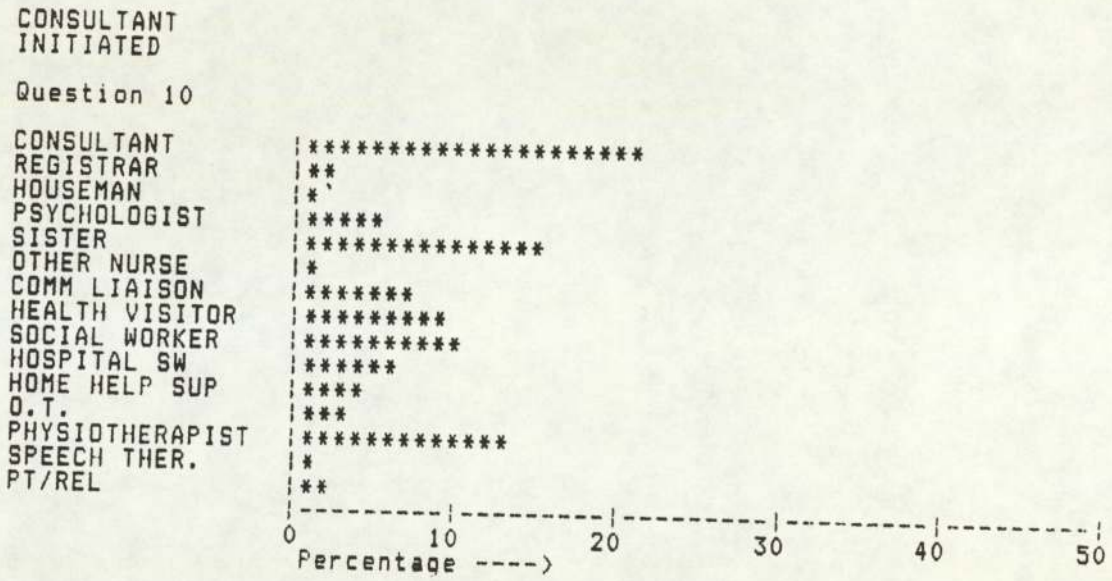


Asks for suggestion, direction, possible ways of action.



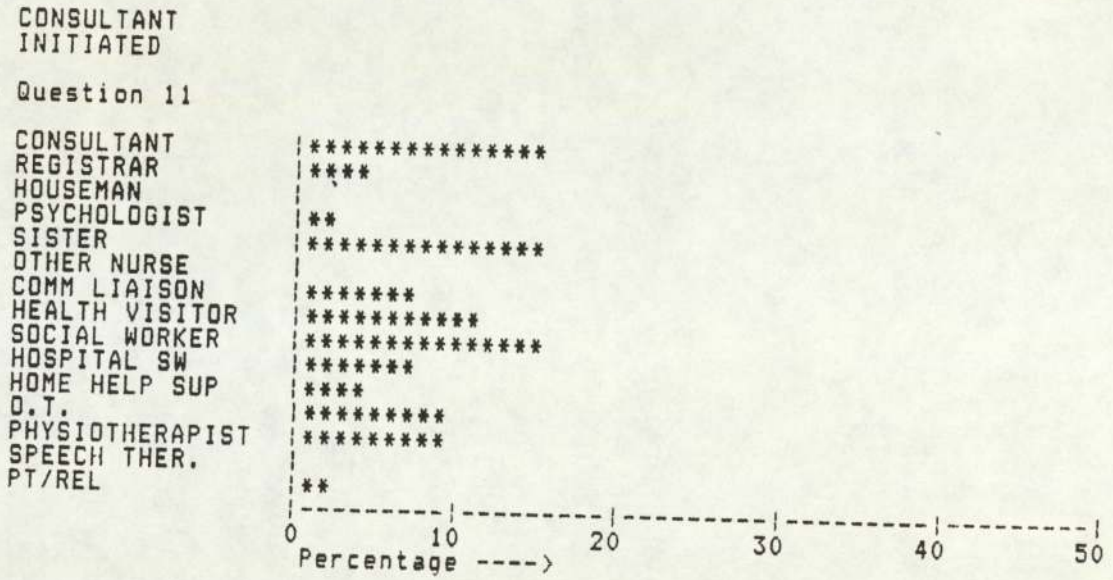
GRAPH 22

Disagrees, shows passive rejection, formality, withholds, held.



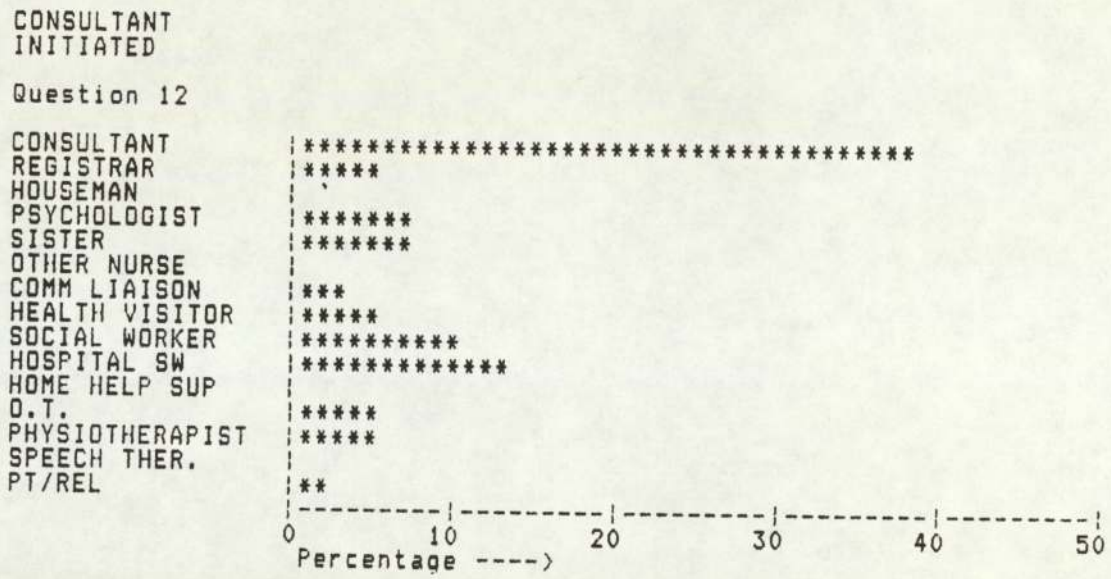
GRAPH 23

Shows tension, asks for help, withdraws out of field.



GRAPH 24

Shows antagonism, deflates others status, defends or asserts self.



NON CONSULTANT INITIATED CONFERENCES

The purpose at this stage is to identify differences in response behaviour with and without the leadership of the consultant.

The random selection process has determined a natural sample in which the number of non consultant initiated conferences are few, amounting to only 32% of the total. Were Senior Registrars to be considered as consultants the percentage would reduce to 16%. It is important to recognise that no statistical significance is attributed. The presence of consultants/medical staff was rare, although because of low numbers it would appear more prevalent than is the case.

Question 1

Shows solidarity, raises others status, gives help, reward.

Here an alternative leader emerges - the dominant conference initiator - the ward sister, but it is worthy of note that this is less marked than previously recorded for consultants. Response among other groups is generally similar, with a noteably higher input from social workers and physiotherapists.

The tone of the sisters response was observed to have changed. There was less of a 'banter' response to others and a general air of support and encouragement.

Question 2

Shows tension release, jokes laughs, shows satisfaction.

There was little recorded difference between this and previous responses in respect of individuals or as a total contribution to the conferences amounting to 10.5% of the total responses for non consultant initiated compared with 8.6%.

Question 3

Agrees, shows passive acceptance, understands, concurs, complies.

Here too, a similar level of response was recorded, in the order of 16%.

An interesting supposition was made by a health visitor, when asked to comment on the similarity in levels of agreement between the two circumstances stated:

> "Yes, but do we agree in the former (consultant initiated) because we feel compelled to and in the latter because we genuinely agree".

The author is not able to judge whether this is a valid representation and acknowledges a failure in the research design to accommodate this perspective.

Question 4

Gives suggestion, direction, possible ways of action.

What is clearly evident here is the greater degree of interaction by all participants, including the previously responsive ward sister, whose response has increased marginally. Overall there is a response rate of 16.8%, an increase of 11% over the similar rate recorded for consultant initiated conferences. There is a 50% increase in contribution by community staff, social workers and by paramedical groups.

Comments on this were as follows:-

> "I feel my contribution is valued more when consultants are not involved".
>
> Social Worker

> "I was not conscious of it, but I suppose I leave it up to the ward sister, when doctors are present".
>
> Health Visitor

"There's not a lot to say, clearly people hold back because they know I will make any decision".

Consultant

"There is just a better feel about things when doctor is not here - more freedom to act".

Sister

"When doctor is not around I think we pull together more - share the responsibility - none of us are overly confident".

Sister

"We discuss the right issues - more freely".

Health Visitor

Question 5

Gives opinion, evaluation, analysis, expresses feeling, wish.

Again, a significantly higher response rate, even more markedly increased among physiotherapists and occupational therapists. It is reasonable to consider that these disciplines would have a significant contribution to make in the care decision, the nature of their relationship with the patient enables them to be well informed and in a position to offer professional evaluation of the patients physical ability.

> "It is sad to consider that this is not achieved in the presence of consultants - an opportunity missed, but I know its true. I never feel my comments are welcome - I used to try but soon realised it was more expedient to remain silent".
>
> Health Visitor

> "We share our opinions on a day to day basis, but I know some staff feel inhibited in a big meeting".
>
> Ward Sister

> "I meet with the staff individually to share ideas and generally update - its quicker that way, we agree an action plan and everyone knows where they are".
>
> Community Liaison

Question 6

Gives orientation, information, repartition, confirmation.

The general trend of increased responsiveness continues. It is particularly interesting to note that the contribution of the social worker is significantly higher. One cannot deny the value of knowledge of the social care situation in determining courses of action. It is important to recognise that not all home situations would warrant social worker input, however, it was frequently observed that even when the social worker had no 'case responsibility' there was, in the non consultant initiated conferences, a valued information exchange, particularly with regard to financial issues - availability of grants and benefits.

Question 7

Asks for orientation, information, repetition, confirmation.

In this area of interaction it would have been reasonable to expect little change, recognising that any 'orientation' would be relevant only to an individual's required action. However, that does not appear to be the case. Particularly in respect of community practitioners, there is on average a 40% increase in interaction.

This insight poses several questions in respect of the consultant initiated conference, for example:

- do members leave the conference less well informed?

- do they have an adequate information base to perform effectively and efficiently?

- do participants derive information from an alternative source?

if so,

- what are the time and cost implications of this behaviour?

- is the source as reliable?

- is there an element of duplication?

These are questions which professionals should ask themselves.

Question 8

Asks for opinion - evaluation of analysis, expression of feeling.

Interestingly, in common with other disciplines, junior medical staff are more responsive in this area. One may consider the degree to which their confidence is subsumed by the presence of the consultant on other occasions.

There is little difference, however, in the response of ward sisters. One might submit that this is due to the more intimate working relationships built up between consultant and ward sister. Confidence rewarding competence through experience by both partners, over time. It is interesting to observe the reduced contribution of home help supervisors in this section, where the consultant is not present. Asked to comment on this, three home help supervisors inferred the same feelings, summed up by one as:-

> "The consultant holds the power, keeping everyone in check. At other times there is a 'free for all', I can't keep up with the pace of exchange".

Question 9

Asks for suggestion, direction, possible ways of action.

Again, the freedom of exchange is magnified in the absence of consultant direction. The total contribution by each member is proportionately increased. This may well be indicative of the response variable in each role that is - the need to ask, as is appropriate to the care need and action planned.

Social workers expressed the view that they felt more free to ask for suggestions without feeling ridiculed for their ignorance. There was general assent to this opinion.

Question 10

Disagrees, shows passive rejection, formality, witholds held.

Most notable, particularly within the nursing orientated disciplines, is the higher level of disagreement. When asked to comment on this the common response was:

> "disagreement within the profession is one thing - public disagreement would only weaken still further our position in the team".

The notion of a 'rank order' within team was commonly referred to in respect of consultant initiated conferences. As though there was an expectation of position, behaviour and their response. Consultants had mixed opinions as to the significant differences, but broadly conceeded that a type of hierarchy, which they headed, did exist.

Question 11

Shows tension, asks for help, withdraws out of field.

The significance of the presentation on the graph must be treated with some caution.

One observer reported a marked clash of personalities between two participants in one particular group observed, this continued over several observations.

What does appear to be of some significance is the absence of tension among the majority of participants in the non consultant arena compared with a commonality of tension symptoms in other conferences. Considered overall one must question the degree to which interaction is or is not inhibited by tension and the effect which this might have on care outcome.

Question 12

Shows antagonism, deflates others status, defends or asserts self.

In keeping with the common response, it would appear that in general there is a change in pattern between types of conferences. However, it is difficult to determine either causes, effect or relationship in the response indicated here.

Surprised to note the contribution of the sister to this forum of interaction, the question was posed to multi disciplines - why; responses inferred that the sister needed to be assertive in what might be considered a 'peer' group situation - to stamp authority and ensure order and progress.

Typical comment being:

> "Its wonderful to have a free and progressive professional debate - an exchange of views between disciplines".
>
> Physiotherapist

> "Unfortunately we get carried away with useful debate on policy or practice, if we are not careful we would never review any cases".
>
> Social Worker

Sisters held a slightly different view, they reported feeling a need to succeed - to prove themselves capable. Several expressed a sense of disloyalty to consultants by having the conferences, but justified their behaviour by recognising that in general they were far more active and made better progress.

TABLE 14

Section Three - Cost Summary

Based on 1986 mid-point salary scales:

Staff Member	Time - Minutes	No. of Records	£ Cost
Consultant	12281	148	3,005.1
Senior Registrar	8390	97	979.5
Other Doctor	2659	37	246.1
Psychologist	3868	50	517.7
Sister	14596	197	1,090.3
Other Nurse	3130	40	168.4
Community Liaison	13571	174	1,013.7
Health Visitor	13027	175	1,055.5
Hospital Social Worker	8556	126	804.4
Social Worker	7552	89	710.0
Home Help Supervisor	10717	120	791.4
Occupational Therapist	13311	171	1,200.8
Physiotherapist	13831	185	910.2
Speech Therapist	1630	20	85.5
	127119		£12,578.6

= 2118.65 hours

= 56.49 wte man days

Costs - as measures of efficiency and effectiveness

Efficiency -

It is suggested that a measure of efficiency would be the achievement of the lowest cost per unit of production. Application of this assertion to the conference population reveals that conferences 31 to 39, 62 to 76 and 167 and 168 hold the lowest order of costs. These conferences were initiated by ward sisters and community liaison staff. The lower cost may, therefore, be a consequence of inequality in salary rather than an achievement of production. It is however, not insignificant to the purpose of this exercise to note that consultant initiated conferences are substantially more costly.

Effectiveness -

It is acknowledged that an improved study design would have facilitated a more detailed analysis of the interaction content, from which at this juncture one could attribute costs more precisely to action. However, in respect of two measures of effectiveness the researcher questions whether this would have been of any great benefit in the light of the conclusion of the outcome study, pages 213 to 218, which suggest little relationships between conference activity and the ultimate care outcome. For the present purpose a simplistic comparison is made between cost per case actioned by consultant and by sisters and liaison staff.

Selection of Conferences for Comparison

The population of sister/community liaison staff identified were 22 in number (these are identified by the characters XS in Appendix 10). As the consultant population is disproportionate, it was deemed necessary for comparison to select an equal number from the consultant conferences - this was achieved by identifying every fifth consultant conference to a total of 22 (those selected are identified by the characters XXXC in appendix 10). Total costs were then compared as follows:-

Figure 15

Consultant	Sister/Community Liaison
Cost per cases actioned	Cost per cases actioned
£541.49	£281.95
Unit cost £7.02	Unit cost £0.2

The cost was determined by dividing the total cost per conference by the number of cases actioned totalled for each of the 22 conferences. As previously discussed, there are limitations imposed upon the ability of non medical staff to action cases without medical authority. It was, therefore, anticipated that fewer cases would have been actioned by non medical staff, thereby increasing the unit cost per case actioned. This was not so, consultants actioned 77 cases compared to 60 actioned by sisters. As can be seen from the totals, the differential remains great - a consequence of higher costs overall (due to salaries) in consultant initiated conferences. In terms of value for money one could assert that non consultant initiated conferences are the preferred option. This is, however, too

simplistic an approach, recognising the complexities of health care and the demands for medical judgement. Although the researcher would assert that medical judgement is imposed in many forums outside the case conference situation, to equal effect.

Conference Costs - General Discussion

There are a number of hidden costs not assessed in the cost summary, these include:-

- travel
- accommodation
- opportunity cost
- clerical resources

Without access to detailed information it was not possible to determine such factors. Suffice to say that the true cost of the case conferences observed would be significantly higher than those identified in the cost summary.

It must also be acknowledged that the sample represented a range of costs across various locations. Considered as a reflection upon outcome, where it is indicated that achievement levels vary very little between locations one could postulate that there is evidence of substantial wasted resources in certain locations.

Section III

Chapter Six

Development of Methodology in The Assessment of Outcome

Assessment of Outcome

- a selected after-care survey.

In an ideal situation, the preference would be to follow up all conference subjects, developing criteria against which to measure outcomes in order to make judgements as to the effectiveness of the case conference approach. Due to both time and financial constraint, this was not possible. However, a randomly selected sample of 95 patients were assessed, following discharge. Whilst one cannot infer that the outcome is to be directly attributed to the case conference, nor that the sample was sufficiently large to be considered truly representative, the results were both conclusive and alarming.

Discharge from hospital - an overview.

For the majority of patients discharge from hospital is the most important event of a hospital stay. The discharge of patients from hospital to home has been the subject of several research studies. Despite adverse findings and constructive recommendations for the handling of discharge procedures, the issue continues to be an area of concern. (69), (70).

The case conference approach to care may in part have originated from a need to mobilise a disparate band of forces to achieve the transfer of hospital patients into the community.

Evidence amassed from a wide range of research indicates that many patients who need support following discharge are either not

offered it or do not receive it. (71), (72). Various factors contribute to this - a lack of planning, inadequate channels for liaison, or ineffective use of established channels. The result being that the needs of the patient and family are not met and the appropriate domicillary services are not mobilised.

The main aims and objectives of an effective discharge procedure should be:

1) To provide continuity of care between hospital and the community by encouraging effective communication.

2) To prepare the patient and family, both physiologically and psychologically for the transfer home.

3) To promote the highest level of independence for patient and family.

4) To ensure a smooth transfer between hospital and home.

It has been demonstrated that 10% of all re-admissions are as a result of patients failure to cope with their illness, often through lack of understanding and adherence to prescribed treatment. In order to minimise this risk patients needs must be fully assessed before discharge. (73). In the same way that during hospitalisation all care and treatment is carefully planned and scheduled.

Early discharge planning is advocated to ensure that all necessary services are actioned. Presentation of cases at conference, from the outset of hospitalisation through to discharge offers the potential to ensure that all patient needs are assessed and met; that there is adequate communication between hospital and home and the objectives outlined previously are achieved. The degree to which this is successful is questioned here.

Methodology

Sample selection

Over a period of one year ten patients per month, to a total of 120 patients, were selected at random from the conference population for discharge. Of these seven patients subsequently died. Five proved to be unreliable as witnesses, due to dementia type illnesses. Four moved out of the area to live with relatives and a further nine declined to be involved in the study.

Initial Patient Contact

After obtaining permission from the various ethical committees, patients, and where appropriate relatives, were approached by the researcher and asked if they would consider being involved in the study. At this stage little detail was given, other than to say that the research concerned the observation of discharge procedures and that the researcher would like to visit them at home for an interview which would last about twenty minutes. Most patients welcomed the prospect and many voiced concern at the loneliness experienced at home, a factor possibly exacerbated by hospitalisation. A date and time was agreed, set at ten days after discharge from hospital. Each patient was given a card containing the details and researchers signature, which for their security they were advised to compare with a similar card carried by the researcher. Appendix 11.

Interview Schedule

This was derived through discussion with ward staff, community liaison and social workers, who determined the twelve most common services required on discharge from hospital. The form was kept

as simple as possible in order that it did not pose a distraction in the interview. No patient identifiers were included on the form, although a copy of the appointment card was pinned to each form in the first instance in order that the first four information columns could be completed prior to discharge. See figure 7 page 201 , figure 8 page 202 , also appendix 11.

Validity

All interviews were conducted by the researcher. The information recorded related to fact, i.e. the presence or absence of services. No judgement was made as to whether the patients perception of need was valid. It was not considered necessary therefore to persue any further objective validation procedures.

Interview Schedule

DISCHARGE SERVICES SURVEY														
Service	Received After Discharge and not Received Before Admission	Received Before Admission but not After Discharge	Service Discussed at Case Conference	Service Received in Hospital	Received After Discharge							Total	% Wanting Service
					Same Day	Next Day	2 – 3 Days	4 – 7 Days	8 Days	Not Known	Total		
Bathing – Nursing Auxiliary													
Tuck In (Evening Auxiliary or Vonunteer)													
Commode													
Home Help													
Meals on Wheels													
Walking Aides													
Wheelchair													
Chiropodist													
Social Worker													
Health Visitor													
District Nurse													
Doctor													

FIG. 8

Interview Schedule

Result Totals

DISCHARGE SERVICES SURVEY

Service	Received After Discharge and not Received Before Admission %	Received Before Admission but not after Discharge %	Service Discussed at Case Conference %	Service Received in Hospital %	Received After Discharge							Not Received	
					% Same Day	% Next Day	% 2 – 3 Days	% 4 – 7 Days	% 8 Days	% Not Known	% Total	% Total	% Wanting Service
Bathing – Nursing Auxiliary	9	–	5	N.A	–	1	3	4	–	–	11	79	11
Tuck In (Evening Auxiliary or Volunteer)	2	–	3	N.A	–	1	2	6	–	–	9	76	15
Commode	6	–	6	N.A	4	–	2	1	2	–	9	65	8
Home Help	5	4	20	N.A	2	6	12	10	1	4	35	65	7
Meals on Wheels	5	1	16	N.A	4	4	5	1	–	–	14	80	4
Walking Aides	2	–	3	4	1	1	1	–	–	–	2	76	1
Wheelchair	1	–	–	1	–	1	–	2	2	–	3	80	6
Chiropodist	5	22 (incl. clinics)	5	1	–	–	–	–	–	5	5	95	29
Social Worker	11	17	10	1	5	1	2	2	–	2	12	71	17
Health Visitor	–	–	4	–	–	–	–	1	–	1	1	98	5
District Nurse	7	–	20	–	2	15	7	6	1	–	31	69	–
Doctor	2	20	5	–	2	5	8	10	20	2	44	56	30

Note: In considering the results it must be recognised that the interviews took place on day ten after discharge, the pattern of services received may vary after this time. No follow-up visits were undertaken.

Results

Implementation of Services

A. **Services received after discharge and not before admission.**

The range of services provided has substantially increased. Two factors may contribute to this. Firstly the higher dependency of patients resulting from the illness itself or from temporary immobility consequent upon treatment (e.g. limb surgery). The second being the exposure to services resulting from admission.

Exposure to service may take one of three forms, that which is:

a) directly related to treatment

b) initiated by care staff as a result of an assessment of needs

c) initiated at the patients request

a) Those services related to treatment are often pre-planned and have become part of custom and practice in a therapy regime e.g.

> Patients having replacement hip operations will have their toilet adapted by the provision of a raised toilet seat and hand rail

Within the case conference rarely were such detailed issues discussed. A typical reference would be.

> "You will organise all of the usual bits and pieces sister".
>
> Consultant

b) Medical, nursing and paramedical staff are responsible for making total care assessments. These will include treatment, therapy and social care needs. Frequently needs are highlighted which are totally unrelated to the current illness, more a consequence of ageing or social deprevation which without exposure to service will go undetected. Examples of documentation are contained in Appendix 12.

c) Patients are stimulated to request services by the convenience of the hospital situation, as a result of prompting by staff or more commonly by discussion with other patients receiving services. All of these circumstances were described in the interview.

Whilst the range of services increased, among those previously provided there was a marked decrease in chiropody, medicine and social worker input. The chiropody service reduction may have been the result of the purpose of hospitalisation having resolved the problem. No diagnostic or treatment factors were recorded - from general conversation one would have reason to suspect that this was not the case, a more rational explanation would be that having been hospitalised, routine appointments were missed and not re-arranged. The admission and discharge procedures observed did not account for this factor.

The decrease in social worker activity is surprising. Much of their workload concerns social and family needs which commonly have an inverse relationship to illness and thus are likely to continue after discharge. On questioning social workers frequently referred to the cancellation of patients from workload lists, upon hospital admission. They also indicated that as the case conference social workers were not necessarily of the same team, cross referencing was not always effective.

Medical involvement would reflect the pattern of illness, treatment and cure.

B. **Services received before admission but not after discharge.**

Significant factors have been referred to under item A.

C. **Services- these are considered individually under a separate heading.**

D. Services - discussed at case conference.

In retrospect the researcher considers that a different research design would have been beneficial here. Had detail of the issues discussed at conferences been recorded, this would have allowed for direct comparison of data between the two research studies. The enormity of such a task would demand observational resources beyond the limits of the present study but would be recommended as an area for further work.

Subjective View

There appeared to be no relationship between the subject of interaction and the consequent service needs, either met or unmet. The recorded observation activity shows no relationship between the contribution of the service provided in case conferences and the service needs met, examples are as follows:-

- No verbal contribution was recorded by the Womens Royal Voluntary Service, although meals on wheels was noted as a conference issue in 16% of patient care.

- Home help services feature significantly although the home help supervisors contribution was recorded as negligable. (see page 202).

- District nursing contributions were comparable.

E. Services Received in Hospital.

There appears to be no relationship between these factors.

F. Services Received after Discharge.

These are considered under the appropriate heading.

G. Services Not Received.

It is not the purpose here to explore the relationship between needs and demands or between service expectations, potentials and met needs. This could usefully be the subject of a separate study.

Of relevance is the recorded high proportion of services not received. These are services which are of professionally proven need as opposed to the perceived needs of the patient or relative. It could be contended that the date of interview, influenced the outcome and had further follow up visits have been made an improved pattern of service would emerge. One must consider however, that hospital discharge is a significant event, largely due to economic exegiences early discharge is common. People returning home are often of high dependency and require continuation of treatment, therapy and care.

All of the patients interviewed had been the subject of case conference, it would be reasonable to contend that were conferences effective, services would have been mobilised to meet early discharge needs. Further, it would be reasonable to expect these within ten days of discharge.

Services

Bathing -

Services of untrained personnel could in theory be mobilised more readily than where specialist resources are required.

The outcome may, however, be distorted by the effects of timing - bathing schedules are weekly in some areas.

Tuck In Service -

Such services are provided only to those patients without other means of support - the infirm living alone or with other disabled relatives. The level of provision is significantly higher although response is not immediate and one again is led to question whether case conference discussion was effective in providing for discharge in this context.

Commode -

Evidence of effective arrangements but significantly less than ideal for what may be considered an essential service. It should be recognised that mobility does sometimes become problematic after discharge as the hospital situation does not test the situation fully.

Home Help -

Frequently the discussion at conference and evidence suggests an adequate response. It should be noted that this would not necessarily be a daily service provision. One must also consider the high level of service input prior to hospitalisation.

Meals on Wheels -

It is interesting to note that this issue was predominant on the case conference agenda. The relationship of diet to health is a significant one. Interestingly the relationship of provision to contribution of the voluntary sector is striking. This applauds the effectiveness of systems used to mobilise services outside the conference forum.

Walking Aids -

Whilst demand will be very much related to physical/clinical need, should there be reliance upon aids, it is imperative that they be provided at an early stage. Mobility for the elderly effects every aspect of their health and welfare, both physiologically and psychologically.

Wheelchair -

Comments as above.

Chiropody -

Discussed under item c above. No relationship should be inferred between supply, demand or apparent delay. It is of note that chiropodists were on no occasion part of the conference team.

Social Work -

This is discussed under item c above. The response time for services is alarming and should be the subject of further investigation.

Health Visitor -

A relatively low issue in case conference as was the interaction response by health visitors. Specialist geriatric health visitors operate in certain Health Districts. There is known to be difficulties in demarcation between the role of health visitor and social worker. Interestingly, despite similarities in training, this does not arise in the relationship between community nurse and health visitor.

District Nurse -

A significantly high demand for this service but noteably no direct relationship between need, supply and conference. Statutory responsibility in district nursing dictates that 'first visits' (that is the visit in which care assessments are made), must always be conducted by a Registered Nurse. It is surprising, therefore, to see the low response rate in the early days after discharge.

Whilst it is noteable that the perceived need for services of the district nurse is significantly higher than for any other service, experience of this research leads the author to question the perception of need by patient. During interview patients strongly expressed to the researcher, feelings of loneliness, fear, isolation and the need for someone "just to talk to". Interviews planned for twenty minutes regularly carried on after the formal session into what could only be termed a 'social event' lasting hours rather than minutes.*

* This is an issue of concern. Had the interviewer not been of a professional background and able to recognise the events in their proper context, where necessary referring on to other agencies - the research situation could have been detrimental to the patient. The responsibility of ethical committees in this regard is unclear and was not taken up by any of the committees to whom the protocol was submitted.

Doctor -

The Doctor in this context was the General Practitioner who was not party to the case conference, although the need for contact was raised in some conferences.

The response by General Practitioners was the highest of all services. This is significant, recognising that discharge letters are not sent from hospital until after the discharge has taken place. There is commonly continuity with patients who have been admitted to hospital, despite the transfer of care responsibility. General Practitioners often visit their patients in hospital. When questioned they indicated that the majority of their information was gleened from the ward sisters informally.

Chapter Seven

Conclusion

Chapter Seven

Conclusions

To those working in the caring professions, the continual quest for efficiency and effectiveness becomes overpowering. Much time and energy is deployed in measuring performance and determining new and more cost effective approaches to care.

Somewhere in the flurry of activity surrounding performance measurement and the business of meeting the continual demands of service, the most basic question of all is lost - is that performance, that activity really necessary? Is the activity itself beneficial.

This work has attempted to correct that failing in respect of one small aspect of service-in the use of case conferences. Assumed in the acceptance of the case conference approach to decision making is the mythical value afforded teamwork itself. This too is questioned. Evidence presented herein suggests that particularly where case conferences are led by a consultant - there is limited expression of true teamwork - defined by Woodcock as:

> "a group of people working together to accomplish more than they could alone". (op.cit., 27).

In order to place the case conference approach into context the first part of this study has been addressed to an exploration of teamwork and its practice in the structural context of public service. From this exploration it is clear to see that the ethos

of team working permeates through all levels of public sector activity and is often imposed by statute determining compliance for example with prescribed management styles.

In circumstances of such indoctrination it is not surprising that acquiescence prevails, further supported by the natural phenomena in human behaviour - the desire to be part of a group - to be wanted.

From evaluation of the individual contribution of team members, one is led to question whether the outcome of individual working would not contribute more greatly to care outcome. It has been demonstrated both by comparison between groups of differing composition and by assessment of care outcomes that more is achieved outside the customary case conference practice.

From the analysis of interaction it is evident that Doctors and Ward Sisters make the greatest contribution. Ironically these are the two participants for whom communication, other than through case conferences, is easily achieved. Anecdotal evidence leads one to consider that other conference participants use external communication mediums for the true assessment of care. Appendix 12 provides examples of record systems used totally independently of case conferences. At no time were such records prepared within a case conference, or it is reported, as a direct consequence of the knowledge gleened in conferences.

Working harmoniously in a team depends so much on individual personalities - on a willingness to listen to other members, which requires a climate of trust and understanding. There was limited evidence in the interaction analysis to suggest either recognition of the willingness to listen or of trusting. Can a case conference team prosper without such a climate? It would

appear that hierachial relationships all be they imaginary, like the prevelance of professionalism militates against effective working in this forum.

There are declared benefits to group working. The process of shared learning and commonality of purpose. In this context it is interesting to note that no conference organiser could provide an explicit statement of purpose, defined terms of reference or aims and objectives for the conference. One could contest that with the benefit of such guidance the true value of case conferences would be manifest. With declared parameters one may find that participants have greater confidence in their team role and thus contribute more freely.

The author considered it important to hold the natural state constant for the purpose of observation. Had an experimental design been employed the work may have been improved by the opportunity to assess the value of defined purpose - that is a research design in which a control group are observed without explicit aims and objectives whilst a second or several groups operate to defined aims and objectives - this would be a useful area for further study.

Many issues of concern are raised by the study of outcomes. Not least with regard to unmet needs and delay in the provision of services. A report has been provided to all of the Authorities concerned. In two situations the author has been advised that this has compelled changes in practice. In one Health District case conferences have been abandoned for the past nine months. The Authority is conducting its own evaluation, preliminary findings indicate improvements in service, such as quicker response times and a manpower saving of two whole time equivalent community liaison staff, has been made. It would be useful to conduct such an assessment on a wider scale.

The costs of operating case conferences are substantial. The sample selected in this study consumed well in excess of the accounted £12,578 simply in salaries. One could speculate on the cost of such activity nationally using the following assumptions:-

The cost of one conference = £12,578	200 =	£62.89 **
An average of 6 conferences per District per week	=	£377.34
52 weeks per year	=	£19,621.68
191 Health Districts in England and Wales ∴ x 191	=	£3,747,740.88

The hidden costs of conferences - travel, accommodation, etc, together with rises in salary since 1986 would put the cost more realistically in excess of £5 million. Additionally one must consider the opportunity cost in respect of alternative uses of staff time.

Managers must responsibly ask the question - are conferences an efficient use of resources? More importantly professionals must ask of themselves - have they the right to subscribe to unproven and ineffective practice?

Evidence in this research supports the hypothesis:

> "Teamwork as practiced in case conferences makes a very limited contribution to the outcome of care, and does not respect the need for efficiency and effectiveness".

** Based on 1986 mid point salary scales

It is the professional responsibility of all carers to ameliorate these facts - the author presents this challenge to all responsible professionals whose contribution is a valuable resource, to be vigorously deployed with wisdom and sincerity for the benefit of those we serve.

Recommendations - including issues for further study

1) That professionals of all disciplines should examine their working patterns, particularly those established by custom and practice.

2) That where case conferences are practiced they conform to some general statement of purpose, including:-

   Terms of reference
   Aim
   Objectives

3) That discharge planning is examined.

4) That assessment of need is related in statement of time to its achievement in order that patients discharged from hospital receive at an appropriate time the services and resources to enable them to achieve an acceptable quality of life.

5) That Social Worker response time should be examined. (page 202).

Issues for further study

1) To explore the control mechanisms of decision and their influence on team working. (page 20).

2) To examine the process of discharge decision, to ensure that 'assumption' does not negate instruction. (page 71).

3) To examine the effects of the environment/location upon the behaviour of team members in case conference. (page 74).

4) To re-examine the data provided herein and explore more fully the quality and process of interaction. (page 101).

5) To determine the degree of patient/relative involvement in care decision. To assess the benefits of their involvement in terms of care decision and outcome. (page 114).

6) To conduct a major observational study which examines in detail the verbal content of case conferences; to enable a more thorough examination of decision and outcome. (page 206).

7) To examine the difference between professional and patient determined need and assess the relationship to care outcome. (page 207).

8) To construct an experimental study design in which comparison is made between the outcome of case conference which:

a) operate to explicit objectives, and
b) do not

(page 216).

9) To monitor the effects upon outcome where case conferences are withdrawn from practice, across a number of Health Districts and to compare costs and benefits. (page 216).

APPENDICES

APPENDIX I

NATIONAL ASSISTANCE ACT

SECTION 47 OF THE NATIONAL ASSISTANCE ACT 1948
AS AMENDED BY
SECTION I NATIONAL ASSISTANCE (AMENDMENT) ACT 1951

INTRODUCTION

Section 47 makes it possible for someone who needs care and attention to be removed against their will to suitable premises with an Order from a Magistrates Court. As this section, whichever way it is used, involves depriving an innocent person of their liberty it must only be used in circumstances where he or she is unable to care for themselves, when every method of providing care in that person's home has been tried extensively to no avail, and when admission to an appropriate place of care has been refused.

The criteria for the application of the Act require that the person in question must be one who:-

a) is suffering from grave chronic disease
or
being aged, infirm,
or
physically handicapped
IS living in insanitary conditions
AND

b) is unable to devote to him/herself, and is not receiving from others, proper care and attention.

The requirements in a) and b) above are absolute and must be noted carefully.

APPENDIX 2

E S A INFORMATION RETRIEVAL SERVICE

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*                                                            *
*                                                            *
*          E S A    INFORMATION RETRIEVAL SERVICE            *
*                                                            *
*                                                            *
**************************************************************

USER1696   DATE:03/01/83   TIME:14:53:31

            SEARCH HISTORY
SET ITEMS DESCRIPTION                                  PRINT SUMMARY
                                                NO. FILE ACCN/SET FMT   ITEM-RANGE
  1     0  TEAMWORK? OR TEAMWORKING/CT             1   35       31  4      1-38
  2     0 CT=TEAMWORKING
  3     0 TEAMWORK OR TEAM(W)WORK
  4     0 TEAMWORKING
  5   235 TEAM?
  6     0 CT=CASE REVIEW SYSTEM
  7     1  CASE(W)REVIEW(W)SYSTEM?
  8    61 COLLABORATION
  9     1 COOPERATIVE(W)CARE
 10   214 INTERACTION
 11     2  CASE(W)CONFERENCE?
 12   141 COOPERATION
 13     6 JOINT(W)CARE
 14   416 7+8+9+10+11+12+13
 15   638 SOCIAL(W)WELFARE
 16   178 HEALTH(W)CARE
 17   579 HEALTH(W)SERVICE
 18  1066 SOCIAL(W)SERVICE
 19     7 SOCIAL(W)SERVICE(W)DEPARTMENT
 20   187 NATIONAL(W)HEALTH(W)SERVICE
 21     0 DEPARTMENT(W)OF(W)HEALTH(W)AND(W
 22     0 DEPARTMENT(W)OF(W)HEALTH
 23    96 DHSS
 24    89 NHS
 25     4 PSSC
 26    22 MEDICAL(W)CARE
 27  2179 15+16+17+18+19+20+22+23+24+25+26
 28  2080 15+16+17+18+19
 29   330 20+22+23+24+25
 30  2179 28+29+26
 31    38 30*14

SRCH TIME     19.40   PRINT COUNT      38   DESCS.:          37
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82-NZ-25968 Acompline 82007898
HEALTH CARE OF THE HOMELESS AND ROOTLESS: FINAL REPORT OF THE JOINT CARE PLANNING TEAM WORKING PARTY
CS: LAMBETH SOUTHWARK AND LEWISHAM AREA HEALTH AUTHORI / JOINT CARE PLANNING TEAM WORKING PARTY
THE AHA, 1980 UNPAGED Res.Lib.Ident.: P50391

MAKES A SERIES OF RECOMMENDATIONS FOR IMPROVEMENT AND AVAILABILITY OF HEALTH CARE SERVICES TO THE HOMELESS AND ROOTLESS, CONSIDERING GENERAL PRACTITIONER SERVICES, NURSING, RADIOGRAPHY, CHIROPODY, HEALTH EDUCATION AND NUTRITION, ACCIDENT AND EMERGENCY DEPARTMENTS, PSYCHIATRIC SERVICES AND DENTAL SERVICES

Geo-Location: UNITED KINGDOM
Controlled Terms: CARE / ACCIDENT / GP / HOMELESS / HEALTH / LONDON / HOSTEL / IMPROVEMENT / EMERGENCY / HEALTH EDUCATION / DAY CENTRE / CHIROPODY / LODGING HOUSE / PSYCHIATRY / CAMBERWELL RECEPTION CENTRE / NUTRITION / DENTAL HEALTH SERVICE / NURSING / HEALTH CARE / RADIOGRAPHY

82-NZ-21478 Acompline 82004492
COLLABORATION BETWEEN HEALTH AND LOCAL AUTHORITIES; WHY IS IT NECESSARY?
WISTOW G. CS: NATIONAL HEALTH SERVICE
SOCIAL POLICY & ADMINSTRATION, SPRING 1982 165(1) PP44-62

FOUR CATEGORIES OF COLLABORATION FEATURING IN THE 1974 REORGANISATION OF THE NATIONAL HEALTH SERVICE ARE DISCUSSED - THE SHARING OF SERVICES, COORDINATION OF SERVICE DELIVERY, JOINT PLANNING AND JOINT PREVENTION. THE NEED FOR EACH IS CONSIDERED IN THE CONTEXT OF THE REORGANISATION DEBATE AND SUBSEQUENT EVENTS. CONCLUDES THAT THE PRESENT GOVERNMENT'S APPROACH TO THE STRUCTURE AND MANAGEMENT OF NHS IS LIKELY TO UNDERMINE ITS POLICY OBJECTIVES, ESPECIALLY IN COMMUNITY CARE
Controlled Terms: COLLABORATION / COMMUNITY CARE / GOVERNMENT / HEALTH / MANAGEMENT / LOCAL GOVERNMENT / POLICY / STRUCTURE / PLANNING / REORGANISATION / HEALTH AUTHORITY

82-NZ-24414 Acompline 82003377
TENANTS AND TOWN HALL
ANDREWS C. L. CS: DEPARTMENT OF THE ENVIRONMENT
HMSO, 1979 342PP 50647,50648

STUDY OF AN INNER LONDON HOUSING ESTATE IN THE CONTEXT OF THE SURROUNDING NEIGHBOURHOOD AND IN RELATIONSHIP TO THE LOCAL AUTHORITY DEPARTMENT CONCERNED WITH THE WELFARE OF THE ESTATE AND ITS RESIDENTS

Geo-Location: INNER LONDON
Controlled Terms: HOUSING / CHILDREN / COMMUNITY CENTRE / COMMUNITY / EMPLOYMENT / LOCAL GOVERNMENT / RECREATION / SCHOOL / TENANTS ASSOCIATION / TENANT / SOCIAL INTERACTION / SOCIAL WELFARE / TENANT / YOUTH CLUB / HOUSING ESTATE / TOWN HALL

82-NZ-23609 Acompline 82001712
VOLUNTARY AND STATUTORY COLLABORATION - RHETORIC OR REALITY?
LEAT D. UNELL J.; SMOLKA G. CS: WOLFENDEN COMMITTEE / NATIONAL COUNCIL FOR VOLUNTARY ORGANISATIONS / COUNCIL OF VOLUNTARY SERVICE / PARTICIPAT
BEDFORD SQUARE PRESS/NCVO, 1981 216PP

IN 1977 THE WOLFENDEN COMMITTEE REPORT, 'THE FUTURE OF VOLUNTARY ORGANISATIONS', REVEALED THE SUBSTANTIAL ROLE THE VOLUNTARY SECTOR PLAYS IN SOCIAL WELFARE, AND ENCOURAGED GREATER CONSIDERATION OF THE PART VOLUNTARY ORGANISATIONS SHOULD PLAY IN SOCIAL PLANNING IN CO-OPERATION WITH THE STATUTORY PROVIDERS. CASE STUDIES AT LOCAL LEVEL OF THE VOLUNTARY-STATUTORY RELATIONSHIP ARE REPORTED. IT IS CONCLUDED THAT A MORE EXPLICIT GOVERNMENT FRAMEWORK OF COLLABORATIVE PLANNING IS NEEDED
Controlled Terms: FUNDING / VOLUNTARY SECTOR / COLLABORATION / GOVERNMENT / REGULATION / LOCAL GOVERNMENT / POLICY / SOCIAL WELFARE / SOCIAL SERVICE / SOCIAL PLANNING / FUTURE / LOCAL / PLANNING / PLAY / FINANCE / COMMUNITY WORK / REFORM / VOLUNTARY GROUPS / VOLUNTARY / STAFFING

81-NZ-23448 Acompline 81007411
VOLUNTARY SOCIAL SERVICES
JOHNSON N.
MARTIN ROBERTSON AND BASIL BLACKWELL, 1981 184PP

WRITTEN IN THE LIGHT OF PUBLIC EXPENDITURE CUTS AND THE CONSEQUENT INCREASINGLY IMPORTANT ROLE OF VOLUNTARY ORGANISATIONS. AN ANALYSIS OF THE PURPOSES AND FUNCTIONS OF VOLUNTARY SOCIAL SERVICES INCLUDING CONSIDERATION OF THEIR COOPERATION WITH EACH OTHER AND WITH CENTRAL AND LOCAL GOVERNMENT. ALSO DEALS WITH FINANCE AND STAFFING. APPENDIX LISTING NATIONAL VOLUNTARY SOCIAL SERVICE ORGANISATIONS
Controlled Terms: LOCAL GOVERNMENT / SOCIAL SERVICE / VOLUNTARY GROUPS / FINANCE / VOLUNTARY / STAFFING / ANALYSIS / PUBLIC EXPENDITURE CUTS

81-NZ-23447 Acompline 81007410
VOLUNTARY OR STATUTORY COLLABORATION; RHETORIC OR REALITY?
LEAT D. UNELL J.; SMOLKA G. CS: NATIONAL COUNCIL FOR VOLUNTARY ORGANISATIONS
NCVO, 1981 216PP

ANALYSES THE ROLE OF VOLUNTARY ORGANISATIONS IN THE PLANNING OF WELFARE PROVISION. QUESTIONS OF FUNDING, MEMBERSHIP, STAFFING AND WORKING RELATIONSHIPS WITH LOCAL AUTHORITIES ARE EXAMINED
Controlled Terms: REGULATION / LOCAL GOVERNMENT / SOCIAL SERVICE / SOCIAL WELFARE / PLANNING / VOLUNTARY GROUPS / VOLUNTARY / STAFFING / FUNDING / COLLABORATION

81-NZ-20525 Acompline 81006820
HOUSING - LOOKING AFTER THE DISABLED
GOLDSMITH S.
LOCAL GOVERNMENT CHRON, 4 SEPT 1981 5965, PP905-908

DURING THE PAST TWO YEARS FINANCIAL AID FOR HOUSE ADAPTATION FOR DISABLED PEOPLE IN THE PRIVATE SECTOR HAS BECOME INCREASINGLY CHANNELLED THROUGH THE HOUSE RENOVATION GRANT SYSTEM, USING POWERS UNDER THE HOUSING ACT 1974 . ARTICLE LOOKS AT THE EFFECTIVE COLLABORATION IN THIS AREA WHICH HAS DEVELOPED BETWEEN ONE COUNCIL'S ENVIRONMENTAL HEALTH DEPARTMENT AND THE LOCAL SOCIAL SERVICES DEPARTMENT

Geo-Location: PRIVATE SECTOR
Controlled Terms: ACCOMMODATION / DISABLED / SOCIAL SERVICE / LOCAL / POWER / FINANCE / HOUSING ACT 1974 / ENVIRONMENTAL HEALTH / HOUSING RENEWAL / HOUSE RENOVATION GRANT / HOUSING ADAPTATION

81-NZ-20229 Acompline 81006115
THE MEDIA PROJECT: SOCIAL ACTION AND THE BROADCASTING MEDIA
DRESNER S. CS: VOLUNTEER CENTRE
EDUC BROADCASTING INT, JUN 1981 14(2) PP72-74

THE AIMS OF THE MEDIA PROJECT, ESTABLISHED IN 1977 BY THE VOLUNTEER CENTRE ARE OUTLINED AND ITS WORK IN COMPILING AND DISSEMINATING INFORMATION ABOUT SOCIAL ACTION BROADCASTING IS DISCUSSED. ALSO COMMENTS ON RESEARCH ACTIVITY AND COOPERATION WITH OTHER ORGANISATIONS IN THE EDUCATION AND WELFARE FIELD
Controlled Terms: INFORMATION / SOCIAL WELFARE / SOCIAL ACTION / WORK / MEDIA / EDUCATION / BROADCAST / INFORMATION DISSEMINATION / MEDIA PROJECT

81-NZ-21934 Acompline 81004647
LIAISON IN PRACTICE
CS: DEPARTMENT OF HEALTH AND SOCIAL SECURITY / ASSOCIATION OF COUNTY COUNCILS
DHSS, 1980 26PP

PREPARED BY A JOINT LOCAL AUTHORITY ASSOCIATIONS AND DHSS WORKING PARTY, TO GIVE GUIDANCE ON COOPERATION BETWEEN SOCIAL SERVICES AND SUPPLEMENTARY BENEFIT LOCAL OFFICES

Geo-Location: ENGLAND; SCOTLAND; WALES
Controlled Terms: LOCAL GOVERNMENT / SOCIAL SERVICE / OFFICE / SOCIAL WORK / MANAGEMENT / LOCAL / SUPPLEMENTARY BENEFIT / TRAINING

81-NZ-19458 Acompline 81003677
COLLABORATION BETWEEN THE HEALTH AND SOCIAL SERVICES: PART I, A CASE STUDY OF JOINT CARE PLANNING
BOOTH T. A. CS: NATIONAL HEALTH SERVICE
POLICY POLITICS, 1981 9(1) PP23-49

HEALTH SERVICES, SOCIAL WELFARE, NATIONAL HEALTH SERVICE , LONDON,
Controlled Terms: CARE / HEALTH / LONDON / SOCIAL SERVICE / SOCIAL WELFARE / PLANNING / HEALTH SERVICE / STUDY

80-NZ-00730 Acompline 80008430
COLLABORATION - LITERATURE REVIEW
WEBLEY M. CS: NATIONAL HEALTH SERVICE
COMMUNITY CARE, 13 MAR 1980, P107

BIBLIOGRAPHY ON COOPERATION BETWEEN SOCIAL SERVICES AND THE NATIONAL HEALTH SERVICE
Controlled Terms: HEALTH SERVICE / BIBLIOGRAPHY / ON / COMMUNITY CARE / SOCIAL WELFARE / SOCIAL SERVICE

80-NZ-18467 Acompline 80007095
A SURVEY OF YOUNG MENTALLY HANDICAPPED PEOPLE IN THE LONDON BOROUGH OF EALING
WOODTHORPE J.; MITCHELL S. CS: NATIONAL HEALTH SERVICE / EALING HAMMERSMITH AND HOUNSLOW AREA HEALTH AUTHOR / HOUNSLOW LB SOCIAL SERVICES DEPARTMENT
HOUNSLOW LB, 1980 114PP

SURVEY UNDERTAKEN AT THE REQUEST OF THE JOINT CARE PLANNING TEAM (SUB-GROUP ON MENTAL HANDICAP) FOR EALING, HAMMERSMITH AND HOUNSLOW AHA , TO EXAMINE THE PREVALENCE OF MENTAL HANDICAP IN A PARTICULAR GEOGRAPHICAL AREA AND EXISTING LOCAL AUTHORITY AND NHS PROVISION. THE NEEDS OF SCHOOL LEAVERS AND YOUNG ADULTS WERE PARTICULARLY EXAMINED

Geo-Location: EALING
Controlled Terms: PLANNING / GROUP / LONDON BOROUGHS / MENTALLY HANDICAPPED / SCHOOL LEAVER / SURVEY / ON / DISABLED / CARE / DISABLED / GEOGRAPHY / LOCAL GOVERNMENT / RESIDENTIAL CARE / YOUNG PEOPLE

80-NZ-17937 Acompline 80004393
CO-OPERATION BETWEEN HEALTH AND SOCIAL SERVICES : IMPLICATIONS FOR POLICY
KAHAN B.
SOCIAL WK SERV, FEB 1980 (22) 29-34

HEALTH SERVICE, SOCIAL SERVICES, COOPERATION, DECISION MAKING
Controlled Terms: HEALTH SERVICE / DECISION MAKING / POLICY / SOCIAL SERVICE

80-NZ-17548 Acompline 80003922
JOINT CARE: CONFLICTS IN CO-OPERATION JOINT CARE: KEEPING UP THE PIONEER SPIRIT
REYNOLDS J. RATHWELL T.
HLTH SOCIAL SERV J, 7 SEP 1979 89(4658) 1144-5 14 SEP 1979 89 (4659) 1172-3
Controlled Terms: LOCAL / PLANNING / CONFLICT / HEALTH SERVICE / ON / FUNDING / JOINT CARE / BARRIER / CARE / HEALTH / LOCAL GOVERNMENT / POLITIC / SOCIAL SERVICE

80-NZ-17547 Acompline 80003921
THE PLEASURES AND PERILS OF JOINT CARE PLANNING 1) THE ADMINISTRATOR'S VIEWPOINT AND 2) THE SOCIAL SERVICES VIEWPOINT
DAVIES B. M. SHAW S. H. A.
ROYAL SOC HLTH J, AUG 1979 98(4) 164-169, 169-172, 198

EXAMINES SOME OF THE CONCEPTS OF JOINT HEALTH CARE PLANNING BETWEEN THE AREA HEALTH AUTHORITY AND LOCAL AUTHORITIES JOINT CONSULTATIVE COMMITTEES AND JOINT FINANCING ARE CRITICISED
Controlled Terms: PLANNING / FINANCE / AREA HEALTH AUTHORITY / HEALTH CARE / JOINT CARE / LOCAL GOVERNMENT / SOCIAL SERVICE

80-NZ-17371 Acompline 80003745
GETTING A FAIR COP?
DRAPER J.
COMMUN CARE, 6 SEP 1979 (280) 18-19

EXAMINES THE COOPERATION BETWEEN A LONG-ESTABLISHED POLICE JUVENILE LIAISON BUREAU IN MERSEYSIDE AND THE SOCIAL SERVICES CONSIDERS THE PROBLEM OF THE VOLUME OF WORK, AND THE DIFFERENCE OF APPROACH TO JUVENILE OFFENDERS OF POLICE OFFICERS AND SOCIAL WORKERS

Geo-Location: MERSEYSIDE
Controlled Terms: WORK / YOUNG PEOPLE / OFFENDER / JUVENILE BUREAU / POLICE / SOCIAL SERVICE / SOCIAL WORKER

80-NZ-15510 Acompline 80002011
ORGANISATION OF SERVICES FOR THE MENTALLY ILL A WORKING PAPER
HEY R. R. *. CS: BRUNEL INST OF ORGANISATION AND SOCIAL STUDIES
BIOSS, DEC 1978 38PP

NEEDS AND RANGE OF SERVICES REQUIRED; NEED FOR CLOSE PROFESSIONAL COLLABORATION; NEED FOR MULTIDISCIPLINARY SERVICES; TEAMS AND NETWORKS; DIFFERENCE OF STATUS AND LEVEL,AUTHORITY RELATIONSHIPS; 'DUAL INFLUENCE' SITUATIONS, PRIMACY AND PRIME RESPONSIBILITY; THE EXAMPLE OF CRISIS INTERVENTION TEAMS; DESIGNING ORGANISATION FOR COMBINED PROFESSIONAL WORK IN INDIVIDUAL CASES; PLANNING, DEVELOPMENT, AND OVERALL MANAGEMENT OF SERVICES
Controlled Terms: WORK / NETWORK / PLANNING / STATUS / MULTIDISCIPLINARY / MENTALLY ILL / DESIGN / HEALTH CARE / COMMUNITY SERVICES / COMMUNITY CARE / MANAGEMENT / PROFESSIONAL / RESIDENTIAL CARE

80-NZ-16244 Acompline 80000013
CLOSING GAPS IN THE CARE OF UNDER FIVES
10998 HLTH SOCIAL SERV J, 4 MAY 1979 89(4640)518-519

CONSIDERS A RECENT POLICY REVIEW ON DAY CARE FOR THE UNDER FIVES BEING DISCUSSED BY WANDSWORTH, IN WHICH THE IMPORTANCE OF COLLABORATION BETWEEN MEDICAL AND SOCIAL SERVICE TO AVOID DUPLICATION OF EFFORT WAS STRESSED. DISCUSSES THE REASONS BEHIND THE LOW UPTAKE OF PREVENTIVE SERVICES IN INNER CITY AREAS

Geo-Location: WANDSWORTH
Controlled Terms: DUPLICATION / INTER-CITY / UNDER FIVE / CARE / DAY CARE / HEALTH / POLICY / SOCIAL SERVICE

79-NZ-15977 Acompline 79004050
HOUSING FOR THE DISABLED
BARNES W.
10394 GLAD Q J, JAN 1979 4(1) 11-15

DISCUSSES THE POLICY IN CAMDEN FOR PROVIDING HOUSING FOR THE DISABLED, WHICH IT IDENTIFIES AS THOSE WHOSE MOBILITY IS LIMITED, WHETHER OR NOT THEY ARE ELDERLY OR CONFINED TO A WHEEL-CHAIR. CAMDEN MAINTAINS ITS OWN INDEX OF DISABLED PEOPLE FOR HOUSING BECAUSE IT DOES NOT REGARD EITHER THE REGISTER OF DISABLED PERSONS OR THE HOUSING WAITING LIST TO BE ADEQUATE, THE HOUSING DEPARTMENT WORKS IN CLOSE COOPERATION WITH BOTH THE ARCHITECTS' DEPARTMENT AND THE OCCUPATIONAL THERAPISTS IN THE SOCIAL SERVICES DEPARTMENT

Geo-Location: CAMDEN
Controlled Terms: ARCHITECTURE / MOBILITY / WAITING LISTS / SOCIAL / WAITING / ACCOMMODATION / DISABLED / EMPLOYMENT / OLD PEOPLE / POLICY / SOCIAL SERVICE

79-NZ-13654 Acompline 79003018
HOUSING AND SOCIAL POLICIES; SOME INTERACTIONS (P24227)
CS: CENTRAL POLICY REVIEW STAFF
09876L HMSO 1978 50PP

RESULTS OF A STUDY INTO ORGANISATIONAL DEFICIENCIES IN PUBLIC HOUSING, PERSONAL SOCIAL SERVICES, EDUCATION HEALTH SERVICE, SOCIAL SECURITY, POLICE AND EMPLOYMENT
Controlled Terms: INTERACTION / HEALTH SERVICE / SOCIAL / EDUCATION / ACCOMMODATION / COUNCIL HOUSING / EMPLOYMENT / GOVERNMENT / PERSONNEL / POLICE / POLICY / SOCIAL WELFARE / SOCIAL SERVICE

79-NZ-14712 Acompline 79000068
COLLABORATION BETWEEN THE HEALTH AND SOCIAL SERVICES IN ENGLAND
SCHNEIDERMAN L.
08379 SOCIAL WK, MAY 1978 192-197

Geo-Location: ENGLAND
Controlled Terms: HEALTH SERVICE / HEALTH / SOCIAL SERVICE

78-NZ-11240 Acompline 78003546
STRATEGIES AND GUIDELINES FOR THE CARE OF ELDERLY PEOPLE: DRAFT (P23347)
CS: SOUTH EAST THAMES REGIONAL HEALTH AUTHORITY
07173L SETRHA, 1978

CONSIDERS THE NEEDS OF ELDERLY PEOPLE WITH A VIEW TO MORE COLLABORATION BETWEEN THE HEALTH SERVICE AND LOCAL AUTHORITIES IN THE PLANNING AND DELIVERY OF SUCH SERVICES
Controlled Terms: PLANNING / HEALTH SERVICE / CARE / HEALTH / LOCAL GOVERNMENT / OLD PEOPLE

77-NZ-08980 Acompline 77004473
COLLABORATION BETWEEN HEALTH AND SOCIAL SERVICES; A WORKING PAPER (P22417)
CS: BRUNEL INST OF ORGANISATION AND SOCIAL STUDIES
BIOSS, NOV 1976 25PP

DISCUSSES PRINCIPALLY THE PROBLEMS OR ORGANISING FOR COLLABORATION IN INDIVIDUAL CASES AND COLLABORATION IN BROADER PLANNING AND DEVELOPMENT
Controlled Terms: PLANNING / HEALTH / SOCIAL SERVICE

77-NZ-13095 Acompline 77003588
CAN THE GLADIATOR AND OUR SOLDIERS CO-EXIST?
PRICE J. CS: ISLINGTON LB
05241 HLTH SOCIAL SERV J 8 JUL 1977 87 (4548) 1022-23

THE DIRECTOR OF SOCIAL SERVICES FOR THE LONDON BOROUGH OF ISLINGTON DESCRIBES THE PROGRESS MADE IN HIS BOROUGH IN COLLABORATION BETWEEN EDUCATION AND SOCIAL SERVICES

Geo-Location: ISLINGTON
Controlled Terms: LONDON BOROUGHS / SOCIAL / EDUCATION / BOROUGH / LONDON / SOCIAL SERVICE

77-NZ-12541 Acompline 77001307
BELL TOLLS FOR SCHOOL BUS COSTS
JOHNSON J.
4091 COMMERCIAL MOTOR 4 FEB 1977 145(3689)77-79

CRITICISES THE REPORT'A FARE DEAL FOR MINIBUSES'PREPARED BY THE NATIONAL COUNCIL OF SOCIAL SERVICE IN COLLABORATION WITH YOUTH ORGANISATIONS WHICH RECOMMENDS CHANGES IN THE LAW FOR VEHICLES WITH OVER 18 SEATS WHICH WOULD ENTAIL INCREASED EXPENDITURE FOR LOCAL AUTHORITIES
Controlled Terms: YOUNG PEOPLE / COSTS / LOCAL / VEHICLES / SOCIAL / MINIBUS / FARE / SCHOOL TRANSPORT / EXPENDITURE / LEGISLAT / LOCAL GOVERNMENT / SOCIAL SERVICE / TOLL

77-NZ-06854 Acompline 77001073
INNER AREA STUDIES LIVERPOOL BIRMINGHAM AND LAMBETH - SUMMARIES OF CONSULTANTS' FINAL REPORTS (P21539)
CS: DEPARTMENT OF THE ENVIRONMENT
03751L HMSO, 1977 49PP

CONTAINS THE SUMMARY REPORTS OF THE THREE INNER AREA STUDIES CARRIED OUT BY CONSULTANTS ON BEHALF OF THE DEPARTMENT OF THE ENVIRONMENT IN LIVERPOOL BIRMINGHAM, AND LAMBETH. IN COLLABORATION WITH THE LOCAL AUTHORITIES CONCERNED THE CONSULTANTS CARRIED OUT A LARGE NUMBER OF ACTION PROJECTS TO SHED FURTHER LIGHT ON THE ISSUES INVOLVED AND AT THE SAME TIME TO BRING ABOUT SOME PRACTICAL BENEFIT TO THE RESIDENTS OF THE STUDY AREAS NEARLY FORTY REPORTS ON SEPARATE POLICY ASPECTS AND AN ACTION RESEARCH, HAVE SO FAR BEEN PUBLISHED. AMONG THE TOPICS DISCUSSED ARE POVERTY,HOUSING, EMPLOYMENT, URBAN GOVERNMENT, WELFARE,PLANNING, AND RESOURCES

Geo-Location: BIRMINGHAM; LAMBETH; LIVERPOOL
Controlled Terms: URBAN / LOCAL / PLANNING / BENEFIT / INNER AREA / ACCOMMODATION / EMPLOYMENT / ENVIRONMENT / GOVERNMENT / LOCAL GOVERNMENT / POLICY / POVERTY / RESOURCE / SOCIAL WELFARE / TENANT

77-NZ-06719 Acompline 77000956
INTERACTION OF SOCIAL WELFARE AND HEATLH PERSONNEL IN THE DELIVERY OF SERVICES - IMPLICATIONS FOR TRAINING (P21177)
CS: EUROPEAN CENTRE FOR SOCIAL WELFARE TRAINING
03528L THE CENTRE, 1976 113PP

REPORTS ON A SEMINAR HELD IN AUSTRIA NOVEMBER 1975 WHICH AIMED TO DISCUSS THE PROBLEMS OF AN OPPORTUNITIES FOR COOPERATION BETWEEN PERSONNEL IN THE HEALTH AND WELFARE SERVICES AND TO EXAMINE THE IMPLICATIONS FOR TRAINING

Geo-Location: AUSTRIA
Controlled Terms: INTERACTION / TRAINING / HEALTH / PERSONNEL / SOCIAL WELFARE

76-NZ-11426 Acompline 76004136
TAX AND POVERTY
02187 ECONOMIST, 24 JUL 1976 260(6934) 60-61

DISCUSSES ANOMALIES IN BRITAIN'S TAX SYSTEM WHICH RESULT IN THE 'POVERTY TRAP', A RESULT OF THE UNCOORDINATED INTERACTION OF TAXATION AND WELFARE BENEFITS.TABLES SHOW HOW THE EFFECTIVE MARGINAL 'TAX' RATE VARIES WITH GROSS EARNINGS.QUESTIONS THE GOVERNMENT ESTIMATE OF THOSE AFFECTED BY THE POVERTY TRAP

Geo-Location: GREAT BRITAIN
Controlled Terms: INTERACTION / BENEFIT / SOCIAL BENEFIT / POVERTY TRAP / EARN / GOVERNMENT / POVERTY / SOCIAL WELFARE / TAXATION

76-NZ-11105 Acompline 76003827
COLLABORATION BETWEEN THE NHS AND LOCAL GOVERNMENT (01357)
BROWN R. G. S. CS: NATIONAL HEALTH SERVICE / HUMBERSIDE CC
LOCAL GOV STUD, APR 1976, 2(2), 15-25

LOOKS AT THE ATTTANGEMENTS DEVELOPED BY HUMBERSIDE CC AND ARGUES THAT MACHINERY , SUCH AS JOINT CONSULTATIVE COMMITTEES BETWEEN LOCAL*AUTHORITES AND AREA HEALTH AUTHORITES , CAN ONLY RESULT IN GENUINE COOPERATION IF THERE IS SUFFICENT WILL. LOCAL GOVERNMENT IS STILL SOMETIMES INFLUENCED BY DEPARTMENTALISM WHILE PRACTICAL COOPERATION IS HINDRED BY DIFFERING BOUNARIES OF JURISDICTION AND VARYING POWERS. IN THIS SITUATION FORMAL COOPERATION MAY HAVE A LIMITED EFFECT. 12
Controlled Terms: LOCAL / AREA HEALTH AUTHORITY / LOCAL GOVERNMENT

76-NZ-10599 Acompline 76003061
BUILDING SOCIETIES CAN USE WELFARE FUNDS TO HELP WIVES (01163)
FLETCHER J. CS: SHELTER HOUSING AID CENTRE
BUILDING SOCS GAZ,APR 1976,58(1300), 322-323

A MAJOR CAUSE OF BUILDING SOCIETY ARREARS IS THE BREAK UP OF A MARRIAGE BUT THE SOCIETIES CAN DO MUCH TO PREVENT HOMELESSNESS THROUGH REPOSSESSION BY USING WELFARE FUNDS, SUCH A SCHEME IS BEING OPERATED BY SEVERAL LEADING SOCIETIES IN COOPERATION WITH THE SHELTER HOUSING AID CENTRE
Controlled Terms: BUILDING SOCIETY / HOMELESSNESS / MARRIAGE / SOCIAL WELFARE

76-NZ-09415 Acompline 76001336
EMERGENCY PLANNING-ANOTHER SOCIAL SERVICE? (00227)
DAVIES R.
HLTH AND SOC SERV J, 29 NOV 1975, 85(4467), 2652-2653

PUTS A CASE FOR GREATER COOPERATION BETWEEN THE EMERGENCY SERVICES AND COMMUNITY SERVICES IN ORDER TO DEAL MORE EFFECTIVELY WITH THE LESS IMMEDIATE RESULTS OF DISASTERS SUCH AS DISTRESS AND BEREAVEMENT
Controlled Terms: EMERGENCY SERVICE / BEREAVEMENT / DISASTER / EMERGENCY PLANNING / COMMUNITY / SOCIAL SERVICE

75-NZ-03909 Acompline 75007006
BARGAIN OR BARRICADE - THE ROLE OF THE SOCIAL SERVICES DEPARTMENT IN MEETING SOCIAL NEED THROUGH INVOLVING THE COMMUNITY (P18466)
DARVILL G.
THE CENTRE, APR 1975 31P

LOOKS IN SOME DETAIL AT THE ATTITUDE OF SOCIAL SERVICES DEPARTMENTS TO COMMUNITY INVOLVEMENT AND COOPERATION WITH VOLUNTARY GROUPS
Controlled Terms: SOCIAL / VOLUNTARY GROUPS / COMMUNITY / SOCIAL SERVICE

75-NZ-00073 Acompline 75006414
ECONOMIC, SOCIAL AND LAND USE PLANNING
STONE DR P. A.
GLC QUARTERLY BULLETIN DEC 1972 PP 11-15

DESCRIBES THE STRUCTURE PLAN-ITS CONCEPTS, AIMS, AND NECESSARY STEPS TO ACHIEVEMENT. STRUCTURE PLANNING INVOLVES A WIDER BASIS AND ACHIEVES BROADER ENDS THAN LAND USE PLANNING. IT GIVES CONSIDERATION TO INTERACTIONS IN THE GIVEN AREA BETWEEN THE PEOPLE WHO LIVE THERE, THE BUILT ENVIRONMENT, STANDARDS, ECONOMIC ACTIVITY AND DEVELOPMENT RESOURCES, THE OVERALL CONCERN BEING FOR HUMAN WELFARE. THE AIM IS TO SELECT FROM THE FEASIBLE SETS OF STRATEGIES THAT WHICH MOST NEARLY MEETS THE PLAN'S OBJECTIVES. THE PROCESS CAN BEST BE REGARDED AS A CHOICE BETWEEN INVESTMENTS TO OBTAIN THE BEST RETURNS FOR THE RESOURCE EXPENDED. THE NECESSARY TESTING FOR THE PLAN'S FEASIBILITY ENTAILS CO-OPERATION AND CONSULTATION, BOTH AMONG PUBLIC AGENCIES AT ALL LEVEL AND THE PRIVATE CONCERNS INVOLVED. IN ORDER TO DEVELOP SUCCESSFULLY TH STRUCTURE OF AN AREA, STRUCTURE PLANS NEED TO BE FORWARD-LOOKING AND SUBJECT TO A CONTINUOUS DEVELOPMENT, TAKING ACCOUNT OF CHANGES IN THE RELATED POLICIES AND PLANS IN BOTH THE REGIONAL AND NATIONAL CONTEXT
Controlled Terms: PLANNING / STANDARDS / STRUCTURE / STRUCTURE PLANS / CONSULTATION / INTERACTION / CHOICE / SOCIAL / PRIVATE / ECONOMIC ACTIVITY / ACCOUNT / BUILT ENVIRONMENT / ECONOMIC / INVESTMENT / LAND USE / GOALS / POLICY / REGION / RESOURCE / SOCIAL WELFARE

75-NZ-08345 Acompline 75006110
AN EXERCISE IN COLLABORATION (9544)
HALL S. M.; DOWNES C. E.
SOCIAL WK TODAY, 24 JUL 1975, 6(9), 258-262

OUTLINES AN APPROACH TO COLLABORATIVE WORK IN THE SOCIAL SERVICES USING AS ILLUSTRATION THE PROBLEMS PRESENTED BY AN ADOLESCENT IN THE CARE OF A LOCAL AUTHORITY . 10 REFERENCES. (FROM JOURNAL ABSTRACT)
Controlled Terms: WORK / ADOLESCENT / CARE / LOCAL GOVERNMENT / SOCIAL SERVICE

75-NZ-02164 Acompline 75002738
SOCIAL WORK SUPPORT FOR THE HEALTH SERVICE- REPORT OF THE WORKING PARTY. (P17356)
CS: DEPARTMENT OF HEALTH AND SOCIAL SECURITY
H.M.S.O. JUNE 1974. 70 PP

EXAMINES THE NATURE OF COLLABORATION BETWEEN HEALTH AUTHORITIES AND LOCAL AUTHORITIES FOLLOWING THE SEEBOHM REPORT. LOOKS IN PARTICULAR AT THE RELATIONSHIPS BETWEEN SOCIAL WORK AND THE CLINICAL TEAM, PRIMARY HEALTH CARE AND HOSPITAL WORKERS. FINALLY DISCUSSES THE STAFFING OF THE SOCIAL WORK-SUPPORT FOR THE HEALTH SERVICE
Controlled Terms: HEALTH SERVICE / SUPPORT / SEEBOHM REPORT / STAFFING / LOCAL GOVERNMENT / SOCIAL WORK

75-NZ-00183 Acompline 75000460
A REPORT FROM THE WORKING PARTY ON COLLABORATION BETWEEN THE NHS AND LOCAL GOVERNMENT ON ITS ACTIVITIES FOR JANUARY TO JULY 1973. PAMPHLET 15871
CS: NATIONAL HEALTH SERVICE / DEPARTMENT OF HEALTH AND SOCIAL SECURITY
HMSO, 1973 85 PP

CONTAINS THE SECOND REPORT OF THE SCHOOL HEALTH SERVICE SUB-COMMITTEE , AND REPORTS OF THE SPECIALIST GROUPS ON SUPPLIES, BUILDING AND ENGINEERING, MANAGEMENT SERVICES AND STATISTICS, AND ANCILLARY SERVICES
Controlled Terms: ENGINEER / GROUP / REORGANISATION / BUILDING / LOCAL GOVERNMENT / MANAGEMENT / STATISTIC

75-NZ-07149 Acompline 75000270
IMPACT OF THE ENERGY CRISIS ON TRAFFIC ACCIDENTS 8016
TIHANSKY D. P.
TRANSP RES, OCT 1974, 8(4/5),481-492

AN AMERICAN STUDY WHICH EXPLAINS VARIATIONS OF ACCIDENT RATES, STATE BY STATE, IN TERMS OF MANDATORY SPEED LIMITS, REDUCTIONS IN PETROL SALES, VOLUNTARY COOPERATION IN CONSERVING ENERGY ETC. ALSO DISCUSSES THE ECONOMIC LOSSES INCURRED BY VARIOUS ACCIDENTS AND GIVES AN ESTIMATE, AT THE NATIONAL LEVEL, OF THE WELFARE GAINS FROM IMPROVEMENTS IN ROAD SAFETY

Geo-Location: AMERICA
Controlled Terms: IMPROVEMENT / TRAFFIC / ENERGY CRISIS / VOLUNTARY / ACCIDENT / ECONOMIC / ENERGY / PETROL / ROAD SAFETY / SOCIAL WELFARE / SPEED LIMIT

74-NZ-04064 Acompline 74000214
SOCIAL POLICY IMPLICATIONS OF BRITAIN'S ENTRY INTO THE COMMON MARKET
RODGERS B. N.
J SOCIAL POLICY, JAN 1973, 2(1), PP. 55-62

DISCUSSES HOW EXISTING EEC LAW DIRECTLY AFFECTS THE WELFARE OF INDIVIDUAL CITIZENS OF THE UK AND THEN TRIES TO ASSESS THE LIKELY EFFECTS ON SOCIAL POLICIES OF THOSE SECTIONS OF THE TREATIES OF ROME AND PARIS WHICH LAY DOWN THE COMMUNITY'S BROAD SOCIO-ECONOMIC GOALS CONSIDERS THE DEVELOPMENT OF SOCIAL SECURITY BASED ON INDUSTRIAL OR OCCUPATIONAL GROUPS, REGIONAL DEVELOPMENT POLICIES, MOVES TOWARDS HARMONIZATION OF LIVING AND WORKING STANDARDS AND THE INCREASING RECOGNITION OF THE INTERACTION BETWEEN SOCIAL AND ECONOMIC POLICIES

Geo-Location: GREAT BRITAIN; PARIS; ROME; UNITED KINGDOM
Controlled Terms: GROUP / INDUSTRY / STANDARDS / INTERACTION / EUROPEAN ECONOMIC COMMUNITY / SOCIAL / CITIZEN / SOCIO-ECONOMIC / TREATY OF PARIS / TREATY OF ROME / COMMUNITY / ECONOMIC / EMPLOYMENT / LEGISLAT / GOALS / POLICY / REGION / SOCIAL WELFARE

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  2     0  HEALTH(W)TEAM?                          1   35       41   4      1-20
  3     2  CLINICAL(W)TEAM?
  4    13  MANAGEMENT(W)TEAM?
  5     0 TEAM(W)PRACTICE
  6    15 3+4
  7     0  TEAM? OR NETWORK?
  8   235 TEAM?
  9   676 NETWORK?
 10   908 8+9
 11  1099 DECISION?
 12     7 MULTIDISCIPLINARY
 13    42 CLINICAL
 14  3984 MANAGEMENT
 15  4968 11+12+13+14
 16   176 10*15
 17     0 PROFESSIONALISM AND ATTITUD?
 18    18 PROFESSIONALISM
 19   671 ATTITUDE?
 20     1 18*19
 21     0  PROFESSIONAL(W)ATTITUDE?
 22     1  DUAL(W)INFLUENCE?
 23     1  COMBINED(W)PROFESSION?
 24     2 20+22+23
 25   638 SOCIAL(W)WELFARE
 26   178 HEALTH(W)CARE
 27   616  HEALTH(W)SERVICE?
 28  1233  SOCIAL(W)SERVICE?
 29   187 NATIONAL(W)HEALTH(W)SERVICE
 30    96 DHSS
 31    89 NHS
 32     4 PSSC
 33  1088 CARE
 34    32  WELFARE(W)SERVICE?
 35   510  SOCIAL(W)WORK?
 36  3263 25+26+27+28+29+30+31+32+33+34+35
 37  2319 25+26+27+28+29+30
 38  1655 30+31+32+33+34+35
 39  3263 38+37
 40   177 6+16+24
 41    20 40*39

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82-NZ-24316 Acompline 82002752
THE BLOOMSBURY PROJECT A COMMUNITY SERVICE FOR PEOPLE WITH MENTAL HANDICAP. RESEARCH REPORT VOLUME 1
MCCARTHY M. CS: SOUTH CAMDEN HEALTH DISTRICT / UNIVERSITY COLLEGE LONDON DEPARTMENT OF COMMUNITY / CAMDEN LB / VOORHEES ALAN M. AND ASSOCIATES LTD / CAMDEN LB SOCIAL SERVICES DEPARTMENT
UCM, DEC 1981 IV + 43PP

REPORT OF RESEARCH TO IDENTIFY MENTALLY HANDICAPPED ADULTS LIVING IN (OR, FOR PEOPLE NOW IN RESIDENTIAL CARE OR HOSPITAL CARE, PREVIOUSLY LIVING IN) PART OF SOUTH CAMDEN HEALTH DISTRICT , TO DESCRIBE THEIR HEALTH, HOUSING, EDUCATION AND SOCIAL SERVICES NEEDS, AND TO SUGGEST HOW APPROPRIATE SERVICES COULD BE CREATED TO MEET THOSE NEEDS. THE REPORT WAS COMMISSIONED BY CAMDEN LB SOCIAL SERVICES DEPARTMENT , SOUTH CAMDEN DISTRICT MANAGEMENT TEAM . HOW FAR COULD THE PEOPLE STUDIED BE SUPPORTED IN THE COMMUNITY BY VOLUNTEERS AND BY LOCAL GOVERNMENT SERVICES? RECOMMENDATIONS FOR A NEIGHBOURHOOD SERVICE ARE MADE
Controlled Terms: HOSPITAL CARE / BLOOMSBURY PROJECT / ACCOMMODATION / DAY CARE / COMMUNITY / HOSTEL / HEALTH / LOCAL GOVERNMENT / SOCIAL SERVICE / RESIDENTIAL CARE / FINANCE / MENTALLY HANDICAPPED / VOLUNTARY GROUPS / MENTALLY HANDICAPPED / CHILDRENS HOME / TRAINING CENTRE / STAFFING / EDUCATION / COMMUNITY SERVICE / ADULT / ADMINISTRATION

82-NZ-23920 Acompline 82002023
NEEDS ASSESSMENT OF ELEDERLY CLIENTS. NEW OPERATIONAL PROCEDURES BRIEFING
COOPER M. CS: ESSEX COUNTY COUNCIL SOCIAL SERVICES DEPARTMENT
ESSEX CC, MAR 1981 28PP

THE COUNCIL'S SOCIAL SERVICES MANAGEMENT TEAM HAS RECEIVED A REPORT OF A SURVEY OF FUTURE DEMAND FOR RESIDENTIAL ACCOMMODATION FOR OLD PEOPLE. THE REPORT'S RECOMMENDATION OF A NEW ASSESSMENT PROCEDURE WAS ACCEPTED. THIS LATER REPORT DISCUSSES THE MANAGEMENT AND OPERATIONAL IMPLICATIONS OF THAT DECISION AND DISCUSSES THE NEW SYSTEM IN VARIOUS ASPECTS, INCLUDING CASE FILE RECORDING, WAITING LIST POLICY, ADMISSIONS POLICY, AREA MANAGEMENT INFORMATION SYSTEMS AND LONG TERM PLANNING
Controlled Terms: RESIDENTIAL ACCOMMODATION / ADMISSIONS POLICY / NEEDS ASSESSMENT / ACCOMMODATION / COMMUNITY CARE / DAY CARE / DEMAND / OLD PEOPLE / LOCAL GOVERNMENT / MANAGEMENT / POLICY / RESIDENTIAL CARE / SOCIAL SERVICE / FUTURE / CLIENT / WAITING LISTS / MANAGEMENT INFORMATION SYSTEM / REORGANISATION / SHELTERED HOUSING / DOMICILIARY SERVICE / SURVEY

81-NZ-22510 Acompline 81005913
REPORT OF THE JOINT WORKING GROUP ON THE PRIMARY HEALTH CARE TEAM
CS: DEPARTMENT OF HEALTH AND SOCIAL SECURITY / JOINT WORKING GROUP ON THE PRIMARY HEALTH CARE TEA
DHSS, MAY 1981 69PP

REPORT OF A GROUP WHOSE CONCERN FOCUSSED ON REPORTS THAT NURSE ATTACHMENT ARRANGEMENTS IN A NUMBER OF HEALTH AUTHORITY AREAS, PARTICULARLY IN INNER CITY AREAS, WERE THREATENED. RECOMMENDS THAT THE CONCEPT OF THE PRIMARY HEALTH CARE TEAM IS VIABLE AND SHOULD BE PROMOTED IN THE INTEREST OF IMPROVED PATIENT CARE
Controlled Terms: CARE / HEALTH / MANAGEMENT / GROUP / HEALTH VISITOR / INTER-CITY / NURSING / TRAINING / PATIENT / PRIMARY HEALTH CARE / HARDING REPORT

81-NZ-21510 Acompline 81003765
REVIEW OF GOVERNMENT STATISTICAL SERVICES: REPORT OF THE DHSS STUDY TEAM
CS: NATIONAL HEALTH SERVICE / DEPARTMENT OF HEALTH AND SOCIAL SECURITY / CIVIL SERVICE
DHSS, JUN 1980 172PP

EXAMINES THE STATISTICAL WORK OF THE DEPARTMENT'S STATISTICS AND RESEARCH DIVISION, BALANCING COSTS AGAINST BENEFITS, AND MAKES RECOMMENDATIONS TOWARD GREATER EFFICIENCY
Controlled Terms: DOCTOR / MANAGEMENT / HOSPITAL / GOVERNMENT / INFORMATION / SOCIAL WELFARE / SOCIAL SERVICE / WORK / COSTS / STATISTIC / BENEFIT / MENTAL HEALTH / COST EFFECTIVENESS / STATISTICS / ECONOMIC POLICY / MEDICAL SERVICE / RAYNER REVIEW

81-NZ-21478 Acompline 81003249
PAYMENT OF BENEFITS TO UNEMPLOYED PEOPLE SECURITY
HMSO, MAR 1981 101PP

REPORT OF A TEAM OF OFFICIALS APPOINTED TO EXAMINE THE ARRANGEMENTS FOR DELIVERING UNEMPLOYMENT BENEFIT AND SUPPLEMENTARY ALLOWANCE TO UNEMPLOYED PEOPLE. THE STRUCTURE OF THE SYSTEM AND ITS ADMINISTRATIVE EFFICIENCY WERE INVESTIGATED, IN CONSULTATION WITH SIR DEREK RAYNER THE TEAM'S RECOMMENDATIONS AND THE GOVERNMENT'S INITIAL RESPONSE ARE INCLUDED. SOCIAL SECURITY, ABUSE, FRAUD,
Controlled Terms: GOVERNMENT / SOCIAL WELFARE / MANAGEMENT / UNEMPLOYMENT / STRUCTURE / CONSULTATION / ALLOWANCE / PAYMENT / SECURITY / REORGANISATION / BENEFIT / FRAUD / UNEMPLOYMENT BENEFIT

80-NZ-15531 Acompline 80002032
LIBRARY AND INFORMATION NETWORKS IN THE UNITD KINGDOM
BURKETT J. CS: ASLIB
ASLIB, 1979 261PP

GUIDE TO BRITISH LIBRARY SERVICES, REGIONAL AND LOCAL LIBRARY NETWORKS, GOVERNMENT LIBRARIES AND INFORMATION ORGANISATIONS, AND SOURCES IN AREAS OF ENERGY, ENGINEERING, METALS, CHEMICALS AGRICULTURE, HEALTH, SOCIAL SERVICES, MEDICINE, ENVIRONMENT, PLANNING, POLLUTION, BUSINESS, MANAGEMENT, LAW, HISTORY, AND THE ARTS. TRENDS IN COMPUTER NETWORKS ARE ALSO REVIEWED

Geo-Location: GREAT BRITAIN; UNITED KINGDOM
Controlled Terms: HISTORIC / LOCAL / NETWORK / PLANNING / BUSINESS / MEDICINE / ENGINEERING / ARTS / CHEMICAL / INFORMATION SOURCE / POLLUTION / LIBRARY SERVICES / AGRICULTURE / COMPUTER BASED / ENERGY / ENVIRONMENT / GOVERNMENT / HEALTH / INFORMATION CENTRE / INFORMATION / INFORMATION SYSTEM / LEGISLAT / LIBRARY / MANAGEMENT / METAL / REGION / SOCIAL SERVICE

80-NZ-15510 Acompline 80002011
ORGANISATION OF SERVICES FOR THE MENTALLY ILL A WORKING PAPER
HEY R. R. *. CS: BRUNEL INST OF ORGANISATION AND SOCIAL STUDIES
BIOSS, DEC 1978 38PP

NEEDS AND RANGE OF SERVICES REQUIRED; NEED FOR CLOSE PROFESSIONAL COLLABORATION; NEED FOR MULTIDISCIPLINARY SERVICES; TEAMS AND NETWORKS; DIFFERENCE OF STATUS AND LEVEL,AUTHORITY RELATIONSHIPS; 'DUAL INFLUENCE' SITUATIONS, PRIMACY AND PRIME RESPONSIBILITY; THE EXAMPLE OF CRISIS INTERVENTION TEAMS; DESIGNING ORGANISATION FOR COMBINED PROFESSIONAL WORK IN INDIVIDUAL CASES; PLANNING, DEVELOPMENT, AND OVERALL MANAGEMENT OF SERVICES
Controlled Terms: WORK / NETWORK / PLANNING / STATUS / MULTIDISCIPLINARY / MENTALLY ILL / DESIGN / HEALTH CARE / COMMUNITY SERVICES / COMMUNITY CARE / MANAGEMENT / PROFESSIONAL / RESIDENTIAL CARE

79-NZ-16171 Acompline 79004240
WHEN SOCIAL WORKERS HOLD THE RING IN CARING
BALLARD R.
10750 COMMUN CARE, 3 MAY 1979 (262) 24-26

SUGGESTS THAT THE MENTALLY ILL PATIENT'S LACK OF DESIRE TO GET WELL MAY MILITATE AGAINST THE DELIVERY OF A HELPING SERVICE. HENCE THE SOCIAL WORKER IN THE MULTIDISCIPLINARY TEAM IS IN A UNIQUE POSITION TO VIEW THE PATIENT FROM WITHIN THE HOSPITAL AND IN THE FAMILY AND COMMUNITY CONTEXT, AND SO SORT OUT THE DYNAMICS OF THE CARING PROCESS
Controlled Terms: MULTIDISCIPLINARY / MENTALLY ILL / TEAM / COMMUNITY / FAMILY / HOSPITAL / PATIENT / SOCIAL WORKER

78-NZ-13929 Acompline 78001720
SEEBOHM - SEVEN YEARS ON
STEVENSON O.
06979 NEW SOC 2 FEB 1978 43(800) 249-251

DESCRIPTION OF A RESEARCH PROJECT ON SOCIAL WORK WHICH EXAMINES THE WAY CASES ARE HANDLED AND ALLOCATED ON REFERRAL; THE ROLE OF THE TEAM OF THE PRESSURES ON THEM; ATTITUDES TO PROFESSIONALISM; RESOURCE ALLOCATION AND THE ROLE OF SOCIAL WORK ASSISTANTS
Controlled Terms: WORK / SOCIAL / SEEBOHM REPORT / PROFESSIONALISM / RESOURCE ALLOCATION / SOCIAL WORK ASSISTANT / TEAM / REFERRAL / RESOURCE / SOCIAL WORKER / SOCIAL WORK

76-NZ-05505 Acompline 76004603
THE REORGANISED NATIONAL HEALTH SERVICE (351.77)
LEVITT R. CS: NATIONAL HEALTH SERVICE / DEPARTMENT OF HEALTH AND SOCIAL SECURITY
01999L CROAN HELM,1976. 251PP

DESCRIBES IN DETAIL THE WORKING OF THE REORGANISED NHS, COVERING SUCH TOPICS AS THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY , THE REGIONAL HEALTH AUTHORITIES , THE DISTRICT MANAGEMENT TEAMS , THE FINANCING OF THE NHS,AND THE WORK OF COMMUNITY HEALTH COUNCILS
Controlled Terms: WORK / FINANCE / REORGANISATION / COMMUNITY HEALTH COUNCIL

76-NZ-11295 Acompline 76004008
AREA TEAMS IN SOCIAL WORK PRACTICE: A PROGRAMME FOR RESEARCH
SMITH G.; AMES J.
02009 BR J SOCIAL WK.1976.6(1),43-69

CRITICALLY EXAMINES ASSUMPTIONS UNDERLYING THE BELIEF THAT THE ORGANISATION OF SERVICE DELIVERY THROUGH A SYSTEM OF OUTLINES A PROGRAMME OF FURTHER RESEARCH TO QUESTION THE PREVALENT VIEW THAT AREA TEAMS ARE ACCOMPANIED BY IMPROVED CLIENT ACCESS TO SERVICE PROVISION,CLOSER IDENTIFICATION OF SOCIAL WORKERS WITH THE LOCAL AREA DECENTRALIZED ORGANIZATIONAL DECISION MAKING AND AN INCREASED SENSE OF COLLEAGUE SUPPORT AMONGST PROFESSIONAL STAFF
Controlled Terms: LOCAL / ACCESS / CLIENT / SOCIAL / SUPPORT / AREA TEAM / PERSONNEL / PROFESSIONAL / SOCIAL WORKER / SOCIAL WORK

76-NZ-11096 Acompline 76003818
'SOCIAL WORK TRAINING AND MANPOWER (01371)
CYPHER J. R.
HLTH SOCIAL SERV J, 24 APR 1976,86(4487),765-7616

SUGGESTS THAT FINANCIAL RESTRAINTS AND OTHER FACTORS MAKE IT IMPORTANT FOR 'SOCIAL SERVICES DEPARTMENTS TO EXAMINE THEIR MANAGEMENT TECHNIQUES MORE CLOSELY MOST DEPARTMENTS HAVE PRIORITY SCHEMES TO CONCENTRATE RESOURCES ON HIGH RISK GROUPS BUT IN MANY CASES THESE ARE NOT COMPLEMENTS BY EFFECTIVE ORGANISATION OF STAFF. VARIOUS ORGANISATIONAL APPROACHES ARE OUTLINED INCLUDING TWO TYPES OF TEAM METHOD

Controlled Terms: WORK / GROUP / FINANCE / SOCIAL / TRAINING / SOCIAL SERVICES DEPARTMENT / MANAGEMENT / PERSONNEL / RESOURCE / SOCIAL SERVICE / SOCIAL WORK

76-NZ-10112 Acompline 76002027
INTERDISCIPLINARY EXPERIMENT (01032)
PAYNE L.
SOCIAL WORK TODAY, 5 FEB 1976, 6(22), 691-693

DESCRIBES THE SETTING UP OF A STUDY GROUP IN SOUTHAMPTON COMPOSED OF GPS, SOCIAL WORKERS AND HEALTH VISITORS AND TRACES ENSUING DEVELOPMENTS OVER A TWO-AND-A-HALF YEAR PERIOD. THESE INCLUDE THE EVOLUTION OF A FLOURISHING NETWORK OF SUB GROUPS AND LIAISON SCHEMES WHICH NOW PROVIDE REGULAR OPPORTUNITIES FOR SHARED LEARNING AND DECISION MAKING. 3 REFERENCES. (FROM JOURNAL ABSTRACT)

Geo-Location: SOUTHAMPTON
Controlled Terms: GROUP / NETWORK / HEALTH VISITOR / INTERDISCIPLINARY GROUP / LEARN / SOCIAL WORKER

76-NZ-08962 Acompline 76000262
INTERMEDIATE SOLUTIONS 10064
ROBERTS J.; MCGLYNN R.
BUILT ENVIRON Q, SEP 1975, 1(2), 112-116

NO REALISTIC ALTERNATIVE TO THE PRIVATE CAR IS YET AVAILABLE SO, IT IS ARGUED, TRANSPORT PLANNING SHOULD CONCENTRATE ON MAXIMISING ACCESSIBILITY AND FINDING CHEAP AND FLEXIBLE MEANS OF USING EXISTING NETWORKS THESE INTERMEDIATE SOLUTIONS INCLUDE SERVICE IMPROVEMENTS, AS ILLUSTRATED BY THE STEVENAGE SUPERBUS , TRAFFIC MANAGEMENT MEASURES TO FAVOUR PUBLIC TRANSPORT, AND THE DEVELOPMENT OF PARA TRANSIT SYSTEMS SUCH AS SUBSCRIPTION BUSES AND CARE POOLING

Controlled Terms: IMPROVEMENT / NETWORK / ACCESS / INEXPENSIVE / CAR POOL / PARA TRANSIT / PRIVATE CAR / SUBCRIPTION BUS / PUBLIC TRANSPORT / TRAFFIC MANAGEMENT

75-NZ-03306 Acompline 75004838
SOCIAL WORK SUPPORT FOR THE HEALTH SERVICE -REPORT OF THE WORKING PARTY (P17897)
CS: DEPARTMENT OF HEALTH AND SOCIAL SECURITY
HMSO, 1974 70 PP

EXAMINES THE PRACTICAL ARRANGEMENTS FOR CO-OPERATION IN THE CONTEXT OF PRIMARY HEALTH CARE, WITHIN HOSPITALS AND IN RELATION TO THE WORK OF THE CLINICAL TEAM. PUTS FORWARD DETAILED ARGUMENTS SUPPORTING THE VIEW THAT LOCAL AUTHORITIES SHOULD PROVIDE SOCIAL WORK SUPPORT FOR THE HEALTH SERVICES AS AN INTEGRAL PART OF THEIR FIELDWORK SERVICES AND DISCUSSES HOW SUCH A SERVICE SHOULD BE MANNED
Controlled Terms: WORK / HEALTH SERVICE / SUPPORT / TRAINING / CARE / FIELDWORK / HEALTH / HOSPITAL / LOCAL GOVERNMENT / SOCIAL WORK

75-NZ-07680 Acompline 75004319
REPORT ON A TRAIL REFERRAL FORM - AREA TEAMS A,B, AND C (8795)
CLEARING HSE L.A. SOC SERV RES, 1975, (3), 85-103

DESCRIBES THE INTRODUCTION OF AND REACTION TO A NEW FORM DESIGNED TO RECONCILE THE NEEDS OF THE SOCIAL WORKER FOR AN UNCOMPLICATED METHOD OF RECORDING REFERRALS WITH THE MANAGEMENT'S INFORMATION REQUIRMENTS. THE NEW FORM WAS ALSO INTENDED TO ENABLE COMPARISON OF THE SITUATION IN EACH AREA AND TO PERMIT RAPID FEEDBACK TO BOTH AREA TEAMS AND MANAGEMENT ON RELEVANT MATTERS ABOUT NEW REFERRALS
Controlled Terms: AREA TEAM / STATIONERY / REFERRAL / FEEDBACK / INFORMATION / MANAGEMENT / SOCIAL WORKER

75-NZ-02164 Acompline 75002738
SOCIAL WORK SUPPORT FOR THE HEALTH SERVICE- REPORT OF THE WORKING PARTY. (P17356)
CS: DEPARTMENT OF HEALTH AND SOCIAL SECURITY
H.M.S.O. JUNE 1974. 70 PP

EXAMINES THE NATURE OF COLLABORATION BETWEEN HEALTH AUTHORITIES AND LOCAL AUTHORITIES FOLLOWING THE SEEBOHM REPORT. LOOKS IN PARTICULAR AT THE RELATIONSHIPS BETWEEN SOCIAL WORK AND THE CLINICAL TEAM, PRIMARY HEALTH CARE AND HOSPITAL WORKERS. FINALLY DISCUSSES THE STAFFING OF THE SOCIAL WORK-SUPPORT FOR THE HEALTH SERVICE
Controlled Terms: HEALTH SERVICE / SUPPORT / SEEBOHM REPORT / STAFFING / LOCAL GOVERNMENT / SOCIAL WORK

75-NZ-00849 Acompline 75001116
AREA OFFICES - REPORT ON A PROJECT TO ASSESS THE ATTITUDES OF SOCIAL WORKERS TO AREA OFFICES FOR AREA SOCIAL WORK TEAMS. P.16960
L.B.RICHMOND, JAN. 1974 10PP

GIVES THE RESULTS OF A SURVEY OF THE DEPARTMENT'S SOCIAL WORK STAFF ON THE QUESTION OF AREA OFFICES WHICH SHOWED THAT THEY GENERALLY FAVOUR THE SCHEME EXCEPT THAT IT MAY MAKE COMMUNICATIONS WITH THE CENTRAL ADMINISTRATION AND WITH EACH OTHER MORE DIFFICULT
Controlled Terms: COMMUNICATIONS / AREA OFFICE / MANAGEMENT / OFFICE / PERSONNEL / SOCIAL WORKER / SOCIAL WORK

74-NZ-05186 Acompline 74000482
SCIENCE FOR SOCIAL WELFARE
ALGIE J.
MANAGEMENT DECISION, SPRING 1973, 2, PP21-26

REVIEWS THE PERSONAL SOCIAL SERVICES IN THE USA WITH PARTICULAR REFERENCE TO SOCIAL CYBERNETICS, MANAGEMENT AND INFORMATION NETWORKS. SIMULATION MODELS IN THE COMMUNITY SITUATION ARE USED TO CHART ADMINISTRATIVE OPERATIONS AND DECISION MAKING, AND TO REGISTER CHANGING SOCIAL PROCESSES. SHOWS HOW SCIENTIFIC METHODS CAN BRING A QUANTITATIVE APPROACH TO PROBLEMS WHICH HAVE HITHERTO BEEN TACKLED INTUITIVELY BY SOCIAL PLANNERS. RELATES THESE DEVELOPMENTS TO THE BRITISH SOCIAL SERVICES, AND SUGGESTS THAT TECHNOLOGY COULD BE USED FOR SOCIAL BENEFIT

Geo-Location: GREAT BRITAIN; UNITED STATES
Controlled Terms: MODEL / NETWORK / SIMULAT / BENEFIT / MANAGEMENT INFORMATION / SOCIAL / TECHNOLOGY / COMMUNITY / DECISION MAKING / INFORMATION / MANAGEMENT / SOCIAL SERVICE / SOCIAL WELFARE

74-NZ-03966 Acompline 74000145
NEIGHBOURHOOD MANAGEMENT
GRAHAM P.
MUNICIPAL J 5 JAN 1973 81(1) PP 19-21

SUGGESTS EXTENDING CORPORATE MANAGEMENT TO LOCAL COMMUNITIES ARGUING THAT AREA ORGANISATIONS, INCLUDING EDUCATIONAL PRIORITY AREAS AND SOCIAL SERVICES AREA TEAMS ARE VALUABLE. THE ROLE OF NEIGHBOURHOOD OFFICES IN IDENTIFYING NEEDS AND OBJECTIVES AND ALLOCATING RESOURCES IN LINE WITH CENTRAL POLICY PLANS IS DISCUSSED, TOGETHER WITH THAT OF THE ELECTED NEIGHBOURHOOD COMMITTEE AND NEIGHBOURHOOD MANAGER IN IMPLEMENTING THE PLAN
Controlled Terms: LOCAL / EDUCATIONAL PRIORITY AREAS / COMMUNITY / CORPORATE PLANN / MANAGEMENT / OFFICE / POLICY / RESOURCE / SOCIAL SERVICE

APPENDIX 3

DHSS NURSING RESEARCH STUDENTSHIP

DHSS NURSING RESEARCH STUDENTSHIP

For many years nursing has suffered from a professional lack of understanding and commitment to research, despite Florence Nightingale's procrastinations as to the 'value of enquiry'. The DHSS studentship awards, available in recent years, are one of very few enterprises supporting the development of research in nursing - the competition is keen and awards highly valued.

The system of awards has recently changed to promote mainly post doctoral work. At the time of this award there was a range of activities supported among the eight successful candidates - the majority at first degree level, two Masters and one Doctoral topic, support was offered ranging from six months to three years in total.

In the first instance a research outline was submitted which enabled shortlisting to the interview stage of 26 from the 110 applicants. The interviews were conducted by a panel of six, three of whom were National research figures and the remainder officers of the Department of Health.

The interview consisted of questions relating to the topic, purpose, methodology and design, as well as domestic issues concerned with the management of the project.

Evidence of academic acceptance and a commitment to supervision was also required. It was surprising to find, therefore, that a very detailed protocol document was required by the DHSS, in

addition to the previous submission. This was additional and differed from that submitted for registration with the Universities.

Meetings of the elite group of students were held twice yearly. In the interim correspondence was exchanged with the Department, which amounted to a critical appraisal of the protocol. Working in isolation one felt a sense of frustration and despair at having to meet unclear criteria which were additional to that required by the academic governors. The protocol of this research was fortunately accepted by the Department after minor expansions to detail. Other students were less fortunate and several revision of protocol were required. Two students disbanded their project at this stage. There was an air of despondency and anger that something which is academically acceptable should be appraised in this way. In particular, concern related to the 'time' which submission of these protocols consumed at the expense of the research work progress. Serving two masters is an almost impractical arrangement.

As time progressed the bi-annual studentship meetings provided a forum whereby shared views, understanding and problems could be aired. Issues such as writing for publishing and research indexing were also explored.

Whilst the financial opportunity for research was greatly appreciated, it was generally felt that the conditions imposed were not fair compensation in addition to research pressures.

APPENDIX 4

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

NURSING RESEARCH STUDENTSHIPS

CONDITIONS OF SUPPORT

APPENDIX 4

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

NURSING RESEARCH STUDENTSHIPS

CONDITIONS OF SUPPORT

1. It must be appreciated that the purpose of the Studentship Scheme is firstly to enable nurses to acquire an education grounding in research theory and methods, and secondly to enable them to undertake research into an aspect of nursing of their own choice.

2. Research Students (graduate or non-graduate) undertaking research by thesis will be expected to submit to the Department:-

a. Detailed proposals for their project, for approval by the end of the first academic term. NO RESEARCH EXPENSES CAN BE PAID UNTIL THE PROPOSAL HAS BEEN APPROVED BY THE DEPARTMENT.

b. An annual progress report at the end of the academic year of 3-5000 words, prepared by the student and submitted through the supervisor.

c. A bound copy of the thesis submitted to the University and a summary of the thesis giving the main findings and their implications for policy on completion of the research.

2.1 Research students (graduate or non-graduate) doing a taught MSC in Research Methods will be expected to submit to the Department:-

a. An annual progress report at the end of the academic year of about 2500 words, prepared by the student and submitted through the supervisor.

b. A detailed proposal for their project for approval. The timing will depend on the plan for the MSC course. NO RESEARCH EXPENSES CAN BE PAID UNTIL THE PROPOSAL HAS BEEN APPROVED BY THE DEPARTMENT.

c. A bound copy of the thesis submitted to the University, and a summary of the thesis giving the main findings and their implications for policy.

3. FINANCE

3.1 Claims for expenses (and the salary costs for full time students) shall be administered through the Institution (normally the Health Authority) by which the student is employed. Claims for University fees shall be submitted direct from the University to the Department.

3.2 Research expenses for fieldwork etc will be allowed subject to the Department's approval of the detailed research proposal. These research expenses are subject to an overall annual limit of £750 for full-time students, and £375 for part-time students. Research expenses will not be adjusted to allow for inflation, and no expenses are allowed in respect of travel to and from the University/Polytechnic. Claims for expenses incurred within the academic year must be submitted before the 1 March of the following year and may not be carried forward from one year to the next.

4. QUESTIONNAIRES (to persons other than NHS Staff)

Any questionnaire and/or surveys which are to form part of the research, shall be submitted in draft together with the form provided for this purpose by the Department, together with explanatory notes, covering letters to respondents and any other relevant documents. Those particulars contained in the surveys when carried out may be forwarded by the Department to the Survey Control Unit of the Central Statistical Office.

5. CONFIDENTIALITY

5.1 The collection, handling and use of data relating to individuals shall be treated as confidential at all times, and in particular:

a. medical information for research shall be used in accordance with the Medical Research Council's "Statement of Responsibility in the use of Medical Information for Research"; and

b. non-medical information shall be used with such guidance as may be issued by the professional body concerned or in accordance with advice as may from time to time be issued by the Department.

5.2 The research student is at all times responsible for ensuring that storage of data (including tape recordings) is secure. A written undertaking to maintain confidentiality shall be obtained from all persons having access to data, and periodic reviews of the need to retain such data shall be carried out.

6. ETHICS

Research involving human subjects in the health field should meet with the ethical standards laid down by the relevant professional bodies.*

- Royal College of Nursing
- Royal College of Physicians
- Medical Research Council
- British Sociological Association
- British Psychological Society

* (See paragraph 11 "References".)

7. RIGHT TO DATA

The Department reserves the right, at its own expense, to have access to and use any data compiled during the course of the research, and will respect the confidentiality of any data so obtained.

8. PUBLICATIONS

Proposed publications arising from the research must be submitted to the Department in draft, before publication takes place, the author being free to accept or reject any comments made by the Department. The Department will, however, expect the author to exclude information which would lead to identification of persons or places subject to the research.

9. CROWN COPYRIGHT

9.1 The copyright in all reports and research material proposed as part of, or incidental to the research, shall rest in the Crown.

9.2 Where publication of material in commercial book form is contemplated, the Department shall be consulted before any arrangements are entered into with publishers, in order that advice on the application of Crown Copyright and royalties may be given.

9.3 Where acknowledgement of Crown Copyright is made in any publication, it shall be in the form of " C Crown Copyright", followed by the year of publication.

9.4 In any event the publication shall acknowledge the Department's assistance and/or carry such disclaimer as the Department may require.

10. PROPERTY RIGHTS

When equipment is purchased as part of the research, it shall become the property of the Department. The disposal of such equipment shall be considered by the Department at the end of the research period, and the proceeds of any sale shall belong to the Department.

11. REFERENCES

- Royal College of Nursing (1977)
  "Ethics Related to Research in Nursing"
  Royal College of Nursing, London.

- Royal College of Physicians (1973)
  "Report of the committee on the supervision of the ethics of clinical investigations in institutions"
  The Royal College of Physicians, London.

- Medical Research Council
  "Responsibility in investigations on human subjects"
  Report of the Medical Research Council, London, for 1962-63.

- British Sociological Association (1973)
  "Statement of ethical principles and their application to sociological practice"
  The British Sociological Association, London.

- British Psychological Society
  "Ethical Principles for research on human subjects"
  Statement published by the Annual Conference of the British Psychological Society, York 1978.

APPENDIX 5

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

NURSING RESEARCH STUDENTSHIP APPROVAL

Department of Health and Social Security
Alexander Fleming House Elephant and Castle London SE1 6BY

Telex 883669 Telephone 01-407 5522 ext
Ext 6226 Room B712

Mrs J Stevens
22St John's Avenue
KIDDERMINSTER
Worcestershire
DY11 6AU

Your reference

Our reference
JR/195/199

Date
23 August 1983

Dear Mrs Stevens

NURSING RESEARCH STUDENTSHIP

Thank you for your letter of 24 May 1983, enclosing details of your University registration. I can therefore now confirm the award of a part-time studentship for 3 years from 1 October 1983. I have asked the University to submit their invoices for fees to me. A copy of the Departments Conditions of Support for Nursing Research Studentships is enclosed, and I would be grateful to receive your written agreement to them.

You will know of course from the original information sheet, that the Department expects you to submit a detailed research proposal for approval. The timing will depend on the plan for the PhD course but at the beginning of the Academic year. I shall send you a Research (student) proposal form for submission. For your preliminary consideration however, these are the main headings:-

1. Project title.
2. Abstract of Research. A brief description of the aims (200 words approx).
3. Duration - with starting date.
4. Estimate of research expenses broken down into various elements. (The maximum that the Department is prepared to pay is £375 per annum). No research expenses are payable before approval of the project.
5. Detailed methodology - covering background and plan of investigation.

It is expected that before submitting your proposal, you will have discussed it with anybody whose co-operation is required in the conduct of the research, and to have received assurances that the co-operation will be forthcoming. It will also be necessary for your supervisor to endorse the application and confirm that he/she agrees the content. An annual progress report of 3000 to 5000 words is required at the end of each academic year prepared by you and submitted through your supervisor.

On completion of the course, one bound copy of the thesis submitted to the University will also be required by the Department.

Miss Elizabeth Scott is the Department's professional Liaison Officer for Nursing Research Studentships and I handle the administrative aspects. If there is anything that remains unclear, or if any problems arise in the course of the studentship, please do not hesitate to contact either one of us as appropriate.

VM40/I7

The first Nursing Research Students Workshop will be held here in the Department on Friday 30 September 1983 when you will be expected to attend. Further details will be sent to you later.

Yours sincerely

Charles South

C A SOUTH
Office of the
Chief Scientist
(Administration)

APPENDIX 6

REQUEST TO ADDISON WESLEY PUBLISHERS LIMITED

APPENDIX 6

JS/JGM

9th October 1984

Addison Wesley Publishers Limited
53 Bedford Square
London WC1B 3DZ

Dear Sir/Madam,

I am currently undertaking research into Teamwork Practice in Health Care, for which I am registered with the University of Aston in Birmingham on the Doctoral programme, in the Faculty of Management.

In the course of the research I shall be observing interaction among team members, for which I would wish to use the following schedule:-

F. Bales, Interaction Process Analysis - 1957.

I understand that you hold the copyright of this work, and would be grateful if you could advise me as to the protocol regarding its application, in the context described.

Yours sincerely,

Janet Stevens

J. STEVENS (Mrs)

APPENDIX 7

REQUEST TO DEPARTMENT OF HEALTH AND SOCIAL SECURITY

APPENDIX 7

22 St. Johns Avenue
Kidderminster
West Midlands

JS/JGM

12th June 1985

Liz Scott
Nursing Officer
Department of Health & Social Security
Alexander Fleming House
Elephant & Castle
London SE1 6 BY

Dear Liz,

Further to the studentship discussion I wish to seek your advice regarding the appropriateness of using "Bales Interaction Process Analysis" in the event of the publishers not being forthcoming with permission for use.

I have contacted the publishers, to no avail, on three occasions. My intention at this stage would be to use the schedule and acknowledge its use in the bibliography.

I should appreciate your advice.

Yours sincerely,

Janet Stevens.

J. STEVENS (Mrs)

APPENDIX 7

Department of Health and Social Security Room C617
Alexander Fleming House Elephant and Castle London SE1 6BY

Telex 883669 Telephone 01-407 5522 ext 6111/7727

Mrs J Stevens
22 St John's Avenue
Kidderminster
WORCESTERSHIRE
DY11 6AU

Your reference

Our reference
JR195/199
Date
20 June 1985

Dear Mrs Stevens

Thank you for your letter of 12 June referring to your problem with 'Bales Interaction Process Analysis' model. We have sought the advice of our Solicitors Branch and their view is that if the model is part of a published work and you do not intend to modify it in any way or reproduce it in a published or presented form then that would not be an infringement of copyright. Section 6(1) of the Copyright Act 1977 states "No fair dealing with a literary ..... work for purposes of research or private study shall constitute an infringement of the copyright in the work".

I hope this will be helpful to you, if there is any further problem please do contact me again.

Yours sincerely

Liz Scott

ELIZABETH J C SCOTT (MISS)
Office of the Chief Scientist

APPENDIX 8

RESEARCH AGREEMENT

RESEARCH AGREEMENT

The observer will record the activity pattern which takes place during the conference proceedings. No participant will be personally identified in the recordings. No record will be made of the verbal exchange.

Patients names or the circumstances of their health or social well-being will not be recorded. No identifiers will be included in the final report. Recordings will be made available for scrutiny upon request after completion of the study.

You have the right to refuse admission to the observer.

Janet S Vevers.

APPENDIX 9

Record of Conference Observations

HASH NUMBER	1
RECORD NUMBER	1/ 1
DATE	10/01/85
VENUE	2
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE		2			2										4
3 .AGREES					2		2	2	4						10
4 .GIVES SUGGESTION	7			2											9
5 .GIVES OPINION	1					2		2							5
6 .GIVES ORIENTATION	2	2	1		2	1		1		1	1	1	3	1	15
7. ASKS FOR ORIENTATION	3				1		1		8		1	1			15
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION	1	1			1	2					1				6
10.DISAGREES						1	1	1	1						3
11.SHOWS TENSION								1							1
12.SHOWS ANTAGONISM															0
	15:	5:	1:	2:	7:	7:	2:	5:	7:	9:	2:	2:	1:	3:	1

HASH NUMBER	2
RECORD NUMBER	1/ 2
DATE	17/01/85
VENUE	2
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	13
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1	1	1		1	1		1		1	1				8
3 .AGREES		1	1		2			1	1			2	1		10
4 .GIVES SUGGESTION	6				1										7
5 .GIVES OPINION	1							1	1						3
6 .GIVES ORIENTATION	1	1	2		2							2	1		9
7. ASKS FOR ORIENTATION	1						1	2	1			1			6
8 .ASKS FOR OPINION		1													1
9 .ASKS FOR SUGGESTION	1														1
10.DISAGREES									1						1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	11:	4:	4:	0:	6:	1:	1:	5:	4:	1:	4:	3:	1:	0:	1

HASH NUMBER	3
RECORD NUMBER	1/ 3
DATE	24/01/85
VENUE	2
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	0
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE		1			1										2
3 .AGREES					1	1	1	1	2						5
4 .GIVES SUGGESTION	7				2										9
5 .GIVES OPINION	1					1			1						3
6 .GIVES ORIENTATION															0
7. ASKS FOR ORIENTATION	1	1	1		2	1		1			1	1	3	1	13
8 .ASKS FOR OPINION									1						1
9 .ASKS FOR SUGGESTION	1	1					1	2						1	6
10.DISAGREES							1		1	1					3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	11:	3:	1:	0:	6:	2:	3:	4:	4:	2:	1:	1:	3:	1:	1

HASH NUMBER	4
RECORD NUMBER	1/ 4
DATE	31/01/85
VENUE	2
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1				1	1	1	1	2		1	1	1		10
3 .AGREES	1				4		1	3	1		1	2	1		14
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	1				1						1				3
6 .GIVES ORIENTATION	1		1		1							1	1		5
7. ASKS FOR ORIENTATION								1	1						2
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	1				1	1					1		1		5
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM								2							2
	9:	0:	1:	0:	8:	2:	2:	5:	6:	0:	4:	4:	4:	0:	0

HASH NUMBER 5
RECORD NUMBER 1/ 5
DATE 21/02/85
VENUE 2
TIME 95
INITIATOR CONSULTANT
CASES ACTIONED 5
NO. CASES 27
PAPERS CIRCULATED 0
NO. PARTS 14
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE				1		2				1		1	1	1	7
3 .AGREES		1		2		1	2	2		1		1	1	1	12
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	2						1				1	1			6
6 .GIVES ORIENTATION	3		1		2								2		3 11
7. ASKS FOR ORIENTATION					1										1
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION									1	1					1 3
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM									1						1
	11:	0:	3:	2:	5:	1:	3:	2:	3:	2:	3:	3:	4:	0:	5

HASH NUMBER 6
RECORD NUMBER 1/ 6
DATE 21/02/85
VENUE 2
TIME 95
INITIATOR CONSULTANT
CASES ACTIONED 6
NO. CASES 28
PAPERS CIRCULATED 0
NO. PARTS 12
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1				2		3	2	1			1	1		11
3 .AGREES	1				2	2	2		3	2			1	1	16
4 .GIVES SUGGESTION	5				2										7
5 .GIVES OPINION	3				1	1		1						2	8
6 .GIVES ORIENTATION	3				2		2				1	3			3 14
7. ASKS FOR ORIENTATION	1							1				1			3
8 .ASKS FOR OPINION	1								1						2
9 .ASKS FOR SUGGESTION	1														1
10.DISAGREES							1			1		1			3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	18:	0:	0:	0:	9:	3:	8:	7:	5:	0:	4:	6:	0:	0:	7

HASH NUMBER	7
RECORD NUMBER	1/ 7
DATE	28/02/85
VENUE	2
TIME	75
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE					2			3	2						7
3 .AGREES	1	1				1						1	1		5
4 .GIVES SUGGESTION	3								1						4
5 .GIVES OPINION	3				1				1	1					6
6 .GIVES ORIENTATION	3				4		2					1	1		11
7. ASKS FOR ORIENTATION					2	1	1		2	1					7
8 .ASKS FOR OPINION	2				1						1	1			5
9 .ASKS FOR SUGGESTION						1									1
10.DISAGREES									1						1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	13:	1:	0:	0:	12:	1:	3:	3:	6:	3:	3:	3:	0:	0:	0

HASH NUMBER	8
RECORD NUMBER	1/ 8
DATE	7 /3 /85
VENUE	2
TIME	70
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2				1		1	1	1		1	1	1		9
3 .AGREES	2	1			1				1		1				6
4 .GIVES SUGGESTION	6				1										7
5 .GIVES OPINION	1	1	1		2			1			1				7
6 .GIVES ORIENTATION	2	2	2		4		4		1						15
7. ASKS FOR ORIENTATION	2	2	2		4	4			1						15
8 .ASKS FOR OPINION	2								1						3
9 .ASKS FOR SUGGESTION						1									1
10.DISAGREES									1						1
11.SHOWS TENSION	2														2
12.SHOWS ANTAGONISM															0
	20:	6:	5:	0:	13:	5:	5:	2:	6:	0:	2:	2:	1:	0:	0

HASH NUMBER 9
RECORD NUMBER 1/ 9
DATE 14/3 /85
VENUE 2
TIME 45
INITIATOR CONSULTANT
CASES ACTIONED 3
NO. CASES 28
PAPERS CIRCULATED 0
NO. PARTS 11
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	2	1			1	1	1	1			1	1	1		10
3 .AGREES	1				3	1	1	3	1			1			11
4 .GIVES SUGGESTION	4	1													5
5 .GIVES OPINION	2	1													3
6 .GIVES ORIENTATION	1	1			4	1	2				1				10
7. ASKS FOR ORIENTATION	1				1		2	1		1					6
8 .ASKS FOR OPINION	2	1						1			1				5
9 .ASKS FOR SUGGESTION						2				2					4
10.DISAGREES					2										2
11.SHOWS TENSION		1													1
12.SHOWS ANTAGONISM	1														1
	16:	6:	0:	0:	11:	3:	8:	6:	2:	2:	3:	2:	1:	0:	0

HASH NUMBER 10
RECORD NUMBER 1/ 10
DATE 21/ 3/85
VENUE 2
TIME 90
INITIATOR CONSULTANT
CASES ACTIONED 3
NO. CASES 25
PAPERS CIRCULATED 0
NO. PARTS 11
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE		1			1				1		1				4
3 .AGREES					2		2	1	1						6
4 .GIVES SUGGESTION	8	1			2										11
5 .GIVES OPINION	3					2			2						7
6 .GIVES ORIENTATION	2	1	1		3	1		1			1		3	2	15
7. ASKS FOR ORIENTATION	3				1	1		1		2		1			10
8 .ASKS FOR OPINION									1	1					2
9 .ASKS FOR SUGGESTION	1	2					1	1					1		6
10.DISAGREES							1		1	1					3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM									1						1
	18:	5:	1:	0:	9:	4:	4:	5:	6:	5:	2:	3:	4:	0:	0

HASH NUMBER	11
RECORD NUMBER	1/ 11
DATE	28/03/85
VENUE	2
TIME	110
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	12
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1				3		4	2	2			1	1		14
3 .AGREES	1		1		2	2	2		4	2				1	15
4 .GIVES SUGGESTION	5				2							1	1	2	11
5 .GIVES OPINION	4				2	1		1						3	11
6 .GIVES ORIENTATION	4	1			2	2	1				2	3		4	19
7. ASKS FOR ORIENTATION	1						2	2					1		6
8 .ASKS FOR OPINION	2				1		1	1							5
9 .ASKS FOR SUGGESTION	1														1
10.DISAGREES							1	1			1				3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21:	1:	1:	0:	12:	5:	11:	11:	4:	0:	5:	5:	1:	10:	0

HASH NUMBER	12
RECORD NUMBER	1/ 12
DATE	04/04/85
VENUE	2
TIME	75
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	4						1	2	1						8
3 .AGREES	1	3			2	1			2			1			10
4 .GIVES SUGGESTION	5				2										7
5 .GIVES OPINION	3							1							4
6 .GIVES ORIENTATION		1			3	1	1	1	1		1	1			10
7. ASKS FOR ORIENTATION	2						2	1							5
8 .ASKS FOR OPINION	2				1				1			1			5
9 .ASKS FOR SUGGESTION	1									1					2
10.DISAGREES															0
11.SHOWS TENSION							1								1
12.SHOWS ANTAGONISM															0
	18:	4:	0:	0:	8:	3:	3:	5:	6:	0:	4:	1:	0:	0:	0

HASH NUMBER	13
RECORD NUMBER	1/ 13
DATE	11/04/85
VENUE	2
TIME	65
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	12
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1				1		2	1	1						6
3 .AGREES	1					1	2	4	3	1		1	1		14
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	4					1									5
6 .GIVES ORIENTATION	3	3			2	2	2					1			13
7. ASKS FOR ORIENTATION							1	1	1	1	2	1			7
8 .ASKS FOR OPINION	1						1	1	1						4
9 .ASKS FOR SUGGESTION						1									1
10.DISAGREES											1				1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	13:	4:	0:	0:	3:	4:	8:	7:	6:	3:	3:	4:	0:	0:	0

HASH NUMBER	14
RECORD NUMBER	1/ 14
DATE	18/4 /85
VENUE	2
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1				2		2	2	1		1	1			10
3 .AGREES	1				3		3	2	1				1	1	2	14
4 .GIVES SUGGESTION	3				1	1	1								5
5 .GIVES OPINION	3				1		1	1					2		8
6 .GIVES ORIENTATION	3									1	3		3		10
7. ASKS FOR ORIENTATION	1	1						1				1	1		5
8 .ASKS FOR OPINION		1					1	1	1						3
9 .ASKS FOR SUGGESTION			1		1					1					3
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	14:	2:	1:	0:	8:	0:	7:	7:	3:	0:	3:	6:	2:	7:	0

HASH NUMBER	15
RECORD NUMBER	1/ 15
DATE	25/04/85
VENUE	2
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	1				1		1	1							4
3 .AGREES					1			1	2						4
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	2	1									1				4
6 .GIVES ORIENTATION	1		1		2										4
7. ASKS FOR ORIENTATION							1	1	1						3
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION						1									1
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	7:	1:	1:	0:	4:	0:	3:	3:	3:	0:	1:	0:	0:	0:	0

HASH NUMBER	16
RECORD NUMBER	1/ 16
DATE	02/05/85
VENUE	2
TIME	65
INITIATOR	CONSULTANT
CASES ACTIONED	6
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2				2	1		2	2	1				1	11
3 .AGREES	3		1		2	1	1								8
4 .GIVES SUGGESTION	5				1										6
5 .GIVES OPINION	4						2	1							7
6 .GIVES ORIENTATION	3	3			3		3	2	1			2	1		18
7. ASKS FOR ORIENTATION	1				1		1	1				1			5
8 .ASKS FOR OPINION					1		1	1					1		4
9 .ASKS FOR SUGGESTION	1														1
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20:	4:	0:	0:	10:	2:	10:	7:	2:	0:	0:	3:	3:	0:	0

HASH NUMBER	17
RECORD NUMBER	1/ 17
DATE	09/05/85
VENUE	2
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	12
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	1				1		2						1		5
3 .AGREES	1	1			1	1									4
4 .GIVES SUGGESTION	3								2						5
5 .GIVES OPINION	4				1										5
6 .GIVES ORIENTATION	1	1	1		4			1	2	1			1	1	13
7. ASKS FOR ORIENTATION		1			1		1	1	1						5
8 .ASKS FOR OPINION	3					1									4
9 .ASKS FOR SUGGESTION	1														1
10.DISAGREES	1														1
11.SHOWS TENSION											1				1
12.SHOWS ANTAGONISM															0
	16:	3:	1:	0:	7:	3:	3:	2:	5:	1:	0:	3:	1:	0:	0

HASH NUMBER	18
RECORD NUMBER	1/ 18
DATE	16/05/85
VENUE	2
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE					2			3	2						7
3 .AGREES	1	1						1							3
4 .GIVES SUGGESTION	3				1			1							5
5 .GIVES OPINION	3				1			2							6
6 .GIVES ORIENTATION	3				4		2								9
7. ASKS FOR ORIENTATION					2		1	1	3				1	1	9
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION															0
10.DISAGREES							1								1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	13:	1:	0:	0:	10:	0:	3:	5:	5:	0:	0:	1:	1:	0:	0

HASH NUMBER	19
RECORD NUMBER	1/ 19
DATE	23/05/85
VENUE	2
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE													1		1
3 .AGREES	2	1					1	2	1						7
4 .GIVES SUGGESTION	6														6
5 .GIVES OPINION	2				2										4
6 .GIVES ORIENTATION	1				2		1	1	2				1	2	11
7. ASKS FOR ORIENTATION	1				1	1	1	1							5
8 .ASKS FOR OPINION											1				1
9 .ASKS FOR SUGGESTION						1									1
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	14:	1:	0:	0:	5:	1:	4:	4:	3:	0:	1:	1:	1:	3:	0

HASH NUMBER	20
RECORD NUMBER	1/ 20
DATE	06/06/85
VENUE	2
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	12
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1							1							2
3 .AGREES	1	1	1		2		3	2	2			1	1	1	15
4 .GIVES SUGGESTION	9				1										10
5 .GIVES OPINION	2				1	1		1		1		1	2		9
6 .GIVES ORIENTATION	1	3			5			1			1	1	2		14
7. ASKS FOR ORIENTATION	1						1	1				1			4
8 .ASKS FOR OPINION	1										1	2			4
9 .ASKS FOR SUGGESTION								1							1
10.DISAGREES															0
11.SHOWS TENSION	1							1							2
12.SHOWS ANTAGONISM															0
	17:	4:	1:	0:	9:	2:	6:	4:	4:	2:	6:	5:	1:	0:	0

HASH NUMBER 21
RECORD NUMBER 1/ 21
DATE 21/05/85
VENUE 2
TIME 60
INITIATOR CONSULTANT
CASES ACTIONED 3
NO. CASES 26
PAPERS CIRCULATED 0
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2	2			1			1				1			7
2 .SHOWS TENSION RELEASE	1	1			2			1	1		1	1	1		9
3 .AGREES	2				3		2				3				10
4 .GIVES SUGGESTION	7														7
5 .GIVES OPINION	4	2			2		1	1	2			2			14
6 .GIVES ORIENTATION					6		1					1	1		9
7. ASKS FOR ORIENTATION	1			2								1	2		6
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION	2	1			2		2					1			8
10.DISAGREES	1						1								2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	22:	6:	0:	0:	18:	0:	4:	5:	4:	0:	1:	6:	8:	0:	0

HASH NUMBER 22
RECORD NUMBER 1/ 22
DATE 24/05/85
VENUE 2
TIME 65
INITIATOR REGISTRAR
CASES ACTIONED 1
NO. CASES 24
PAPERS CIRCULATED 0
NO. PARTS 8
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	2			1					1						4
3 .AGREES		3		4		2		1	1		1	2	2		16
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION		4		2				1				1	2		10
6 .GIVES ORIENTATION	1			4			1					2	2		10
7. ASKS FOR ORIENTATION	2							2							4
8 .ASKS FOR OPINION		1		1											2
9 .ASKS FOR SUGGESTION	2				3		1	2			1	2			11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	17:	0:	0:	15:	0:	3:	4:	5:	0:	1:	6:	8:	0:	0

HASH NUMBER	23
RECORD NUMBER	1/ 23
DATE	10/01/85
VENUE	2
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE		2			2										4
3 .AGREES			2		2	2	4								10
4 .GIVES SUGGESTION	7		2												9
5 .GIVES OPINION	1					2	2								5
6 .GIVES ORIENTATION	2	2		2	1		1	1		1	3		1		14
7. ASKS FOR ORIENTATION	3			1			3	1		1					9
8 .ASKS FOR OPINION	1	1		1	2						1				6
9 .ASKS FOR SUGGESTION				1		1		1							3
10.DISAGREES							1								1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	15:	5:	0:	7:	7:	2:	6:	10:	3:	0:	2:	4:	0:	1:	0

HASH NUMBER	24
RECORD NUMBER	2/ 24
DATE	31/05/85
VENUE	4
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1	1			1	1	1	1	1	1	1	1	1		11
3 .AGREES	1				3	1	2		1		1	1	1		11
4 .GIVES SUGGESTION	6				1							1			8
5 .GIVES OPINION	4	2			2			1				1			10
6 .GIVES ORIENTATION	2				6			2				2	3		15
7. ASKS FOR ORIENTATION	1							1				1			3
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	1														1
10.DISAGREES	1			1											2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20:	3:	0:	0:	14:	2:	6:	2:	2:	1:	2:	5:	7:	0:	0

HASH NUMBER	25
RECORD NUMBER	2/ 25
DATE	21/02/85
VENUE	4
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2	2			1			1				1			7
2 .SHOWS TENSION RELEASE	1	1			2	1	1		1	1	1	1	1		10
3 .AGREES	2				3		2			1		3			11
4 .GIVES SUGGESTION	7														7
5 .GIVES OPINION	4	2			2		1		1	2	1				14
6 .GIVES ORIENTATION					5		2	1			1			1	11
7. ASKS FOR ORIENTATION	1	1					2					1	1		6
8 .ASKS FOR OPINION	2	1			2			2					1		8
9 .ASKS FOR SUGGESTION	1										1				2
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20:	7:	0:	0:	15:	2:	7:	5:	2:	4:	2:	7:	5:	0:	0

HASH NUMBER	26
RECORD NUMBER	2/ 26
DATE	21/02/85
VENUE	4
TIME	100
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2														2
3 .AGREES				.	1	1	1	1							4
4 .GIVES SUGGESTION	3								1						4
5 .GIVES OPINION	6	2						1					1		10
6 .GIVES ORIENTATION	4	3			2		2	1				2	3		17
7. ASKS FOR ORIENTATION	2	1					1			1		1			6
8 .ASKS FOR OPINION		2		1			1					1			5
9 .ASKS FOR SUGGESTION	1														1
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	19:	8:	0:	0:	4:	1:	5:	3:	0:	2:	0:	2:	6:	0:	0

HASH NUMBER	27
RECORD NUMBER	2/ 27
DATE	28/02/85
VENUE	4
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	2 11 | | | | | | | | | | | | |	3
2 .SHOWS TENSION RELEASE	11 11 | | 11 | 11 | 11 | 11 11 11 | |	8
3 .AGREES	2 | | | 13 | 12 11 | 11 21 | 11 11 |	13
4 .GIVES SUGGESTION	5 12 | | 11 | | | 11 | | | 11 | |	10
5 .GIVES OPINION	8 12 | | | 11 | | | | 11 | | 21 |	14
6 .GIVES ORIENTATION	4 12 | | | 21 | | 11 | 11 | 11 11 |	12
7. ASKS FOR ORIENTATION	1 11 | | | | | 11 | 11 | | 11 | |	5
8 .ASKS FOR OPINION	12 | | | 11 | 11 | | | | 11 | 11 |	6
9 .ASKS FOR SUGGESTION	1 | | | | 21 | 12 11 | 11 | 21 11 | |	10
10.DISAGREES	| | | | | | 11 | | | | | | |	1
11.SHOWS TENSION	| | | | | | | | | | | | |	0
12.SHOWS ANTAGONISM	| | | | | | | | | | | | |	0
	24:11: 0: 0:11: 0: 7: 5: 4: 4: 4: 5: 7: 0: 0	

HASH NUMBER	28
RECORD NUMBER	2/ 28
DATE	07/03/85
VENUE	4
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 | | | | | | | | | | | | |	1
2 .SHOWS TENSION RELEASE	1 | | | | 11 11 21 11 | | 11 11 | |	8
3 .AGREES	1 | | | | 11 21 41 21 11 11 12 13 | |	17
4 .GIVES SUGGESTION	5 | | | 12 | | | | 11 | | 11 21 |	11
5 .GIVES OPINION	6 | | | | 21 | | | 11 | | 21 21 |	13
6 .GIVES ORIENTATION	2 | | | 15 | | 11 | 11 | | 11 31 |	13
7. ASKS FOR ORIENTATION	2 | | | 11 | | | | | | 11 | 11 |	5
8 .ASKS FOR OPINION	2 | | | 11 | | | | | | | | |	3
9 .ASKS FOR SUGGESTION	1 | | | 12 | | | | | | 11 11 21 |	7
10.DISAGREES	| | | | | | | | | | | | |	0
11.SHOWS TENSION	| | | | | | | | | | | | |	0
12.SHOWS ANTAGONISM	| | | | | | | | | | | | |	0
	21: 0: 0: 0:15: 3: 7: 2: 1: 4: 3: 8:14: 0: 0	

HASH NUMBER	29
RECORD NUMBER	2/ 29
DATE	14/03/85
VENUE	4
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1				2		2	2	1			1	1		10
3 .AGREES	1			4		2	1	1			2	3			14
4 .GIVES SUGGESTION	3			1		1		1							6
5 .GIVES OPINION	5			2		1						1			9
6 .GIVES ORIENTATION	2			5		1		1			2	1			12
7. ASKS FOR ORIENTATION	1							1		1					3
8 .ASKS FOR OPINION	2			1											3
9 .ASKS FOR SUGGESTION	1									1	2	2			6
10.DISAGREES								1			1				2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	18	0	0	0	15	0	7	3	6	0	2	7	9	0	0

HASH NUMBER	30
RECORD NUMBER	2/ 30
DATE	21/03/85
VENUE	4
TIME	100
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2	2			1		1					1			7
2 .SHOWS TENSION RELEASE	1	1			1		1	1			1		1	1	8
3 .AGREES	2	3			3		2	2			1	2	3		18
4 .GIVES SUGGESTION	5	2			1			1				2	2		13
5 .GIVES OPINION	6	2			1										9
6 .GIVES ORIENTATION	2	1			7					1					11
7. ASKS FOR ORIENTATION	1							1		1	1	1			6
8 .ASKS FOR OPINION	1				1							1			3
9 .ASKS FOR SUGGESTION	2				3	1				1	2	1			10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	22	11	0	0	18	1	4	5	0	4	2	8	10	0	0

HASH NUMBER	31
RECORD NUMBER	2/ 31
DATE	04/04/85
VENUE	3
TIME	60
INITIATOR	COMM/L
CASES ACTIONED	2
NO. CASES	20
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ ¦ ¦ ¦1 ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	2
2 .SHOWS TENSION RELEASE	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
3 .AGREES	¦ ¦ ¦ ¦ 4¦ ¦ 3¦ 3¦ ¦ 3¦ ¦ 2¦ 1¦ ¦	16
4 .GIVES SUGGESTION	¦ ¦ ¦ ¦3 ¦ ¦ 3¦ 2¦ ¦ 2¦ ¦ 3¦ 4¦ ¦	17
5 .GIVES OPINION	¦ ¦ ¦ ¦ 5¦ ¦ 3¦3 ¦ ¦ 4¦ ¦ 4¦ 5¦ ¦	24
6 .GIVES ORIENTATION	¦ ¦ ¦ ¦3 ¦ ¦ 2¦ 1¦ ¦ 2¦ ¦ ¦ 1¦ ¦	9
7. ASKS FOR ORIENTATION	¦ ¦ ¦ ¦2 ¦ ¦ ¦2 ¦ ¦ 1¦ ¦ 1¦ 2¦ ¦	8
8 .ASKS FOR OPINION	¦ ¦ ¦ ¦2 ¦ ¦ 2¦3 ¦ ¦ 2¦ ¦ 2¦ 1¦ ¦	12
9 .ASKS FOR SUGGESTION	¦ ¦ ¦ ¦4 ¦ ¦2 ¦3 ¦ ¦ 1¦ ¦ 2¦ 2¦ ¦	14
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦	1
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0: 0: 0: 0:24: 0:16:17: 0:16: 0:14:16: 0: 0	

HASH NUMBER	32
RECORD NUMBER	2/ 32
DATE	11/04/85
VENUE	3
TIME	45
INITIATOR	COMM/L
CASES ACTIONED	1
NO. CASES	12
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ ¦ ¦ ¦ 1¦ ¦ 1¦ 1¦ ¦ 1¦ ¦ 1¦ 1¦ ¦	6
2 .SHOWS TENSION RELEASE	¦ ¦ ¦ ¦ 2¦ ¦ 1¦ ¦ ¦ 1¦ ¦ ¦ 1¦ ¦	5
3 .AGREES	¦ ¦ ¦ ¦ 4¦ ¦ 3¦5 ¦ ¦ 3¦ ¦ 2¦ 3¦ ¦	20
4 .GIVES SUGGESTION	¦ ¦ ¦ ¦6 ¦ ¦ 5¦ 6¦ ¦ 3¦ ¦5 ¦ ¦ ¦	25
5 .GIVES OPINION	¦ ¦ ¦ ¦4 ¦ ¦ 3¦ 4¦ ¦ 5¦ ¦ 2¦ 3¦ ¦	21
6 .GIVES ORIENTATION	¦ ¦ ¦ ¦3 ¦ ¦ 1¦ 2¦ ¦ 2¦ ¦ 1¦ 2¦ ¦	11
7. ASKS FOR ORIENTATION	¦ ¦ ¦ ¦2 ¦ ¦ 3¦ 1¦ ¦ 1¦ ¦ 2¦ 1¦ ¦	10
8 .ASKS FOR OPINION	¦ ¦ ¦ ¦3 ¦ ¦ 2¦ 1¦ ¦ 2¦ ¦ 2¦ 3¦ ¦	13
9 .ASKS FOR SUGGESTION	¦ ¦ ¦ ¦3 ¦ ¦ 2¦ 3¦ ¦ 2¦ ¦ 4¦ 3¦ ¦	17
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0: 0: 0: 0:28: 0:21:23: 0:20: 0:14:22: 0: 0	

HASH NUMBER	33
RECORD NUMBER	2/ 33
DATE	18/04/85
VENUE	3
TIME	35
INITIATOR	COMM/L
CASES ACTIONED	1
NO. CASES	12
PAPERS CIRCULATED	0
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE	1 1 1 1	3
3 .AGREES	4 3 3 2 1 1	13
4 .GIVES SUGGESTION	2 3 1 2 2	10
5 .GIVES OPINION	4 4 3 1	12
6 .GIVES ORIENTATION	3 2 2 1 2	10
7. ASKS FOR ORIENTATION	2 1 1 1	5
8 .ASKS FOR OPINION	1 2 1 1	5
9 .ASKS FOR SUGGESTION	3 2 4 2 3	14
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:20: 0:11:18: 0:12: 0:11: 0: 0: 0	

HASH NUMBER	34
RECORD NUMBER	2/ 34
DATE	25/04/85
VENUE	3
TIME	35
INITIATOR	COMM/L
CASES ACTIONED	2
NO. CASES	15
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE		0
3 .AGREES	6 4 3 3 4 4	24
4 .GIVES SUGGESTION	3 4 4 3 4	18
5 .GIVES OPINION	4 1 3 2 1 2	13
6 .GIVES ORIENTATION	5 2 2 1 2 3	15
7. ASKS FOR ORIENTATION	2 3 2 1	8
8 .ASKS FOR OPINION	3 2 3 4 4 3	19
9 .ASKS FOR SUGGESTION	2 2 2 1 2 3	12
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:25: 0:15:20: 0:13: 0:16:20: 0: 0	

HASH NUMBER	35
RECORD NUMBER	2/ 35
DATE	02/05/85
VENUE	3
TIME	45
INITIATOR	COMM/L
CASES ACTIONED	1
NO. CASES	10
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
2 .SHOWS TENSION RELEASE	¦ ¦ ¦ ¦2 ¦ ¦1 ¦2 ¦ ¦1 ¦ ¦1 ¦2 ¦ ¦	9
3 .AGREES	¦ ¦ ¦ ¦6 ¦ ¦5 ¦ 3¦ ¦2 ¦ ¦3 ¦3 ¦ ¦	22
4 .GIVES SUGGESTION	¦ ¦ ¦ ¦3 ¦ ¦2 ¦ 4¦ ¦ 4¦ ¦ 3¦ 2¦ ¦	18
5 .GIVES OPINION	¦ ¦ ¦ ¦ 3¦ ¦ 4¦ 3¦ ¦ 2¦ ¦ 3¦ 2¦ ¦	17
6 .GIVES ORIENTATION	¦ ¦ ¦ ¦ 5¦ ¦ 2¦ 1¦ ¦ 1¦ ¦ 2¦ 3¦ ¦	14
7. ASKS FOR ORIENTATION	¦ ¦ ¦ ¦1 ¦ ¦ ¦2 ¦ ¦ 3¦ ¦ 2¦ 1¦ ¦	9
8 .ASKS FOR OPINION	¦ ¦ ¦ ¦3 ¦ ¦ 2¦ 3¦ ¦ 2¦ ¦ 2¦ 3¦ ¦	15
9 .ASKS FOR SUGGESTION	¦ ¦ ¦ ¦ 3¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦ 1¦ ¦	5
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0: 0: 0: 0:26: 0:16:19: 0:15: 0:16:17: 0: 0	

HASH NUMBER	36
RECORD NUMBER	2/ 36
DATE	09/05/85
VENUE	3
TIME	30
INITIATOR	COMM/L
CASES ACTIONED	0
NO. CASES	6
PAPERS CIRCULATED	0
NO. PARTS	4
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
2 .SHOWS TENSION RELEASE	¦ ¦ ¦ ¦ ¦1 ¦2 ¦1 ¦ ¦ ¦ ¦ ¦1 ¦ ¦	5
3 .AGREES	¦ ¦ ¦ ¦ ¦2 ¦3 ¦3 ¦ ¦ ¦ ¦ ¦2 ¦ ¦	10
4 .GIVES SUGGESTION	¦ ¦ ¦ ¦ ¦3 ¦4 ¦4 ¦ ¦ ¦ ¦ ¦3 ¦ ¦	14
5 .GIVES OPINION	¦ ¦ ¦ ¦ ¦2 ¦3 ¦2 ¦ ¦ ¦ ¦ ¦1 ¦ ¦	8
6 .GIVES ORIENTATION	¦ ¦ ¦ ¦ ¦4 ¦ 1¦ ¦ ¦ ¦ ¦ ¦2 ¦ ¦	7
7. ASKS FOR ORIENTATION	¦ ¦ ¦ ¦ ¦ ¦ ¦2 ¦ ¦ ¦ ¦ ¦ ¦ ¦	2
8 .ASKS FOR OPINION	¦ ¦ ¦ ¦ ¦3 ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦	4
9 .ASKS FOR SUGGESTION	¦ ¦ ¦ ¦ ¦4 ¦ ¦2 ¦ ¦ ¦ ¦ ¦1 ¦ ¦	7
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0: 0: 0: 0: 0:19:13:15: 0: 0: 0: 0:10: 0: 0	

HASH NUMBER	37
RECORD NUMBER	2/ 37
DATE	16/05/85
VENUE	3
TIME	40
INITIATOR	COMM/L
CASES ACTIONED	2
NO. CASES	10
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 1	2
2 .SHOWS TENSION RELEASE	2	2
3 .AGREES	3 2 4 2 1 2	14
4 .GIVES SUGGESTION	2 1 1 1	4
5 .GIVES OPINION	3 1 2 1 1	7
6 .GIVES ORIENTATION	1 3 1 1	6
7. ASKS FOR ORIENTATION	2 1 1 1	4
8 .ASKS FOR OPINION	3 2 1	6
9 .ASKS FOR SUGGESTION	1 1	2
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:16: 8: 9: 6: 3: 0: 0: 0: 5: 0: 0	

HASH NUMBER	38
RECORD NUMBER	2/ 38
DATE	23/05/85
VENUE	3
TIME	30
INITIATOR	COMM/L
CASES ACTIONED	1
NO. CASES	10
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE		0
3 .AGREES	4 3 2 2 1 1 2	14
4 .GIVES SUGGESTION	3 3 2 1 1 2	11
5 .GIVES OPINION	2 2 1 2 3	10
6 .GIVES ORIENTATION	4 1 2 1 2 3	13
7. ASKS FOR ORIENTATION	1 2 2 2 1	8
8 .ASKS FOR OPINION	2 1 1	4
9 .ASKS FOR SUGGESTION	1 1 1	3
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:17: 0: 9:11: 8: 0: 0: 7:11: 0: 0	

HASH NUMBER	39
RECORD NUMBER	2/ 39
DATE	06/06/85
VENUE	3
TIME	35
INITIATOR	COMM/L
CASES ACTIONED	0
NO. CASES	10
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES				13		12	2		11		11	2			11
4 .GIVES SUGGESTION				12											2
5 .GIVES OPINION				12		12	13		13			2	11		13
6 .GIVES ORIENTATION					31		11						11		5
7. ASKS FOR ORIENTATION								12			11				3
8 .ASKS FOR OPINION				12			11					11			4
9 .ASKS FOR SUGGESTION					21		11			11					4
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	0:	0:	0:	14:	0:	5:	9:	0:	6:	0:	4:	4:	0:	0

HASH NUMBER	40
RECORD NUMBER	2/ 40
DATE	08/01/85
VENUE	2
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	30
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	3

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	3														3
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4	11			15		13	3		312	13	12		11	27
4 .GIVES SUGGESTION	3	11													4
5 .GIVES OPINION	7	13			21		11			11	11		11		16
6 .GIVES ORIENTATION	8	12			31			11			11		11		16
7. ASKS FOR ORIENTATION	1				21					11	11			1	6
8 .ASKS FOR OPINION	3				11					11			21		7
9 .ASKS FOR SUGGESTION	1				21		11						11	1	6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	30:	7:	0:	0:	15:	0:	5:	4:	0:	6:	5:	3:	7:	0:	3

HASH NUMBER	41
RECORD NUMBER	2/ 41
DATE	07/01/86
VENUE	2
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2	1				2	1	1	1	1	1	1	2		12
3 .AGREES	3	2				4	2	1	2	3		2	3		22
4 .GIVES SUGGESTION	5	1													6
5 .GIVES OPINION	5	4							1						10
6 .GIVES ORIENTATION	2	3			6				1		2			1	15
7. ASKS FOR ORIENTATION	2								1			1			4
8 .ASKS FOR OPINION	2				3	1							1		7
9 .ASKS FOR SUGGESTION	2				3			1				2	1		9
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	24:	11:	0:	0:	18:	0:	4:	4:	5:	6:	0:	6:	8:	0:	0

HASH NUMBER	42
RECORD NUMBER	2/ 42
DATE	15/01/85
VENUE	2
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2				1							1			4
2 .SHOWS TENSION RELEASE	1														1
3 .AGREES	4	2				3		2	2		1	1	2	3	20
4 .GIVES SUGGESTION	5	2				1									8
5 .GIVES OPINION	7	3				2							1	1	14
6 .GIVES ORIENTATION	2	3				6		1			2				14
7. ASKS FOR ORIENTATION	1	2												1	4
8 .ASKS FOR OPINION	2					1					1		2		6
9 .ASKS FOR SUGGESTION	1					3		1	1			1	2	1	10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	25:	12:	0:	0:	17:	0:	4:	3:	0:	4:	2:	8:	5:	0:	1

HASH NUMBER	43
RECORD NUMBER	2/ 43
DATE	22/01/85
VENUE	2
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	15
PAPERS CIRCULATED	1
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4	2			4	2		2	1	2	2	3			22
4 .GIVES SUGGESTION	5	3										2			10
5 .GIVES OPINION	6	1			2			1		1		1			12
6 .GIVES ORIENTATION	1	2			6			1			2	1			13
7. ASKS FOR ORIENTATION	2				1						1				4
8 .ASKS FOR OPINION	2				3	1					2	3			11
9 .ASKS FOR SUGGESTION	1				5					2	2	1			11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21	8	0	0	21	0	3	2	2	1	5	9	1	0	0

HASH NUMBER	44
RECORD NUMBER	2/ 44
DATE	29/01/85
VENUE	2
TIME	75
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3	1			4			2	1		2	2	3	1	19
4 .GIVES SUGGESTION	6	3									1				10
5 .GIVES OPINION	4	1			1	1					2	1			9
6 .GIVES ORIENTATION	1	3			5	1				1	1	3			15
7. ASKS FOR ORIENTATION	2									1		1			4
8 .ASKS FOR OPINION	2				1										3
9 .ASKS FOR SUGGESTION										1	1				2
10.DISAGREES					2						1				3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	18	8	0	0	13	0	3	1	0	5	3	7	7	0	0

HASH NUMBER 45
RECORD NUMBER 2/ 45
DATE 05/02/85
VENUE 2
TIME 80
INITIATOR CONSULTANT
CASES ACTIONED 5
NO. CASES 28
PAPERS CIRCULATED 1
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1				1							1			3
2 .SHOWS TENSION RELEASE		1			1		1	1		1	1	1	1		8
3 .AGREES	4	2			3		2	2		3	1	2			19
4 .GIVES SUGGESTION	6				1					1					8
5 .GIVES OPINION	6	2			1					1			1		11
6 .GIVES ORIENTATION	1	2			5							2	1		11
7. ASKS FOR ORIENTATION	1				1										2
8 .ASKS FOR OPINION		1			2										3
9 .ASKS FOR SUGGESTION	1				3		1			1	1	1	2		10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	19:	9:	0:	0:	18:	0:	4:	3:	0:	7:	3:	4:	8:	0:	0

HASH NUMBER 46
RECORD NUMBER 2/ 46
DATE 12/02/85
VENUE 2
TIME 120
INITIATOR CONSULTANT
CASES ACTIONED 4
NO. CASES 28
PAPERS CIRCULATED 1
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 0

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	2	1			2		1	1		2			2	1	12
3 .AGREES	4	3			2					1		1	1	1	13
4 .GIVES SUGGESTION	5	2													7
5 .GIVES OPINION	7	3			3		1		4			1	2	3	24
6 .GIVES ORIENTATION	3	2			6		2	1		2	2			1	19
7. ASKS FOR ORIENTATION	1				1							1			3
8 .ASKS FOR OPINION	1				2		1					1	2	1	8
9 .ASKS FOR SUGGESTION	1				3										4
10.DISAGREES	1									3					4
11.SHOWS TENSION											1				1
12.SHOWS ANTAGONISM											1				1
	27:	11:	0:	0:	19:	0:	5:	2:	12:	4:	4:	7:	7:	0:	0

HASH NUMBER	47
RECORD NUMBER	2/ 47
DATE	19/02/85
VENUE	2
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1				2		1	1	1	1	1	1	1		10
3 .AGREES	4				4			2	1	3	2	1	1		18
4 .GIVES SUGGESTION	5									1					6
5 .GIVES OPINION	2				3		1			1			2	2	11
6 .GIVES ORIENTATION					6		2						3		11
7. ASKS FOR ORIENTATION	1									1					2
8 .ASKS FOR OPINION	2				3								1		6
9 .ASKS FOR SUGGESTION	1				4		1			1	1	1	2		11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	16:	0:	0:	0:	22:	0:	7:	2:	4:	7:	2:	5:	10:	0:	0

HASH NUMBER	48
RECORD NUMBER	2/ 48
DATE	26/02/85
VENUE	2
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3				4		2		1	2	1	2			15
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	5				3			1				1			10
6 .GIVES ORIENTATION	1				6										7
7. ASKS FOR ORIENTATION	1									1		1			3
8 .ASKS FOR OPINION	1				1										2
9 .ASKS FOR SUGGESTION	2				4		1			1	2	1			11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	15:	0:	0:	0:	18:	0:	3:	1:	1:	0:	4:	3:	5:	0:	0

HASH NUMBER	49
RECORD NUMBER	2/ 49
DATE	05/03/85
VENUE	2
TIME	85
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2				3		1	1	2	1	2	3		1	16
4 .GIVES SUGGESTION	3				1							1			5
5 .GIVES OPINION	6				2										8
6 .GIVES ORIENTATION	2				5										7
7. ASKS FOR ORIENTATION	1					2		1	1	1					5
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION				3					1	1	2	3			10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	16:	0:	0:	0:	14:	0:	3:	1:	0:	4:	3:	4:	7:	0:	1

HASH NUMBER	50
RECORD NUMBER	1/ 50
DATE	08/01/85
VENUE	3
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	14
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2				1	1	2								5
2 .SHOWS TENSION RELEASE	2			1	1	1			1		1	1	1	1	10
3 .AGREES		1		2	5	2					1	1			12
4 .GIVES SUGGESTION	6	2	1		4	1	1	1	1		1	1	1		20
5 .GIVES OPINION	3				1				1						5
6 .GIVES ORIENTATION	2				5	1	2	1							11
7. ASKS FOR ORIENTATION						1					1				2
8 .ASKS FOR OPINION		2													2
9 .ASKS FOR SUGGESTION															0
10.DISAGREES				1						1					2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	15:	3:	3:	3:	18:	3:	8:	3:	2:	0:	3:	4:	2:	2:	0

HASH NUMBER	51
RECORD NUMBER	1/ 51
DATE	15/01/85
VENUE	3
TIME	65
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	12
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	2				1			1							4
3 .AGREES	1				2		2	2				1			8
4 .GIVES SUGGESTION	5			1											6
5 .GIVES OPINION	4		1		3		1	1	1	1					11
6 .GIVES ORIENTATION	2	3			4										9
7. ASKS FOR ORIENTATION	1				1			1	2			1	1		7
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION	2														2
10.DISAGREES							1						1		2
11.SHOWS TENSION									1						1
12.SHOWS ANTAGONISM															0
	17:	3:	1:	1:	11:	0:	5:	4:	4:	0:	0:	2:	2:	0:	0

HASH NUMBER	52
RECORD NUMBER	1/ 52
DATE	22/01/85
VENUE	3
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	12
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE				1	1	1		1	1						5
3 .AGREES				2	1	1	1	1			1	1			8
4 .GIVES SUGGESTION	7				1										8
5 .GIVES OPINION	4	2			1		1	1				1	1		11
6 .GIVES ORIENTATION				4							2	1	3		10
7. ASKS FOR ORIENTATION	2		1						1						4
8 .ASKS FOR OPINION	3			1											4
9 .ASKS FOR SUGGESTION				2		1	1	1							4
10.DISAGREES												1			1
11.SHOWS TENSION												1			1
12.SHOWS ANTAGONISM								1							1
	16:	2:	1:	0:	12:	2:	4:	4:	3:	1:	0:	4:	5:	3:	0

HASH NUMBER 53
RECORD NUMBER 1/ 53
DATE 29/01/85
VENUE 3
TIME 99
INITIATOR CONSULTANT
CASES ACTIONED 5
NO. CASES 28
PAPERS CIRCULATED 0
NO. PARTS 11
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1		1		1	1	1	1		1	1	1	1		11
3 .AGREES	1				3	2	2		1		1	1	1		12
4 .GIVES SUGGESTION	5				1							1			7
5 .GIVES OPINION	4	1			2		1						1		9
6 .GIVES ORIENTATION	2				4		1				2	2	2		13
7. ASKS FOR ORIENTATION	1						2					1			4
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	1				2							1			4
10.DISAGREES		1													1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	18:	3:	0:	0:	13:	3:	7:	1:	2:	1:	1:	4:	7:	4:	0

HASH NUMBER 54
RECORD NUMBER 1/ 54
DATE 29/01/85
VENUE 3
TIME 99
INITIATOR CONSULTANT
CASES ACTIONED 4
NO. CASES 28
PAPERS CIRCULATED 0
NO. PARTS 11
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1														1
3 .AGREES	1				3		2					2	1	1	10
4 .GIVES SUGGESTION	3		1		1	1									6
5 .GIVES OPINION	3				1	1									5
6 .GIVES ORIENTATION	3				5										8
7. ASKS FOR ORIENTATION	2												2		4
8 .ASKS FOR OPINION	1		1		1										3
9 .ASKS FOR SUGGESTION		1										1			2
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	14:	0:	3:	0:	11:	2:	2:	0:	0:	0:	0:	2:	2:	3:	0

HASH NUMBER	55
RECORD NUMBER	1/ 55
DATE	05/02/85
VENUE	3
TIME	75
INITIATOR	SEN REG
CASES ACTIONED	2
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
2 .SHOWS TENSION RELEASE	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
3 .AGREES	¦3 ¦ ¦ ¦ ¦ 4¦ ¦2 ¦ ¦ ¦ ¦ ¦ 2¦ 2¦ 2¦ ¦	15
4 .GIVES SUGGESTION	¦4 ¦ ¦ ¦3 ¦3 ¦5 ¦ ¦ ¦ ¦ ¦ ¦1 ¦1 ¦ ¦	17
5 .GIVES OPINION	¦ 6¦ ¦ ¦3 ¦2 ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	12
6 .GIVES ORIENTATION	¦3 ¦ ¦ ¦ ¦ 7¦ ¦2 ¦ ¦ ¦ ¦ ¦ 1¦ 1¦ 1¦ 1¦	16
7. ASKS FOR ORIENTATION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ 2¦ ¦ ¦1 ¦1 ¦ ¦ ¦	4
8 .ASKS FOR OPINION	¦ 2¦ ¦ ¦3 ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	6
9 .ASKS FOR SUGGESTION	¦3 ¦ ¦ ¦ ¦ ¦ ¦2 ¦ ¦ ¦ ¦ ¦1 ¦1 ¦ ¦ ¦	7
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ 1¦ 1¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	2
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0:21: 0: 0:20: 5:14: 3: 0: 0: 5: 6: 4: 1: 0	

HASH NUMBER	56
RECORD NUMBER	1/ 56
DATE	12/02/85
VENUE	3
TIME	65
INITIATOR	SEN REG
CASES ACTIONED	1
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	1
2 .SHOWS TENSION RELEASE	¦2 ¦ ¦ ¦ 1¦ 2¦ ¦1 ¦1 ¦ 1¦ ¦ 1¦ 1¦ 1¦ ¦	11
3 .AGREES	¦ ¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	1
4 .GIVES SUGGESTION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
5 .GIVES OPINION	¦5 ¦ ¦ ¦3 ¦ ¦2 ¦ ¦1 ¦ ¦ ¦1 ¦1 ¦ ¦	13
6 .GIVES ORIENTATION	¦ ¦ ¦ ¦ ¦ 4¦ ¦3 ¦ ¦ ¦ ¦ ¦4 ¦3 ¦ ¦	14
7. ASKS FOR ORIENTATION	¦1 ¦ ¦ ¦2 ¦ ¦ ¦ ¦2 ¦ ¦ ¦ ¦1 ¦ ¦	6
8 .ASKS FOR OPINION	¦2 ¦ ¦ ¦ 2¦ 1¦ 1¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	6
9 .ASKS FOR SUGGESTION	¦3 ¦ ¦ ¦ 2¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ 1¦ ¦	7
10.DISAGREES	¦ 1¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦1 ¦ ¦ ¦	3
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0:15: 0: 1:16: 2: 7: 1: 5: 0: 1: 7: 7: 0: 0	

HASH NUMBER	57
RECORD NUMBER	1/ 57
DATE	19/02/85
VENUE	3
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	0
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1														1
3 .AGREES		1				1			1	1	1		1	1	8
4 .GIVES SUGGESTION	2				1										3
5 .GIVES OPINION	4					1	1					1	1		8
6 .GIVES ORIENTATION		3			6		2					2	1	1	15
7. ASKS FOR ORIENTATION	4							1				1	1		7
8 .ASKS FOR OPINION		1													1
9 .ASKS FOR SUGGESTION		1										1	1		3
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	12:	5:	0:	0:	9:	0:	4:	1:	2:	0:	0:	6:	5:	2:	0

HASH NUMBER	58
RECORD NUMBER	1/ 58
DATE	26/02/85
VENUE	3
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	6
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	1				5		2	1			1	1	1		12
4 .GIVES SUGGESTION	3								1						4
5 .GIVES OPINION	6	2			2			1					1		12
6 .GIVES ORIENTATION	3				6		2								11
7. ASKS FOR ORIENTATION	1							1				1			3
8 .ASKS FOR OPINION	1	1					1					1			4
9 .ASKS FOR SUGGESTION		1													1
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	15:	3:	1:	0:	13:	0:	6:	1:	2:	1:	1:	0:	4:	0:	0

HASH NUMBER	59
RECORD NUMBER	1/ 59
DATE	05/03/85
VENUE	3
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1													1
2 .SHOWS TENSION RELEASE	2													2
3 .AGREES			1	1	1	1								4
4 .GIVES SUGGESTION	6	2						1					1	10
5 .GIVES OPINION	7													7
6 .GIVES ORIENTATION				5		2					1	1	1	10
7. ASKS FOR ORIENTATION	1						2					1	2	6
8 .ASKS FOR OPINION	1			1		1								3
9 .ASKS FOR SUGGESTION	3			2									2	7
10.DISAGREES							1							1
11.SHOWS TENSION														0
12.SHOWS ANTAGONISM														0
	20:	3:	0:	1:	9:	1:	4:	3:	1:	0:	0:	1:	2:	6: 0

HASH NUMBER	60
RECORD NUMBER	1/ 60
DATE	12/03/85
VENUE	3
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	13
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2	2			1		1					1		7
2 .SHOWS TENSION RELEASE	1	1			2	1	1	1		1		1	1	11
3 .AGREES	2				3		2			1		3		11
4 .GIVES SUGGESTION	6													6
5 .GIVES OPINION	4	3			2		2	1	2	1		1		16
6 .GIVES ORIENTATION					5		3		1	1		2	2	14
7. ASKS FOR ORIENTATION	1	1					2	1				1	1	8
8 .ASKS FOR OPINION		2			1	1			1			1		6
9 .ASKS FOR SUGGESTION	2	1			2		2					1		8
10.DISAGREES														0
11.SHOWS TENSION														0
12.SHOWS ANTAGONISM														0
	18:	10:	0:	0:	16:	2:	8:	7:	5:	4:	0:	2:	9:	6: 0

HASH NUMBER	61
RECORD NUMBER	1/ 61
DATE	19/03/85
VENUE	3
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	15
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4			2	5		3	4					2	2	22
4 .GIVES SUGGESTION	6														6
5 .GIVES OPINION	5			3		2		1				1	1	1	14
6 .GIVES ORIENTATION	3				6		2					2	2	2	17
7. ASKS FOR ORIENTATION					7	3	2	1				1	1		15
8 .ASKS FOR OPINION	3	2			3	2	2		1				1		14
9 .ASKS FOR SUGGESTION	4				1										5
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	25	2	0	5	22	7	7	7	2	0	0	4	7	5	0

HASH NUMBER	62
RECORD NUMBER	1/ 62
DATE	05/05/86
VENUE	4
TIME	25
INITIATOR	SISTER
CASES ACTIONED	4
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY					1			1				1			3
2 .SHOWS TENSION RELEASE				2			1	1				1	1		6
3 .AGREES				6			3	3				5	2		19
4 .GIVES SUGGESTION				2			1	1				1			4
5 .GIVES OPINION				3			2	2			2	1			10
6 .GIVES ORIENTATION				6			5	1			3	3			18
7. ASKS FOR ORIENTATION				3			3	2			3	2			13
8 .ASKS FOR OPINION				4			1	1			1				6
9 .ASKS FOR SUGGESTION				1			2	1			1	1			6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0	0	0	0	28	0	0	17	12	0	0	16	12	0	0

HASH NUMBER	63
RECORD NUMBER	1/ 63
DATE	12/05/86
VENUE	4
TIME	20
INITIATOR	SISTER
CASES ACTIONED	4
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	0
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 1	2
2 .SHOWS TENSION RELEASE	2 1 1 2 2 1 2	10
3 .AGREES	6 5 4 4 3 5 1	27
4 .GIVES SUGGESTION	2 1 1 2 1 1 1	7
5 .GIVES OPINION	3 3 4 3 3 4 2	20
6 .GIVES ORIENTATION	7 2 1 1 2 2 1	15
7. ASKS FOR ORIENTATION	3 4 4 3 4 2 1	20
8 .ASKS FOR OPINION	3 4 3 2 1 1 1	12
9 .ASKS FOR SUGGESTION	3 2 2 1 1 1	8
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:30: 0:20:18:20: 0: 0:15:18: 0: 0	

HASH NUMBER	64
RECORD NUMBER	1/ 64
DATE	19/05/86
VENUE	4
TIME	25
INITIATOR	SISTER
CASES ACTIONED	5
NO. CASES	23
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 1	1
2 .SHOWS TENSION RELEASE	2 1 1 1 2 2	9
3 .AGREES	4 3 2 2 2 1 2	15
4 .GIVES SUGGESTION	1 1 1	2
5 .GIVES OPINION	3 2 4 2 1 1 2	14
6 .GIVES ORIENTATION	6 1 2 2 1 1 3	15
7. ASKS FOR ORIENTATION	2 2 1 1 2 1	8
8 .ASKS FOR OPINION	5 3 2 1 1 3	14
9 .ASKS FOR SUGGESTION	4 2	6
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:28: 0: 9:14:13: 0: 0: 8:12: 0: 0	

HASH NUMBER	65
RECORD NUMBER	1/ 65
DATE	26/05/86
VENUE	4
TIME	25
INITIATOR	SISTER
CASES ACTIONED	3
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	; ; ; ; 1; ; ; ; 1; ; ; ; ; ;	2
2 .SHOWS TENSION RELEASE	; ; ; ; 1; ; 1; ; 3;2; ; ; ; 2;2; ;	11
3 .AGREES	; ; ; ; 7; ; 5; 6; 4; ; ; ; 3; 4; ;	29
4 .GIVES SUGGESTION	; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
5 .GIVES OPINION	; ; ; ; 4; ; ; 3; 5; 2; ; ; 3; 4; ;	21
6 .GIVES ORIENTATION	; ; ; ; 6; ; 2; 1; 1; ; ; ; 2; 3; ;	15
7. ASKS FOR ORIENTATION	; ; ; ; 2; ; 1; 4; 3; ; ; ; 3; 2; ;	15
8 .ASKS FOR OPINION	; ; ; ; 4; ; ; 3; 2; 3; ; ; 2; 3; ;	17
9 .ASKS FOR SUGGESTION	; ; ; ; 3; ; ; ; 1; 1; ; ; 1; 2; ;	8
10.DISAGREES	; ; ; ; ; ; ; 1; ; ; ; ; ; ; ;	1
11.SHOWS TENSION	; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
12.SHOWS ANTAGONISM	; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
	0: 0: 0: 0:28: 0:16:22:17: 0: 0:16:20: 0: 0	

HASH NUMBER	66
RECORD NUMBER	1/ 66
DATE	21/01/86
VENUE	4
TIME	25
INITIATOR	SISTER
CASES ACTIONED	2
NO. CASES	23
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
2 .SHOWS TENSION RELEASE	; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
3 .AGREES	; ; ; ; 3; ; 2; 4; 3; ; ; 2; 4; ;	18
4 .GIVES SUGGESTION	; ; ; ; 1; ; ; ; 1; ; ; 1; 1; ;	4
5 .GIVES OPINION	; ; ; ; 3; ; 3; 4; 2; ; ; 3; 2; ;	17
6 .GIVES ORIENTATION	; ; ; ; 5; ; 4; 4; 2; ; ; 4;3; ;	22
7. ASKS FOR ORIENTATION	; ; ; ; 2; ; 4; 3; 2; ; ; 4; 2; ;	17
8 .ASKS FOR OPINION	; ; ; ; 3; ; 3; 4; 3; ; ; 2; 2; ;	17
9 .ASKS FOR SUGGESTION	; ; ; ; 4; ; 2; 3; ; ; ; 1; ; ;	10
10.DISAGREES	; ; ; ; 1; ; ; ; ; ; ; ; ; ; ;	1
11.SHOWS TENSION	; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
12.SHOWS ANTAGONISM	; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
	0: 0: 0: 0:22: 0:18:19:16: 0: 0:16:15: 0: 0	

HASH NUMBER	67
RECORD NUMBER	1/ 67
DATE	28/01/86
VENUE	4
TIME	30
INITIATOR	SISTER
CASES ACTIONED	1
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	: : : : : : : : : : : : : :	0
2 .SHOWS TENSION RELEASE	: : : : : : 1: : : : : : :	1
3 .AGREES	: : : : 3: 2 : 1: 1: : 2 : 1:	10
4 .GIVES SUGGESTION	: : : : : : : : : : : : : :	0
5 .GIVES OPINION	: : : 3 : 4 4 3 : : 2 4 : :	20
6 .GIVES ORIENTATION	: : : 5 : 2 : 1 : : : 2: 3: :	13
7. ASKS FOR ORIENTATION	: : : 2 : : 2 2 : : 1: 3 : :	10
8 .ASKS FOR OPINION	: : : 3 : : 2: 5: 3: : : 3: 1: :	17
9 .ASKS FOR SUGGESTION	: : : 4 : 1 : 2: 2: : : 2: 1: :	12
10.DISAGREES	: : : : : : 1 : : : : 1: : :	2
11.SHOWS TENSION	: : : : : : : : : : : : : :	0
12.SHOWS ANTAGONISM	: : : : : : : : : : : : : :	0
	0: 0: 0: 0:20: 0:11:16:12: 0: 0:13:13: 0: 0	

HASH NUMBER	68
RECORD NUMBER	1/ 68
DATE	04/02/86
VENUE	4
TIME	35
INITIATOR	SISTER
CASES ACTIONED	0
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	: : : : : : : : : : : : : :	0
2 .SHOWS TENSION RELEASE	: : : : 2: 1 :2 :1 : : :2 :2 : :	10
3 .AGREES	: : : 4 : : 3: 3:4 : : :4 :2 : :	20
4 .GIVES SUGGESTION	: : : : : : : : : : : : : :	0
5 .GIVES OPINION	: : : 3 : 1 :3 : 2: : :2 : 2: :	13
6 .GIVES ORIENTATION	: : : 5 : :2 :4 : 1: : :3 : 4: :	19
7. ASKS FOR ORIENTATION	: : : 3 : : 5: 4 : : : 3: 3: :	18
8 .ASKS FOR OPINION	: : : : 2: :3 : 2: 2: : :3 :1 : :	13
9 .ASKS FOR SUGGESTION	: : : 3 : : 1: 2: 1: : : 1: 2: :	10
10.DISAGREES	: : : : : : 1 : : : : 1 : :	2
11.SHOWS TENSION	: : : : : : : : : : : 1 : :	1
12.SHOWS ANTAGONISM	: : : : : : : : : : : : : :	0
	0: 0: 0: 0:22: 0:16:17:15: 0: 0:18:18: 0: 0	

HASH NUMBER	69
RECORD NUMBER	1/ 69
DATE	11/02/86
VENUE	4
TIME	20
INITIATOR	SISTER
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY														0
2 .SHOWS TENSION RELEASE				2				1						3
3 .AGREES				3			3	2	2			3	3	16
4 .GIVES SUGGESTION				1				1				1		3
5 .GIVES OPINION				2		1	1	2	1			2	1	10
6 .GIVES ORIENTATION				4	3		2	3	3		2		2	19
7. ASKS FOR ORIENTATION				1		1	2	2	2			1	2	11
8 .ASKS FOR OPINION					3		1		1			1	2	8
9 .ASKS FOR SUGGESTION				4			3	2	1				2	12
10.DISAGREES						1		1						2
11.SHOWS TENSION														0
12.SHOWS ANTAGONISM														0
	0:	0:	0:	0:	20:	5:	13:	12:	12:	0:	0:	9:	13:	0: 0

HASH NUMBER	70
RECORD NUMBER	1/ 70
DATE	18/02/86
VENUE	4
TIME	25
INITIATOR	SISTER
CASES ACTIONED	4
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY														0
2 .SHOWS TENSION RELEASE														0
3 .AGREES				6		4	3	3		2	4			22
4 .GIVES SUGGESTION				1							1			2
5 .GIVES OPINION				6		2	4	3		4	3			22
6 .GIVES ORIENTATION				7		2	2	2			5	3		21
7. ASKS FOR ORIENTATION				3			4	2	1			3	1	14
8 .ASKS FOR OPINION				4			3				2	3		12
9 .ASKS FOR SUGGESTION				2		1	1	2				1		7
10.DISAGREES							1							1
11.SHOWS TENSION														0
12.SHOWS ANTAGONISM														0
	0:	0:	0:	0:	29:	0:	14:	15:	11:	0:	0:	17:	15:	0: 0

HASH NUMBER	71
RECORD NUMBER	1/ 71
DATE	25/02/86
VENUE	4
TIME	20
INITIATOR	SISTER
CASES ACTIONED	1
NO. CASES	20
PAPERS CIRCULATED	0
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE		0
3 .AGREES	3 | 2 | 2 | 3 | 3 | 3 |	13
4 .GIVES SUGGESTION	3 | 2 | 3 | 3 | 2 | 2 |	12
5 .GIVES OPINION	4 | 3 | 4 | 3 | 4 | 4 |	18
6 .GIVES ORIENTATION	5 | 1 | 2 | 4 | 2 | 2 |	14
7. ASKS FOR ORIENTATION	2 | 1 | 3 | 2 | 2 | 2 |	10
8 .ASKS FOR OPINION	3 | 4 | 3 | 4 | 1 | 1 |	16
9 .ASKS FOR SUGGESTION	4 | 1 | 2 | 2 |	7
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:24: 0: 0:13:18: 0: 0:16:19: 0: 0	

HASH NUMBER	72
RECORD NUMBER	1/ 72
DATE	04/03/86
VENUE	4
TIME	15
INITIATOR	SISTER
CASES ACTIONED	0
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	4
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE		0
3 .AGREES	3 | 2 | 1 | 1 | 3 |	9
4 .GIVES SUGGESTION	2 | 1 | 2 |	5
5 .GIVES OPINION	5 | 3 | 4 | 3 |	15
6 .GIVES ORIENTATION	5 | 2 | 2 | 1 |	10
7. ASKS FOR ORIENTATION	3 | 3 | 4 | 3 |	13
8 .ASKS FOR OPINION	4 | 1 | 2 | 2 |	9
9 .ASKS FOR SUGGESTION	3 | 1 |	4
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 0: 0: 0:25: 0: 0:12: 0: 0: 0:15:13: 0: 0	

HASH NUMBER	73
RECORD NUMBER	1/ 73
DATE	11/03/86
VENUE	4
TIME	35
INITIATOR	SISTER
CASES ACTIONED	5
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY					1										1
2 .SHOWS TENSION RELEASE					1	1	2	2			1	1			7
3 .AGREES					4	4	3	4			2	5			22
4 .GIVES SUGGESTION					2	1	1	1			1				6
5 .GIVES OPINION					3	4	4	3			2	1			17
6 .GIVES ORIENTATION					7	4	1	2			3	2			19
7. ASKS FOR ORIENTATION					2	1		1				2			6
8 .ASKS FOR OPINION					2	1	1				3				7
9 .ASKS FOR SUGGESTION					1	2					2				5
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0	0	0	0	23	0	19	11	12	0	0	12	13	0	0

HASH NUMBER	74
RECORD NUMBER	1/ 74
DATE	18/03/86
VENUE	4
TIME	25
INITIATOR	SISTER
CASES ACTIONED	3
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE					1			1	1			1	1		5
3 .AGREES					5	4	3				3	3			18
4 .GIVES SUGGESTION					1		1		1			2			5
5 .GIVES OPINION					4		2	2	1			2	2		13
6 .GIVES ORIENTATION					3			2	2			1	2		10
7. ASKS FOR ORIENTATION					2		2	1	1			2			8
8 .ASKS FOR OPINION					3		2	2	2			2			11
9 .ASKS FOR SUGGESTION					4		1		1			3	4		13
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0	0	0	0	23	0	13	11	8	0	0	12	16	0	0

HASH NUMBER	75
RECORD NUMBER	1/ 75
DATE	25/03/86
VENUE	4
TIME	20
INITIATOR	SISTER
CASES ACTIONED	2
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE					2	1	1	1	2			2	2		10
3 .AGREES					5	3	3	4			3	4			22
4 .GIVES SUGGESTION					1			1							2
5 .GIVES OPINION				3			1		2			2	3		11
6 .GIVES ORIENTATION				7		2	1	1				3	4		18
7. ASKS FOR ORIENTATION				3		1	2	2				1	2		11
8 .ASKS FOR OPINION				3			2	2	1		3	2			13
9 .ASKS FOR SUGGESTION					3		1		2			1	1		8
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	0:	0:	0:	27:	0:	11:	9:	15:	0:	0:	15:	18:	0:	0

HASH NUMBER	76
RECORD NUMBER	1/ 76
DATE	15/03/86
VENUE	4
TIME	25
INITIATOR	SISTER
CASES ACTIONED	1
NO. CASES	6
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE				3			2	1	2			1	1		10
3 .AGREES				4		2		2	3			3	2		16
4 .GIVES SUGGESTION				1					1						2
5 .GIVES OPINION				3			2		1		2	1			9
6 .GIVES ORIENTATION					5		2	1	2			1			11
7. ASKS FOR ORIENTATION					3		2	2	1			1	2		11
8 .ASKS FOR OPINION					1				1						2
9 .ASKS FOR SUGGESTION					2		1		2				1		6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	0:	0:	0:	22:	0:	11:	6:	13:	0:	0:	7:	8:	0:	0

HASH NUMBER	77
RECORD NUMBER	1/ 77
DATE	05/12/85
VENUE	1
TIME	125
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	30
PAPERS CIRCULATED	1
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2	1				2		1	1		1	1	1	1	11
3 .AGREES	3	2				5		2	3			2	1	3	23
4 .GIVES SUGGESTION	6	1									1				8
5 .GIVES OPINION	8	2										1			11
6 .GIVES ORIENTATION		3				6							1		10
7. ASKS FOR ORIENTATION	2									1	1				4
8 .ASKS FOR OPINION	2					2		2	1			2	1		10
9 .ASKS FOR SUGGESTION	1					5		1			1		2		10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	25	9	0	0	20	0	6	5	0	5	4	7	7	0	0

HASH NUMBER	78
RECORD NUMBER	1/ 78
DATE	12/11/85
VENUE	1
TIME	100
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4	2				4		2		2		1	2	3	20
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	6												1		7
6 .GIVES ORIENTATION	1	1				7							1		10
7. ASKS FOR ORIENTATION	1						1				1	1	2		6
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION	2	2				3			1	1		1	2		12
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20	5	0	0	14	0	3	3	1	1	2	3	9	0	0

HASH NUMBER	79
RECORD NUMBER	1/ 79
DATE	19/11/85
VENUE	1
TIME	110
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3				5		2	1			3	2	1	2	19
4 .GIVES SUGGESTION	5										1			1	7
5 .GIVES OPINION	6				1						2				9
6 .GIVES ORIENTATION	1				8		1				2				12
7. ASKS FOR ORIENTATION	2				1					1	1			1	6
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION					2			1			1		1		5
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	19	0	0	0	17	0	4	1	0	5	4	5	5	0	0

HASH NUMBER	80
RECORD NUMBER	1/ 80
DATE	26/11/85
VENUE	1
TIME	75
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	27
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2				1										3
2 .SHOWS TENSION RELEASE	3		1		2			1	1	2		1	2	2	16
3 .AGREES	2	3			5		1	1		2	1	2	2		19
4 .GIVES SUGGESTION	7														7
5 .GIVES OPINION	6				1							1		1	9
6 .GIVES ORIENTATION	2	2			5			1	2		1	1			14
7. ASKS FOR ORIENTATION	1								1	2					4
8 .ASKS FOR OPINION	2	1			3									1	7
9 .ASKS FOR SUGGESTION	1				6				2	2	1	2			14
10.DISAGREES	1				1							1			3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	27	7	0	0	24	0	2	3	0	9	6	6	9	0	3

HASH NUMBER	81
RECORD NUMBER	1/ 81
DATE	01/10/85
VENUE	1
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3				4			2	2		1	1	3	2	18
4 .GIVES SUGGESTION	5										1				6
5 .GIVES OPINION	6				2							2	1		11
6 .GIVES ORIENTATION	1				6		1	1		2	1				12
7. ASKS FOR ORIENTATION	2							1		2		1	1		7
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	2				3						1				6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21:	0:	0:	0:	15:	0:	3:	4:	0:	6:	3:	6:	4:	0:	0

HASH NUMBER	82
RECORD NUMBER	1/ 82
DATE	16/01/85
VENUE	1
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4				13			2	2		1	1	3	4	20
4 .GIVES SUGGESTION	6														6
5 .GIVES OPINION	5				2						1		2	1	11
6 .GIVES ORIENTATION	2				5			1			1		1		10
7. ASKS FOR ORIENTATION	1										1		1		3
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION					3						2	2	1		8
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	19:	0:	0:	0:	13:	0:	3:	2:	0:	4:	3:	8:	7:	0:	0

HASH NUMBER	83
RECORD NUMBER	1/ 83
DATE	23/01/85
VENUE	1
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3				3		2	2		2	2	3	1		18
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	4				2							2	3		11
6 .GIVES ORIENTATION	1				5		1	1				2	1		11
7. ASKS FOR ORIENTATION									1	1					2
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION					2						1		1		4
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	11:	0:	0:	0:	12:	0:	3:	3:	0:	3:	4:	7:	6:	0:	0

HASH NUMBER	84
RECORD NUMBER	1/ 84
DATE	20/02/85
VENUE	1
TIME	105
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2		1			1			1			1	1	1	8
3 .AGREES	3		2			4			1	2		2		2	19
4 .GIVES SUGGESTION	6														6
5 .GIVES OPINION	4	2				2					2			2	13
6 .GIVES ORIENTATION		2				5					1			1	9
7. ASKS FOR ORIENTATION	1										1	1	1	2	6
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION					2					1	1				4
10.DISAGREES										1					1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM										1					1
	19:	7:	0:	0:	14:	0:	2:	2:	0:	10:	2:	5:	9:	0:	0

HASH NUMBER	85
RECORD NUMBER	1/ 85
DATE	27/02/85
VENUE	1
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	30
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2				5	2	2		1	1		3	4		20
4 .GIVES SUGGESTION	6														6
5 .GIVES OPINION	5				2	1			2		2	3			15
6 .GIVES ORIENTATION	1				7		2	1					1		12
7. ASKS FOR ORIENTATION	1								1		1				3
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION					4	2	1				1	1	2		11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	17	0	0	0	18	2	6	3	0	4	2	7	10	0	0

HASH NUMBER	86
RECORD NUMBER	1/ 86
DATE	06/03/85
VENUE	1
TIME	100
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	29
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4	2			3		1	2		1	1	2	3		19
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	5	1			2				1			3	1		13
6 .GIVES ORIENTATION					6		1		2			1	1		11
7. ASKS FOR ORIENTATION	1										1			1	3
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION					3		1		1	2	1	2			10
10.DISAGREES					1							1			2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	15	3	0	0	15	0	2	3	0	5	4	7	8	0	1

HASH NUMBER	87
RECORD NUMBER	1/ 87
DATE	13/03/85
VENUE	1
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2										1				3
2 .SHOWS TENSION RELEASE	1	1				1	1	1	1		1	1	1	1	9
3 .AGREES	3	2			4		3	3		2	3	4	3		27
4 .GIVES SUGGESTION	8														8
5 .GIVES OPINION	3	1		2			2					1			9
6 .GIVES ORIENTATION				4			1			1					6
7. ASKS FOR ORIENTATION	1					1					1		1		4
8 .ASKS FOR OPINION	1										1	1			3
9 .ASKS FOR SUGGESTION	1				2								1		4
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM				1											1
	20:	4:	0:	0:	14:	0:	5:	7:	0:	4:	5:	8:	7:	0:	0

HASH NUMBER	88
RECORD NUMBER	1/ 88
DATE	20/03/85
VENUE	1
TIME	110
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY		1													1
2 .SHOWS TENSION RELEASE	1					1	1		2	1		1	1		8
3 .AGREES	4	2			6		1	4	2	1	3	2			25
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	4	3			1			1			1				10
6 .GIVES ORIENTATION		2			5			1		1		1			10
7. ASKS FOR ORIENTATION	2				2						1				6
8 .ASKS FOR OPINION					1										1
9 .ASKS FOR SUGGESTION		1			2							1	2		6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	15:	9:	0:	0:	18:	1:	1:	6:	5:	2:	1:	6:	7:	0:	0

HASH NUMBER	89
RECORD NUMBER	1/ 89
DATE	20/03/85
VENUE	1
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	5	2			6		2	3			1	2	4	3	28
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	5	2				1									8
6 .GIVES ORIENTATION	2	1			4			1					2	2	12
7. ASKS FOR ORIENTATION	2						1				1				4
8 .ASKS FOR OPINION	1	2													3
9 .ASKS FOR SUGGESTION		1			2		1			1		2	3		10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	19	8	0	0	13	0	4	4	0	2	3	8	8	0	0

HASH NUMBER	90
RECORD NUMBER	1/ 90
DATE	8 /10/85
VENUE	2
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2				3		1	2	1		1	2	2		14
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	4				2								1		7
6 .GIVES ORIENTATION	2				3			1	1			1	2		10
7. ASKS FOR ORIENTATION	1								1	1					3
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION					2							2	1		5
10.DISAGREES						1									1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	11	0	0	0	10	0	2	3	0	3	2	5	6	0	0

HASH NUMBER	91
RECORD NUMBER	1/ 91
DATE	15/10/85
VENUE	2
TIME	75
INITIATOR	SEN REG
CASES ACTIONED	2
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1			2		1	1		1		1	1			8
3 .AGREES	4			5		3	2		3		2	3	4		26
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	6														6
6 .GIVES ORIENTATION	1			3							2				6
7. ASKS FOR ORIENTATION										1	1				2
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION		3		2						1		1			7
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	19:	0:	0:	12:	0:	4:	3:	0:	5:	5:	5:	6:	0:	0

HASH NUMBER	92
RECORD NUMBER	1/ 92
DATE	22/10/85
VENUE	2
TIME	60
INITIATOR	SEN REG
CASES ACTIONED	1
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	2					1			1		1		1		6
3 .AGREES	4			5			2	2				1	1		15
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	3			1			1	1		1	2	1			10
6 .GIVES ORIENTATION	2			3											5
7. ASKS FOR ORIENTATION				1											1
8 .ASKS FOR OPINION	1						1								2
9 .ASKS FOR SUGGESTION					1			1		2	1				5
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM				1											1
	0:	13:	0:	0:	12:	0:	4:	5:	1:	0:	3:	4:	4:	0:	0

HASH NUMBER	93
RECORD NUMBER	1/ 93
DATE	09/10/85
VENUE	2
TIME	85
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2	3			4		2		1	2	2	3			19
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	2	2					1						1		6
6 .GIVES ORIENTATION		3			5							1	1		10
7. ASKS FOR ORIENTATION	4														4
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION		1			3		1					1			6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	10:	9:	0:	0:	12:	0:	4:	0:	0:	1:	2:	3:	6:	0:	0

HASH NUMBER	94
RECORD NUMBER	3/ 94
DATE	03/10/85
VENUE	1
TIME	75
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2					1	2		1						6
3 .AGREES	2	1				4		2	2	3		1	2	3	20
4 .GIVES SUGGESTION	5				3		1		1						10
5 .GIVES OPINION	6				2				2						10
6 .GIVES ORIENTATION	3				4										7
7. ASKS FOR ORIENTATION	2				2			1	2	1	1	1	1		11
8 .ASKS FOR OPINION	2				2			1	1						6
9 .ASKS FOR SUGGESTION					3			1	1				2	1	8
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	23:	1:	0:	0:	21:	0:	7:	5:	10:	0:	2:	5:	5:	0:	0

HASH NUMBER	95
RECORD NUMBER	3/ 95
DATE	10/10/85
VENUE	1
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2	1			3			1	1		2	1	2	3	16
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	3	1			1								1		6
6 .GIVES ORIENTATION		1			4			2			1	1	2		11
7. ASKS FOR ORIENTATION							1	1			1				3
8 .ASKS FOR OPINION							1								1
9 .ASKS FOR SUGGESTION	1				2			1			1	2	1		8
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	8:	3:	0:	0:	10:	0:	3:	5:	0:	3:	3:	5:	7:	0:	0

HASH NUMBER	96
RECORD NUMBER	3/ 96
DATE	17/10/85
VENUE	1
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	1
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	1				1		1	1			1	1	1	1	8
3 .AGREES	5				4		3					1		2	15
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	7														7
6 .GIVES ORIENTATION	2				6		3	1				1			13
7. ASKS FOR ORIENTATION									1						1
8 .ASKS FOR OPINION	1						1								2
9 .ASKS FOR SUGGESTION					2					1					3
10.DISAGREES								1							1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM								1		1					2
	18:	0:	0:	0:	13:	0:	8:	4:	0:	3:	3:	2:	3:	0:	0

HASH NUMBER	97
RECORD NUMBER	3/ 97
DATE	24/10/85
VENUE	1
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	5		2		5			3	3	2		1	2	3	26
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	6	3							2						11
6 .GIVES ORIENTATION		1			6			2			2	3			14
7. ASKS FOR ORIENTATION															0
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	2				6			4	1			1	3		17
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	17:	6:	0:	0:	17:	0:	7:	5:	5:	0:	2:	4:	9:	0:	0

HASH NUMBER	98
RECORD NUMBER	3/ 98
DATE	31/10/85
VENUE	1
TIME	75
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	1														1
3 .AGREES	2				3			1	1		2	1	1	2	13
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	6				1										7
6 .GIVES ORIENTATION					4			1			2	2	2		11
7. ASKS FOR ORIENTATION	1									1					2
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION					3			2				1	3		9
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	14:	0:	0:	0:	11:	0:	3:	2:	0:	3:	3:	4:	7:	0:	0

HASH NUMBER	99
RECORD NUMBER	3/ 99
DATE	06/09/85
VENUE	1
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2				1			1							4
2 .SHOWS TENSION RELEASE	2			1	2			1			2	1	1	1	11
3 .AGREES	4				6		2	2			3	2	3	3	25
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	5				1	2									8
6 .GIVES ORIENTATION					2	3					1			1	7
7. ASKS FOR ORIENTATION	1											1			2
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION					2			1				1	2	2	8
10.DISAGREES					1										1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1					1		1							3
	19	0	0	4	18	0	5	3	0	6	5	6	7	0	0

HASH NUMBER	100
RECORD NUMBER	4/100
DATE	03/04/85
VENUE	4
TIME	2
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1				2		2	2	1		1	1			10
3 .AGREES	1				4	1	3	2	2	1	2	2	1	1	20
4 .GIVES SUGGESTION	5				2		3	1		1			1	1	14
5 .GIVES OPINION	6				2		3	2					1		14
6 .GIVES ORIENTATION	3				4						1		1		9
7. ASKS FOR ORIENTATION	2				2			1	1				1		7
8 .ASKS FOR OPINION	3						1		1						5
9 .ASKS FOR SUGGESTION					1		1	1							3
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	23	0	0	0	17	1	12	9	4	4	4	4	4	2	0

HASH NUMBER	101
RECORD NUMBER	4/101
DATE	10/04/85
VENUE	4
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	1				3	2	1	1			1	1	1		11
3 .AGREES	2	1			4	2	1	1		1		1	1		14
4 .GIVES SUGGESTION	3				1		1								5
5 .GIVES OPINION	4	2			3			2	1		2		1		15
6 .GIVES ORIENTATION	3				5							2	1		11
7. ASKS FOR ORIENTATION	1	2			3						1	2	2		11
8 .ASKS FOR OPINION	1	2			2				1			1			7
9 .ASKS FOR SUGGESTION	4				3		1					1	1		10
10.DISAGREES									1						1
11.SHOWS TENSION										1					1
12.SHOWS ANTAGONISM									1						1
	20:	7:	0:	0:	24:	4:	6:	4:	0:	5:	3:	8:	7:	0:	0

HASH NUMBER	102
RECORD NUMBER	4/102
DATE	17/04/85
VENUE	4
TIME	85
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1				3			2					1		7
3 .AGREES	2	1			4			3				2	2	3	17
4 .GIVES SUGGESTION	5	2						1							8
5 .GIVES OPINION	7	3			2			2	1				1	2	18
6 .GIVES ORIENTATION	3				5			1	1				1	1	13
7. ASKS FOR ORIENTATION	2	1			2			1	1			2		2	11
8 .ASKS FOR OPINION	1	2			2							2	1		8
9 .ASKS FOR SUGGESTION					3			2				3	1		9
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21:	9:	0:	0:	21:	0:	9:	6:	0:	0:	5:	9:	11:	0:	0

HASH NUMBER	103
RECORD NUMBER	4/103
DATE	24/04/85
VENUE	4
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1				1										2
2 .SHOWS TENSION RELEASE	2				2	1	1	1			1	1	1		10
3 .AGREES	2				4	3	5	3			2	4	3		26
4 .GIVES SUGGESTION	7				4	2		1				3			17
5 .GIVES OPINION	6				5			3	3			2	3		22
6 .GIVES ORIENTATION	3					6			2				3	2	16
7. ASKS FOR ORIENTATION	4					2		1	2				2	1	14
8 .ASKS FOR OPINION	5					3		2	1				1	1	14
9 .ASKS FOR SUGGESTION						4			1				2	1	8
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	30:	0:	0:	0:	31:	6:	12:	14:	0:	0:	6:	17:	13:	0:	0

HASH NUMBER	104
RECORD NUMBER	4/104
DATE	01/05/85
VENUE	4
TIME	98
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	3				2			1	2		1	1	2	1	13
3 .AGREES	3	2			3			2	1		1	1	3	1	17
4 .GIVES SUGGESTION	4	1				2					1				8
5 .GIVES OPINION	6		2			2		1			2			1	15
6 .GIVES ORIENTATION	3	3				4			1				2	3	16
7. ASKS FOR ORIENTATION	1				2				1				1		5
8 .ASKS FOR OPINION	2	1			3		2			1			2		11
9 .ASKS FOR SUGGESTION	2					1					1		1		5
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	26:	9:	0:	0:	19:	0:	7:	4:	0:	6:	3:	9:	9:	0:	0

HASH NUMBER	105
RECORD NUMBER	4/105
DATE	08/05/85
VENUE	4
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 |1 | | |2 | |1 | |1 | | 1| 1| 1| |	9
2 .SHOWS TENSION RELEASE	| | | | | | | | | | | | |	0
3 .AGREES	2 |2 | | |3 | |2 | |1 | | 1| 2| 2| |	15
4 .GIVES SUGGESTION	5 |4 | | | | |1 | |1 | | | | |	11
5 .GIVES OPINION	6| 4| | | 2| | 1| |2 | | |2 |2 | |	19
6 .GIVES ORIENTATION	3 |2 | | | 4| | 1| | 1| | | 1| 1| |	13
7. ASKS FOR ORIENTATION	2 |1 | | |3 | | 1| | 2| | 1| 2| 2| |	14
8 .ASKS FOR OPINION	2 | | | | 2| | 1| | | | 1| | | |	6
9 .ASKS FOR SUGGESTION	3 | 1| | | 2| | | | | 1| | |1 | | |	8
10.DISAGREES	| | | | | | | | | | | | | |	0
11.SHOWS TENSION	| | | | | | | | | | | | | |	0
12.SHOWS ANTAGONISM	| | | | | | | | | | | | | |	0
	24:15: 0: 0:18: 0: 8: 0: 9: 0: 4: 9: 8: 0: 0	

HASH NUMBER	106
RECORD NUMBER	4/106
DATE	15/05/85
VENUE	4
TIME	60
INITIATOR	REGISTRAR
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	|1 | | | | | | | | | | | | |	1
2 .SHOWS TENSION RELEASE	|2 | | | 2| | 1| 1| |1 | | 1| 1| |	9
3 .AGREES	| 2| | |3 | | 3| 2| | 1| | 2|1 | |	14
4 .GIVES SUGGESTION	| 3| | | 3| | 2| | | 2| | 1| | |	11
5 .GIVES OPINION	|4 | | |3 | | 2| 3| |3 | | 2| 2| |	19
6 .GIVES ORIENTATION	|3 | | | 4| | |1 | | | |2 |2 | |	12
7. ASKS FOR ORIENTATION	| 2| | | 1| | |1 | |1 | | |1 | |	6
8 .ASKS FOR OPINION	|3 | | |3 | | 2| 2| |1 | | 1| 1| |	13
9 .ASKS FOR SUGGESTION	| 2| | |1 | | | | | | | 1| 1| |	5
10.DISAGREES	| | | | | | | | | | | | | |	0
11.SHOWS TENSION	| | | | | | | | | | | | | |	0
12.SHOWS ANTAGONISM	| | | | | | | | | | | | | |	0
	0:22: 0: 0:20: 0:10:10: 0: 9: 0:10: 9: 0: 0	

HASH NUMBER	107
RECORD NUMBER	1/107
DATE	22/05/86
VENUE	4
TIME	80
INITIATOR	REGISTRAR
CASES ACTIONED	2
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ 2¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	3
2 .SHOWS TENSION RELEASE	¦ 1¦ ¦ ¦ 1¦ ¦1 ¦1 ¦ ¦1 ¦ ¦1 ¦1 ¦ ¦	7
3 .AGREES	¦ 3¦ ¦ ¦ 4¦ ¦ 2¦ 2¦ ¦2 ¦ ¦ 3¦ 2¦ ¦	18
4 .GIVES SUGGESTION	¦ 4¦ ¦ ¦ 2¦ ¦1 ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦	8
5 .GIVES OPINION	¦ 3¦ ¦ ¦ 1¦ ¦ 2¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	6
6 .GIVES ORIENTATION	¦ 2¦ ¦ ¦ 5¦ ¦ 2¦ 1¦ ¦ 2¦ ¦ 3¦ 4¦ ¦	19
7. ASKS FOR ORIENTATION	¦2 ¦ ¦ ¦ 1¦ ¦ 1¦ 2¦ ¦ 2¦ ¦ ¦1 ¦ ¦	9
8 .ASKS FOR OPINION	¦ 2¦ ¦ ¦ 2¦ ¦ ¦ ¦ ¦ ¦ ¦ 2¦ ¦ ¦	6
9 .ASKS FOR SUGGESTION	¦1 ¦ ¦ ¦ 2¦ ¦ ¦ 3¦ ¦ 1¦ ¦ 1¦2 ¦ ¦	10
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	1
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0:20: 0: 0:19: 0:10: 9: 0: 9: 0:10:10: 0: 0	

HASH NUMBER	108
RECORD NUMBER	1/108
DATE	29/05/85
VENUE	4
TIME	85
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	2
2 .SHOWS TENSION RELEASE	2 ¦1 ¦ ¦ ¦ 2¦ ¦1 ¦ ¦ ¦1 ¦1 ¦1 ¦1 ¦ ¦	10
3 .AGREES	1 ¦2 ¦ ¦ ¦ 3¦ ¦ 2¦ ¦ ¦ 2¦ 1¦ ¦ 1¦ ¦	12
4 .GIVES SUGGESTION	3 ¦1 ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	5
5 .GIVES OPINION	4 ¦1 ¦ ¦ ¦2 ¦ ¦ ¦ ¦ ¦1 ¦ ¦2 ¦1 ¦ ¦	11
6 .GIVES ORIENTATION	¦4 ¦ ¦ ¦5 ¦ ¦1 ¦ ¦ ¦ ¦ ¦3 ¦4 ¦ ¦ ¦	17
7. ASKS FOR ORIENTATION	3¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ 1¦ ¦1 ¦ ¦	6
8 .ASKS FOR OPINION	2¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦	4
9 .ASKS FOR SUGGESTION	¦ ¦3 ¦ ¦2 ¦ ¦1 ¦ ¦ ¦ 1¦ ¦ ¦1 ¦ ¦	8
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	16:10: 3: 0:17: 0: 5: 0: 0: 6: 3: 6: 9: 0: 0	

HASH NUMBER	109
RECORD NUMBER	1/109
DATE	05/06/85
VENUE	4
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	2 | | | | | | | | | | | | |	2
2 .SHOWS TENSION RELEASE	1 | | 1| | 2| |1 | 1| | 1| | 1| 1| |	9
3 .AGREES	2 | |1 | | 2| | 2| 1| | 2| |1 | 3| |	14
4 .GIVES SUGGESTION	5 | | 3| | 2| |1 | | | 1| | 2|3 | |	17
5 .GIVES OPINION	7 | | 2| | 3| |1 | 2| | 1| | 2| 1| |	19
6 .GIVES ORIENTATION	3 | | 4| | 4| | | | | | | 1| | |	12
7. ASKS FOR ORIENTATION	2 | | | |1 | |2 | 1| | 2| | 1| 1| |	10
8 .ASKS FOR OPINION	1 | | | |2 | | | | | | |2 | | |	5
9 .ASKS FOR SUGGESTION	2 | | | | | | | | | | |1 |1 | |	4
10.DISAGREES	1 | | | | 1| | | | | 1| | 1| | |	4
11.SHOWS TENSION	| | | | | | | | | | | | | |	0
12.SHOWS ANTAGONISM	| | | | | | | | | | | | | |	0
	26: 0:11: 0:17: 0: 7: 5: 0: 8: 0:12:10: 0: 0	

HASH NUMBER	110
RECORD NUMBER	1/110
DATE	05/06/85
VENUE	4
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	2 | | | |1 | |1 | 1| | 1| |1 |1 | |	8
2 .SHOWS TENSION RELEASE	1 | | | | 1| | 2| 1| |1 |1 |1 | 1| |	9
3 .AGREES	2 | | | |4 | |2 | 2| | 2| 1| 1| 2| |	16
4 .GIVES SUGGESTION	5 | | | |3 | |1 | | | 1| | |1 | |	11
5 .GIVES OPINION	6 | | | | 2| |1 | 1| | 2| |2 | 2| |	16
6 .GIVES ORIENTATION	1| 2| | |5 |1 | 2| | | 1| 1| 3| | |	16
7. ASKS FOR ORIENTATION	| | | | | | |1 | |1 | | | | |	2
8 .ASKS FOR OPINION	| | | |1 | | | | | | | | | |	1
9 .ASKS FOR SUGGESTION	| | | | | | | | | | | | | |	0
10.DISAGREES	1 | | | |1 | | | | | | | | | |	2
11.SHOWS TENSION	2 | | | | | | | | | | | | | |	2
12.SHOWS ANTAGONISM	|1 | | |1 | | |1 | | | |1 | | |	4
	20: 3: 0: 0:19: 1: 9: 7: 0: 9: 3: 9: 7: 0: 0	

HASH NUMBER	111
RECORD NUMBER	1/111
DATE	16/10/85
VENUE	3
TIME	140
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2	1			1	1						1			6
2 .SHOWS TENSION RELEASE	3	1			1	2		2	1	1	1	1	1		14
3 .AGREES	4	2			1	4		2	1	2		1	4	3	24
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	6	1			2										9
6 .GIVES ORIENTATION					4							2	1		7
7. ASKS FOR ORIENTATION	1						1					1			3
8 .ASKS FOR OPINION		1			1	2									4
9 .ASKS FOR SUGGESTION					1										1
10.DISAGREES												1			1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21:	6:	0:	4:	16:	0:	5:	2:	3:	0:	2:	9:	6:	0:	0

HASH NUMBER	112
RECORD NUMBER	1/112
DATE	23/10/85
VENUE	3
TIME	110
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2				1			1		1		2			7
3 .AGREES	3				5			2	1	2	1	3	1		18
4 .GIVES SUGGESTION	4				1										5
5 .GIVES OPINION	6				2										8
6 .GIVES ORIENTATION	1				3							2	1		7
7. ASKS FOR ORIENTATION	1									1					2
8 .ASKS FOR OPINION	1						1								2
9 .ASKS FOR SUGGESTION	1				2		2					1	3		9
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20:	0:	0:	0:	14:	0:	6:	1:	0:	4:	1:	6:	7:	0:	0

HASH NUMBER	113
RECORD NUMBER	1/113
DATE	30/10/85
VENUE	3
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3	2				4			1	1		2	1	2	18
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	6	3			1						1				11
6 .GIVES ORIENTATION					5		1					2	1		9
7. ASKS FOR ORIENTATION	1									1					2
8 .ASKS FOR OPINION	1	2		2		1							1		7
9 .ASKS FOR SUGGESTION	1			3		2				1	1	2			10
10.DISAGREES		1								1			1		3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	16	8	0	0	15	0	5	1	0	5	2	5	7	0	0

HASH NUMBER	114
RECORD NUMBER	1/114
DATE	5 /11/85
VENUE	3
TIME	150
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	5				4			2	2		1	1	2	3	20
4 .GIVES SUGGESTION	8	1													9
5 .GIVES OPINION	7	4													11
6 .GIVES ORIENTATION	2	4			5				1		2		1	3	18
7. ASKS FOR ORIENTATION	2										1				3
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION		2			3			1							6
10.DISAGREES					2			2	1			3	1	4	15
11.SHOWS TENSION	1	3			3			2	1			4		2	16
12.SHOWS ANTAGONISM	2	1									2		1	1	7
	27	15	0	0	17	0	7	5	0	1	3	2	10	9	0	0

HASH NUMBER	115
RECORD NUMBER	1/115
DATE	19/11/85
VENUE	3
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	2	1													3
3 .AGREES	2				3	1	2					1	1		10
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	4	2			2	1						2	4		15
6 .GIVES ORIENTATION		2			4							1	3		10
7. ASKS FOR ORIENTATION	2						2								4
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	2				4		1					2	1		10
10.DISAGREES												1			1
11.SHOWS TENSION					1										1
12.SHOWS ANTAGONISM	1														1
	17:	5:	0:	0:	14:	0:	3:	4:	0:	0:	0:	6:	10:	0:	0

HASH NUMBER	116
RECORD NUMBER	1/116
DATE	26/11/85
VENUE	3
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2				1				1						4
2 .SHOWS TENSION RELEASE	2				1		1	1	2			1	1		9
3 .AGREES	4				5		2		2		1	2	3		19
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	5						1					1			7
6 .GIVES ORIENTATION					3							2			5
7. ASKS FOR ORIENTATION	2								1						3
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION					2		1		1		2	2	1		9
10.DISAGREES												1			1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20:	0:	0:	0:	12:	0:	5:	1:	7:	0:	3:	5:	9:	0:	0

HASH NUMBER	117
RECORD NUMBER	1/117
DATE	03/12/85
VENUE	3
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	1
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2				2		1	2		1	1	2	1		12
4 .GIVES SUGGESTION	3				2			1					1		7
5 .GIVES OPINION	4				3		1			1		1			10
6 .GIVES ORIENTATION					4							2	2		8
7. ASKS FOR ORIENTATION	1				1					1					3
8 .ASKS FOR OPINION	2				1							1			4
9 .ASKS FOR SUGGESTION	1											1			2
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	13:	0:	0:	0:	13:	0:	2:	3:	0:	3:	1:	6:	5:	0:	0

HASH NUMBER	118
RECORD NUMBER	1/118
DATE	10/12/85
VENUE	3
TIME	55
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2				2		1	2		1	1	2	1		12
4 .GIVES SUGGESTION	3				2			1					1		7
5 .GIVES OPINION	4				3		1			1		1			10
6 .GIVES ORIENTATION					4							2	2		8
7. ASKS FOR ORIENTATION	1				1					1					3
8 .ASKS FOR OPINION	2				1							1			4
9 .ASKS FOR SUGGESTION	1											1			2
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	13:	0:	0:	0:	13:	0:	2:	3:	0:	3:	1:	6:	5:	0:	0

HASH NUMBER	119
RECORD NUMBER	1/119
DATE	17/12/85
VENUE	3
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	24
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 ¦2 ¦ ¦ ¦ ¦1¦ ¦2 ¦ 1¦ ¦ ¦ ¦ ¦2 ¦ ¦	9
2 .SHOWS TENSION RELEASE	¦1 ¦ ¦ ¦ ¦1¦ ¦ 2¦2 ¦ ¦ ¦ ¦ ¦3 ¦ 3¦	12
3 .AGREES	3 ¦ 1¦ ¦ ¦ ¦ ¦1 ¦1 ¦ ¦ ¦ ¦ ¦ ¦ 3¦	9
4 .GIVES SUGGESTION	4 ¦ ¦ ¦ ¦ ¦ ¦ ¦2 ¦ ¦ ¦ ¦ ¦ ¦ ¦	6
5 .GIVES OPINION	2 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ 2¦ ¦ ¦ ¦ ¦1	5
6 .GIVES ORIENTATION	¦2 ¦ ¦ ¦ 3¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦1 ¦ ¦	7
7. ASKS FOR ORIENTATION	2 ¦ 1¦ ¦ ¦ ¦ ¦ 2¦ 1¦ ¦ ¦ ¦ ¦1 ¦ ¦	7
8 .ASKS FOR OPINION	¦ ¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦ 2¦ ¦ ¦ ¦1 ¦	4
9 .ASKS FOR SUGGESTION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
10.DISAGREES	1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦	2
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	13: 7: 0: 0: 6: 0: 7: 8: 1: 4: 0: 0: 7: 7: 1	

HASH NUMBER	120
RECORD NUMBER	1/120
DATE	03/12/85
VENUE	3
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	2 ¦ ¦ ¦ 1¦ 1¦ ¦ ¦ ¦ ¦ ¦ ¦ 1¦ ¦	5
2 .SHOWS TENSION RELEASE	3 ¦ ¦ ¦ 2¦ 3¦ ¦ 1¦ ¦ ¦ 2¦ 1¦ 1¦1 ¦ ¦	14
3 .AGREES	5 ¦ ¦ ¦2 ¦3 ¦ ¦1 ¦ ¦ ¦ 2¦ 3¦ 2¦ 2¦ ¦	20
4 .GIVES SUGGESTION	6 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦	7
5 .GIVES OPINION	6 ¦ ¦ ¦ 2¦ 2¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	10
6 .GIVES ORIENTATION	2 ¦ ¦ ¦ 4¦ 6¦ ¦ 2¦ ¦ ¦ 3¦ 1¦ 2¦4 ¦ ¦	24
7. ASKS FOR ORIENTATION	2 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	2
8 .ASKS FOR OPINION	3 ¦ ¦ ¦ ¦ 1¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	4
9 .ASKS FOR SUGGESTION	2 ¦ ¦ ¦ ¦ 3¦ ¦ 1¦ ¦ ¦ ¦ ¦ 2¦ ¦ ¦	8
10.DISAGREES	1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	1
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	32: 0: 0:11:19: 0: 5: 0: 0: 8: 5: 5:10: 0: 0	

HASH NUMBER	121
RECORD NUMBER	1/121
DATE	29/11/85
VENUE	3
TIME	120
INITIATOR	REGISTRAR
CASES ACTIONED	1
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.I.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY							2					2	1		5
2 .SHOWS TENSION RELEASE		1			1		3								5
3 .AGREES		3	1	2	1		3					2	1	1	14
4 .GIVES SUGGESTION	2		3		1		5	2				2	1		16
5 .GIVES OPINION			1									5			6
6 .GIVES ORIENTATION				2	1							1	1		5
7. ASKS FOR ORIENTATION			2				1								3
8 .ASKS FOR OPINION		1	1	2			1					1			6
9 .ASKS FOR SUGGESTION		1		1											2
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	7:	5:	10:	5:	0:	15:	2:	0:	0:	0:	7:	10:	0:	1

HASH NUMBER	122
RECORD NUMBER	1/122
DATE	06/12/85
VENUE	3
TIME	80
INITIATOR	REGISTRAR
CASES ACTIONED	1
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3	1			2		3		2			3	1		15
4 .GIVES SUGGESTION					1							5			6
5 .GIVES OPINION					2		1								3
6 .GIVES ORIENTATION			2		1		1					3	5	2	14
7. ASKS FOR ORIENTATION	1	1			2		1					1			6
8 .ASKS FOR OPINION		1	.	1											2
9 .ASKS FOR SUGGESTION															0
10.DISAGREES												1			1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	4:	5:	0:	9:	0:	6:	2:	0:	0:	4:	14:	3:	0:	0

HASH NUMBER	123
RECORD NUMBER	1/123
DATE	13/12/85
VENUE	3
TIME	65
INITIATOR	REGISTRAR
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 1 2 2 1 3 1 1	11
2 .SHOWS TENSION RELEASE	2	2
3 .AGREES	3 1 1 2 2 3 3	13
4 .GIVES SUGGESTION	5 1	6
5 .GIVES OPINION	5 1 1 2 1	9
6 .GIVES ORIENTATION	2 3 6 1 1 2 2 1	16
7. ASKS FOR ORIENTATION	2 1 1 1 1	5
8 .ASKS FOR OPINION	1 2	3
9 .ASKS FOR SUGGESTION	2 1	3
10.DISAGREES	2	2
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM	1 1	2
	0:23: 6: 0:13: 0: 4: 4: 6: 0: 3: 5: 8: 0: 0	

HASH NUMBER	124
RECORD NUMBER	1/124
DATE	22/11/85
VENUE	3
TIME	115
INITIATOR	REGISTRAR
CASES ACTIONED	2
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	1 2 1 1 1 3 1 1	9
2 .SHOWS TENSION RELEASE	1 1 1 1 1 1 1	7
3 .AGREES	2 1 2 1 1 2 1 1 2	15
4 .GIVES SUGGESTION	2 3 1 1 1 1 2	11
5 .GIVES OPINION	3 2 1 1 1 1	7
6 .GIVES ORIENTATION	1 4 2 1	8
7. ASKS FOR ORIENTATION	2 1 1 1 1 1 1	6
8 .ASKS FOR OPINION	1 2	3
9 .ASKS FOR SUGGESTION	2 2	4
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0:10: 1: 0:18: 0: 8: 6: 4: 0: 4: 5: 9: 0: 5	

HASH NUMBER	125
RECORD NUMBER	3/125
DATE	03/02/86
VENUE	4
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE		0
3 .AGREES	2 1 1 5 2	10
4 .GIVES SUGGESTION	1 1 1 1 5	8
5 .GIVES OPINION	1 1 2 1 1	5
6 .GIVES ORIENTATION	2 2	4
7. ASKS FOR ORIENTATION		0
8 .ASKS FOR OPINION		0
9 .ASKS FOR SUGGESTION	2 3	5
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0: 3: 0: 0: 6: 0: 6: 1: 0: 0: 7: 4: 5: 0: 0	

HASH NUMBER	126
RECORD NUMBER	1/126
DATE	06/12/85
VENUE	3
TIME	80
INITIATOR	REGISTRAR
CASES ACTIONED	1
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	3 1 2 1 1	7
2 .SHOWS TENSION RELEASE	2 2 3 2 1 1 1 1 2	14
3 .AGREES	3 1 3 5 2 3 1	18
4 .GIVES SUGGESTION	2 1	3
5 .GIVES OPINION	3 2 1 1 2 2	13
6 .GIVES ORIENTATION	2 4 2 1 1 1 2	12
7. ASKS FOR ORIENTATION	1 1 1	3
8 .ASKS FOR OPINION	1 1 1	3
9 .ASKS FOR SUGGESTION	1	1
10.DISAGREES	1 1	2
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM		0
	0:16: 5: 0:16: 0:11: 3: 0: 5: 4: 7: 9: 0: 0	

HASH NUMBER	127
RECORD NUMBER	3/127
DATE	10/02/86
VENUE	4
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1	1							1						3
2 .SHOWS TENSION RELEASE	2				1								1		4
3 .AGREES	5	3		5		2	1		3		2	4	3		28
4 .GIVES SUGGESTION	5	1													6
5 .GIVES OPINION	6	2			1					1			1	2	13
6 .GIVES ORIENTATION	1	3		5		1			2			3	2		17
7. ASKS FOR ORIENTATION	2						2						1		5
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION				3		1				1	2	1			8
10.DISAGREES	2			1							1				4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	24:	10:	0:	0:	16:	0:	6:	1:	7:	0:	3:	11:	10:	0:	0

HASH NUMBER	128
RECORD NUMBER	1/128
DATE	30/10/85
VENUE	4
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2		1	1	1		1	1			2	1	2		11
2 .SHOWS TENSION RELEASE	2						2	1			2	1	2		10
3 .AGREES	2			2		1									5
4 .GIVES SUGGESTION	4		1	2		1	1	2							11
5 .GIVES OPINION	3			1		1				2		1			8
6 .GIVES ORIENTATION					1					1		2			4
7. ASKS FOR ORIENTATION	1			1		1									3
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION										1	1				2
10.DISAGREES	1														1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	16:	0:	2:	0:	8:	0:	5:	4:	3:	0:	7:	3:	8:	0:	0

HASH NUMBER	129
RECORD NUMBER	3/129
DATE	17/02/86
VENUE	4
TIME	140
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY					2										2
2 .SHOWS TENSION RELEASE	2		1		2			1	1			1	1		9
3 .AGREES	6	3			6			2	4			4	3		28
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	2	3			4			1	2			6	2		20
6 .GIVES ORIENTATION	1	2			6					1					10
7. ASKS FOR ORIENTATION									1						1
8 .ASKS FOR OPINION	2														2
9 .ASKS FOR SUGGESTION	1									1					2
10.DISAGREES		2													2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	17:	11:	0:	0:	20:	0:	0:	4:	0:	9:	1:	11:	6:	0:	0

HASH NUMBER	130
RECORD NUMBER	3/130
DATE	20/12/85
VENUE	4
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1			1	1		2	1	3			1	1		11
2 .SHOWS TENSION RELEASE							1								1
3 .AGREES	3						1	1				2	3	3	13
4 .GIVES SUGGESTION	5		1		2				1				1		10
5 .GIVES OPINION	5			3	6							2			16
6 .GIVES ORIENTATION	2			3											5
7. ASKS FOR ORIENTATION	2				1			1							4
8 .ASKS FOR OPINION	2		1		1										4
9 .ASKS FOR SUGGESTION	2		1		1							1			5
10.DISAGREES	2														2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	24:	0:	10:	0:	12:	0:	3:	4:	4:	0:	0:	4:	7:	3:	0

HASH NUMBER	131
RECORD NUMBER	3/131
DATE	03/01/86
VENUE	4
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2				2			1	1						6
2 .SHOWS TENSION RELEASE	1		1			1		1		1		2	1		8
3 .AGREES	3				5		1					1	2		12
4 .GIVES SUGGESTION	3		1		2										6
5 .GIVES OPINION	5				1				2			2	1	1	12
6 .GIVES ORIENTATION	1		2			6			1				1	2	13
7. ASKS FOR ORIENTATION	3					1		1	1	2			1		9
8 .ASKS FOR OPINION	1					2		2					1	2	8
9 .ASKS FOR SUGGESTION				1		2			2				1		6
10.DISAGREES	1											1			2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20:	0:	5:	0:	22:	0:	5:	4:	7:	0:	1:	8:	9:	1:	0

HASH NUMBER	132
RECORD NUMBER	3/132
DATE	10/01/86
VENUE	4
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	27
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	1				1		1	1							4
3 .AGREES					1			1	2			1			5
4 .GIVES SUGGESTION															0
5 .GIVES OPINION	3											1			4
6 .GIVES ORIENTATION	2				2										4
7. ASKS FOR ORIENTATION						1	1	1							3
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION						1									1
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	8:	0:	0:	0:	4:	0:	3:	3:	3:	0:	0:	1:	1:	0:	0

HASH NUMBER	133
RECORD NUMBER	3/133
DATE	17/01/86
VENUE	4
TIME	85
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1	2			2			1	1	1			2		10
2 .SHOWS TENSION RELEASE	1	1			1	1		2	1				2		8
3 .AGREES	4	3			4			2	2	1	1	2	3		22
4 .GIVES SUGGESTION	6	1			1			1	2						11
5 .GIVES OPINION	6				1			1					2		10
6 .GIVES ORIENTATION	1	2				1									4
7. ASKS FOR ORIENTATION	3				1								1		5
8 .ASKS FOR OPINION	1				1							1	2		5
9 .ASKS FOR SUGGESTION					1										1
10.DISAGREES	1				1			1	1						4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	24	9	0	0	13	0	8	8	2	0	1	3	12	0	0

HASH NUMBER	134
RECORD NUMBER	1/134
DATE	30/10/85
VENUE	4
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY		1			2	2	1								6
2 .SHOWS TENSION RELEASE					1										1
3 .AGREES	1				1			1					2		5
4 .GIVES SUGGESTION	2	1			1										4
5 .GIVES OPINION	6										2	2			10
6 .GIVES ORIENTATION	1	2			3		1				4	3			14
7. ASKS FOR ORIENTATION	2				1										3
8 .ASKS FOR OPINION	3				3			1			1				8
9 .ASKS FOR SUGGESTION	3				2		1								6
10.DISAGREES					1		2					1			4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM					1			1				1			3
	18	4	0	0	16	0	9	1	0	0	2	8	6	0	0

HASH NUMBER	135
RECORD NUMBER	1/135
DATE	06/09/85
VENUE	2C
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	20
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	1				1		1					1	2		7
3 .AGREES	4				2		1			1		2	1		11
4 .GIVES SUGGESTION	4	1													5
5 .GIVES OPINION	5	3			2				1				1		12
6 .GIVES ORIENTATION					3						2	1			6
7. ASKS FOR ORIENTATION							1								1
8 .ASKS FOR OPINION		2													2
9 .ASKS FOR SUGGESTION	1				4						1				6
10.DISAGREES	1														1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	19:	6:	0:	0:	12:	0:	3:	0:	2:	0:	1:	6:	5:	0:	0

HASH NUMBER	136
RECORD NUMBER	1/136
DATE	20/09/85
VENUE	2
TIME	155
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	29
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4	2			1	2		1		1		2	4		17
4 .GIVES SUGGESTION	6														6
5 .GIVES OPINION	5	1			1										7
6 .GIVES ORIENTATION		2			1	4									7
7. ASKS FOR ORIENTATION									1		1				2
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION				1	2								1		4
10.DISAGREES															0
11.SHOWS TENSION								1		1	1	1			5
12.SHOWS ANTAGONISM	2														2
	17:	5:	0:	4:	8:	0:	2:	0:	3:	0:	2:	3:	5:	1:	0

HASH NUMBER	137
RECORD NUMBER	2/137
DATE	27/09/85
VENUE	3
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2			1	1		1					1	2		8
3 .AGREES	2			2	3			1		1			2		12
4 .GIVES SUGGESTION	4			2	1										7
5 .GIVES OPINION	3				1					1					5
6 .GIVES ORIENTATION				1	4						2	1			8
7. ASKS FOR ORIENTATION	2									1					3
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION	1			2	3						1				7
10.DISAGREES	1										1				2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	16:	0:	0:	8:	13:	0:	1:	1:	0:	3:	0:	5:	6:	0:	0

HASH NUMBER	138
RECORD NUMBER	2/138
DATE	03/02/86
VENUE	4
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4	2			3		1		1	2		1	3	4	21
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	5	2													7
6 .GIVES ORIENTATION		1			4				1						6
7. ASKS FOR ORIENTATION	2														2
8 .ASKS FOR OPINION	4							2				1			7
9 .ASKS FOR SUGGESTION					3		1		1		2	1			8
10.DISAGREES	1														1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	22:	5:	0:	0:	10:	0:	2:	1:	6:	0:	1:	5:	6:	0:	0

HASH NUMBER	139
RECORD NUMBER	2/139
DATE	10/02/86
VENUE	4
TIME	140
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	30
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2			1	1			1		1		1	1	1	9
2 .SHOWS TENSION RELEASE	2			1	2										5
3 .AGREES	6			2	5			2	2	1		2	1	2	23
4 .GIVES SUGGESTION	4					1			1						6
5 .GIVES OPINION	3												1		4
6 .GIVES ORIENTATION					2										2
7. ASKS FOR ORIENTATION	1														1
8 .ASKS FOR OPINION	2			1								1			4
9 .ASKS FOR SUGGESTION				1									2		3
10.DISAGREES	2						1		1				2		6
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	3														3
	25:	0:	0:	5:	12:	0:	4:	2:	4:	0:	3:	3:	8:	0:	0

HASH NUMBER	140
RECORD NUMBER	1/140
DATE	03/08/85
VENUE	2
TIME	45
INITIATOR	REGISTRAR
CASES ACTIONED	1
NO. CASES	15
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY		1		2											3
2 .SHOWS TENSION RELEASE		2		1		1			2			2			8
3 .AGREES		3		4		2			2			1			12
4 .GIVES SUGGESTION		2													2
5 .GIVES OPINION		4			2	1			1				1		9
6 .GIVES ORIENTATION		2		3					1			2			8
7. ASKS FOR ORIENTATION									1						1
8 .ASKS FOR OPINION		3		1											4
9 .ASKS FOR SUGGESTION			2	3		1			2			3			11
10.DISAGREES				2					1						3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	0:	19:	0:	18:	0:	5:	0:	0:	10:	0:	0:	9:	0:	0

HASH NUMBER	141
RECORD NUMBER	1/142
DATE	10/04/85
VENUE	2
TIME	90
INITIATOR	REGISTRAR
CASES ACTIONED	2
NO. CASES	12
PAPERS CIRCULATED	0
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ ¦1 ¦ ¦2 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	3
2 .SHOWS TENSION RELEASE	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
3 .AGREES	¦ ¦3 ¦ ¦1 ¦ ¦2 ¦ ¦ ¦1 ¦ ¦ ¦2¦ 3¦ ¦	12
4 .GIVES SUGGESTION	¦ ¦1 ¦ ¦2 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦1¦ ¦	4
5 .GIVES OPINION	¦ ¦5 ¦ ¦3 ¦ ¦1 ¦ ¦ ¦2 ¦ ¦ ¦1¦ 2¦ ¦	14
6 .GIVES ORIENTATION	¦ ¦1 ¦ ¦4 ¦ ¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦1¦ ¦	7
7. ASKS FOR ORIENTATION	¦ ¦ ¦ ¦ ¦ ¦ ¦1¦ ¦ ¦2 ¦ ¦ ¦ ¦ ¦	3
8 .ASKS FOR OPINION	¦ ¦2 ¦ ¦1 ¦ ¦ ¦ ¦ ¦1 ¦ ¦ ¦1¦ ¦ ¦	5
9 .ASKS FOR SUGGESTION	¦ ¦3 ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦1 ¦ ¦ ¦	5
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0: 0:16: 0:14: 0: 4: 0: 0: 7: 0: 4: 8: 0: 0	

HASH NUMBER	142
RECORD NUMBER	1/143
DATE	15/05/85
VENUE	2
TIME	45
INITIATOR	REGISTRAR
CASES ACTIONED	0
NO. CASES	10
PAPERS CIRCULATED	0
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
2 .SHOWS TENSION RELEASE	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
3 .AGREES	¦ ¦2¦ ¦3 ¦ ¦1 ¦ ¦ ¦1¦ ¦ ¦ ¦2 ¦ ¦	9
4 .GIVES SUGGESTION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
5 .GIVES OPINION	¦ ¦3¦ ¦2¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦	6
6 .GIVES ORIENTATION	¦ ¦ ¦ ¦4 ¦ ¦ ¦ ¦1¦ ¦ ¦2 ¦ ¦ ¦	7
7. ASKS FOR ORIENTATION	¦2 ¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	3
8 .ASKS FOR OPINION	¦1 ¦ ¦ ¦ ¦1 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	2
9 .ASKS FOR SUGGESTION	¦1 ¦ ¦2 ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	3
10.DISAGREES	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
11.SHOWS TENSION	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
12.SHOWS ANTAGONISM	¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦ ¦	0
	0: 0: 9: 0:11: 0: 3: 0: 3: 0: 0: 0: 4: 0: 0	

HASH NUMBER	143
RECORD NUMBER	1/144
DATE	22/05/85
VENUE	3
TIME	30
INITIATOR	REGISTRAR
CASES ACTIONED	1
NO. CASES	12
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE		0
3 .AGREES	3 2 1 2 1 2 1 1	10
4 .GIVES SUGGESTION		0
5 .GIVES OPINION	4 2 2 4 2 1 1	15
6 .GIVES ORIENTATION	3 2 2 1 1	8
7. ASKS FOR ORIENTATION	2 2 1	5
8 .ASKS FOR OPINION	1	1
9 .ASKS FOR SUGGESTION	3 2 3 2 1 1	11
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM	1 1 2	4
	0: 0:14: 0:10: 0: 5: 0: 0:14: 0: 6: 5: 0: 0	

HASH NUMBER	144
RECORD NUMBER	1/145
DATE	05/06/85
VENUE	3
TIME	45
INITIATOR	REGISTRAR
CASES ACTIONED	2
NO. CASES	10
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY		0
2 .SHOWS TENSION RELEASE	2 2 1 1 1 1 1	8
3 .AGREES	5 6 4 2 2 4	23
4 .GIVES SUGGESTION	2	2
5 .GIVES OPINION	3 2 1 3 3	12
6 .GIVES ORIENTATION	1 4 1 2 1 1	9
7. ASKS FOR ORIENTATION	1 1	2
8 .ASKS FOR OPINION	2	2
9 .ASKS FOR SUGGESTION	2 1 2	5
10.DISAGREES		0
11.SHOWS TENSION		0
12.SHOWS ANTAGONISM	1	1
	0: 0:17: 0:16: 0: 9: 0: 9: 0: 0: 4: 9: 0: 0	

HASH NUMBER	145
RECORD NUMBER	2/146
DATE	16/01/85
VENUE	3
TIME	45
INITIATOR	REGISTRAR
CASES ACTIONED	0
NO. CASES	11
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE		1		1											2
3 .AGREES		3		2		1			2			1			9
4 .GIVES SUGGESTION		2													2
5 .GIVES OPINION		3		4		1			1			2	1		12
6 .GIVES ORIENTATION		2			1				1					1	5
7. ASKS FOR ORIENTATION		1					1							1	3
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION		2												1	3
10.DISAGREES				1											1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	0:	14:	0:	9:	0:	3:	0:	4:	0:	0:	2:	2:	0:	3

HASH NUMBER	146
RECORD NUMBER	2/147
DATE	23/01/85
VENUE	3
TIME	35
INITIATOR	REGISTRAR
CASES ACTIONED	0
NO. CASES	8
PAPERS CIRCULATED	0
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE		2		1				1					1		5
3 .AGREES		2		4				1			2	1			10
4 .GIVES SUGGESTION		1													1
5 .GIVES OPINION			3		1		2		1			1			8
6 .GIVES ORIENTATION		2		3						1	2				8
7. ASKS FOR ORIENTATION						1									1
8 .ASKS FOR OPINION			2									1			3
9 .ASKS FOR SUGGESTION					2	1						1			4
10.DISAGREES															0
11.SHOWS TENSION								1							1
12.SHOWS ANTAGONISM															0
	0:	0:	12:	0:	11:	0:	4:	0:	4:	0:	0:	3:	7:	0:	0

HASH NUMBER	147
RECORD NUMBER	2/148
DATE	20/02/85
VENUE	3
TIME	60
INITIATOR	REGISTRAR
CASES ACTIONED	2
NO. CASES	9
PAPERS CIRCULATED	0
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	; ; 1; 1; ; ; ; ; ; ; ; ; ;	2
2 .SHOWS TENSION RELEASE	; ; 3; 1; 2; ; 1; ;1 ; ; ;2 ;1 ; ;	11
3 .AGREES	; ;3 ; ;1 ; ;2 ; ;2 ; ; ; ; ; ;	8
4 .GIVES SUGGESTION	; ; 1; ; ; ; ; ; ; ; ; ; ;	1
5 .GIVES OPINION	; ; 2; ; ; ; ; ; ; ; ; ; ;	2
6 .GIVES ORIENTATION	; ; ; ;3 ; ;1 ; ;1 ; ; ; 2; 2; ;	9
7. ASKS FOR ORIENTATION	; ; ;1 ; ; ; ; ;1 ; ; ; ; ; ;	2
8 .ASKS FOR OPINION	; ; 3; ;1 ; ; ; ; ; ; ; ; ; ;	4
9 .ASKS FOR SUGGESTION	; ; 1; ; ; ;2 ; ; ; ; ;1 ; ; ;	4
10.DISAGREES	; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
11.SHOWS TENSION	; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
12.SHOWS ANTAGONISM	; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
	0: 0:14: 3: 7: 0: 6: 0: 5: 0: 0: 5: 3: 0: 0	

HASH NUMBER	148
RECORD NUMBER	2/149
DATE	27/02/85
VENUE	3
TIME	45
INITIATOR	REGISTRAR
CASES ACTIONED	1
NO. CASES	10
PAPERS CIRCULATED	0
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A /B /C /D /E /F /G /H /I /J /K /L /M /N	
1 .SHOWS SOLIDARITY	; ;1 ;1 ; ; ; ; ; ; ; ; ; ;	2
2 .SHOWS TENSION RELEASE	; ; 1; 2;1 ; ; ; ; ; ; ; ; ;	4
3 .AGREES	; ;5 ; ;16 ; ; 4; ; ; ; ;2 ; 4; ;	22
4 .GIVES SUGGESTION	; ;2 ; ; ; ; ; ; ; ; ; ; ;	2
5 .GIVES OPINION	; ;1 ;2 ; 5; ; 4; ;4 ; ; ;3 ;1 ; ;	20
6 .GIVES ORIENTATION	; ; ; ;3 ; ; ; ;2 ; ; ; ; ; ;	5
7. ASKS FOR ORIENTATION	; ;1 ; ; ; ; ; ; ; ; ; ;1 ; ;	2
8 .ASKS FOR OPINION	; ;3 ; ; ; ; ;1 ; ;2 ; ; ;1 ; ; ;	7
9 .ASKS FOR SUGGESTION	; ;3 ;1 ; 3; ; 2; ; ; ; ; 2; 3; ;	14
10.DISAGREES	; ;1 ; ;1 ; ; ; ;2 ; ; ; ; ; ;	4
11.SHOWS TENSION	; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
12.SHOWS ANTAGONISM	; ; ; ; ; ; ; ; ; ; ; ; ; ;	0
	0: 0:18: 7:19: 0:11: 0:10: 0: 0: 8: 9: 0: 0	

HASH NUMBER	149
RECORD NUMBER	1/150
DATE	16/04/85
VENUE	1A
TIME	75
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	6
PAPERS CIRCULATED	1
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2		1			1			1	1					6
2 .SHOWS TENSION RELEASE	1			1		2			2	1					7
3 .AGREES	4		2	3				2	2						2 15
4 .GIVES SUGGESTION	1			1					1						3
5 .GIVES OPINION	5		3	4			4	2							1 19
6 .GIVES ORIENTATION	1	2		5			3	3							1 15
7. ASKS FOR ORIENTATION	2			1			2	3							2 10
8 .ASKS FOR OPINION	1						1								2
9 .ASKS FOR SUGGESTION	2	1		2			3	2							10
10.DISAGREES		1		1											2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	19:	0:	11:	0:	20:	0:	0:	18:	15:	0:	0:	0:	0:	0:	6

HASH NUMBER	150
RECORD NUMBER	2/151
DATE	23/04/85
VENUE	1A
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1				1				1						3
2 .SHOWS TENSION RELEASE	2			2	3				2	2			1		12
3 .AGREES	4			3	4			3	3				4	2	23
4 .GIVES SUGGESTION	2			1										1	4
5 .GIVES OPINION	3			1	2			2	3				2		4 17
6 .GIVES ORIENTATION	1			2	5			3	2				3		1 17
7. ASKS FOR ORIENTATION	2				2				2	1			3		2 12
8 .ASKS FOR OPINION	3				2										5
9 .ASKS FOR SUGGESTION	2				3			3	2				2		12
10.DISAGREES	2				1			1	2				1		7
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	22:	0:	0:	9:	23:	0:	0:	16:	16:	0:	0:	0:	16:	0:	10

HASH NUMBER	151
RECORD NUMBER	2/152
DATE	30/04/85
VENUE	1A
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2				1										3
2 .SHOWS TENSION RELEASE	2			1				1	2						6
3 .AGREES	4			2	3			4	3				3	2	21
4 .GIVES SUGGESTION	1								1						2
5 .GIVES OPINION	4			3	5			3	4				5	2	26
6 .GIVES ORIENTATION	3			4	6			4	5				3	1	26
7. ASKS FOR ORIENTATION	2							3	3				1		1 10
8 .ASKS FOR OPINION	1				1	2		1					1		6
9 .ASKS FOR SUGGESTION	2				1	4		3	2				3		1 16
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21:	0:	0:	12:	21:	0:	0:	19:	20:	0:	0:	0:	16:	0:	7

HASH NUMBER	152
RECORD NUMBER	2/153
DATE	07/05/85
VENUE	1A
TIME	50
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1			1	1				1						4
2 .SHOWS TENSION RELEASE	1			1	1				1	1			1	1	7
3 .AGREES	4			3	5			2	3				3	2	22
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	4		2			3		3	4				3	2	21
6 .GIVES ORIENTATION			2		5			3	3				4		3 20
7. ASKS FOR ORIENTATION	2		1										2		1 6
8 .ASKS FOR OPINION	2							1	2				1	2	8
9 .ASKS FOR SUGGESTION	1				2			2	1				3	1	10
10.DISAGREES	2														2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	20:	0:	10:	0:	17:	0:	0:	13:	14:	0:	0:	0:	17:	0:	12

HASH NUMBER	153
RECORD NUMBER	1/154
DATE	14/05/85
VENUE	1A
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1							1					1		3
3 .AGREES	4			2	4		3	4				2	3		22
4 .GIVES SUGGESTION	3		1											1	5
5 .GIVES OPINION	6			4	4		3	4				4	4		29
6 .GIVES ORIENTATION	1			2	3		4	3				4	3		20
7. ASKS FOR ORIENTATION	2						1	2				1			6
8 .ASKS FOR OPINION	3		1	1	3			2							9
9 .ASKS FOR SUGGESTION	3		2	5			6	4				4	3		27
10.DISAGREES				1			2							1	4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM							1	1				1			3
	23	0	0	12	20	0	0	21	20	0	0	0	15	17	0

HASH NUMBER	154
RECORD NUMBER	1/155
DATE	21/05/85
VENUE	1A
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	5
NO. CASES	5
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2			1	1										4
2 .SHOWS TENSION RELEASE	3			4	2			2	1				1		13
3 .AGREES	6			4	5			4	5				5		29
4 .GIVES SUGGESTION	3			2									2		7
5 .GIVES OPINION	7			4	5			4	6				5		31
6 .GIVES ORIENTATION	2			3	8			6	5				5		29
7. ASKS FOR ORIENTATION	3			3	2			4	3				3		18
8 .ASKS FOR OPINION	4				1										5
9 .ASKS FOR SUGGESTION	4			1	3			2	2				3		15
10.DISAGREES					1			1					1		3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	34	0	0	22	28	0	0	23	22	0	0	0	25	0	0

HASH NUMBER	155
RECORD NUMBER	1/156
DATE	04/06/85
VENUE	1A
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	4			2	3				3	2			1		1 16
3 .AGREES	7			4	6				6	5			4		3 35
4 .GIVES SUGGESTION	4														1 5
5 .GIVES OPINION	6			2	5			3	2				2		2 22
6 .GIVES ORIENTATION	4			2	6			2	2			3			1 20
7. ASKS FOR ORIENTATION	4			1	3			1	1						3 13
8 .ASKS FOR OPINION	2				2			1							3 8
9 .ASKS FOR SUGGESTION	4				2			3	3			1			13
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	35:	0:	0:	11:	27:	0:	0:	19:	15:	0:	0:	11:	0:	0:	14

HASH NUMBER	156
RECORD NUMBER	1/157
DATE	11/06/85
VENUE	1A
TIME	40
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	3
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	3			1	2				1						7
2 .SHOWS TENSION RELEASE	2			2	3			1	3			2		2	15
3 .AGREES	5			3	6			4	5			4	5		32
4 .GIVES SUGGESTION	2								1			1		2	6
5 .GIVES OPINION	6			3	4			4	3			2	1		23
6 .GIVES ORIENTATION	2			7				1	2			5			18
7. ASKS FOR ORIENTATION	2			1										3	6
8 .ASKS FOR OPINION	2							2					1		5
9 .ASKS FOR SUGGESTION	3			5			3	1				3		2	17
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	27:	0:	0:	10:	28:	0:	0:	13:	18:	0:	0:	0:	17:	0:	16

HASH NUMBER	157
RECORD NUMBER	1/158
DATE	18/06/85
VENUE	1A
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	5
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.T.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	3														3
2 .SHOWS TENSION RELEASE	2				2	3			2				2	2	13
3 .AGREES	5			2	6			4				4	2	2	23
4 .GIVES SUGGESTION	4								1						5
5 .GIVES OPINION	6			3	3			4	5			4	5	0	30
6 .GIVES ORIENTATION	4			8				3	2			3	2	2	22
7. ASKS FOR ORIENTATION	3			1								2		3	9
8 .ASKS FOR OPINION	3				2			1							6
9 .ASKS FOR SUGGESTION	2			1	4			4	2			3			16
10.DISAGREES				2				1	2			1	2	8	
11.SHOWS TENSION	2			1				1					2	6	
12.SHOWS ANTAGONISM	1												2	3	
	35:	0:	0:	9:	29:	0:	0:	19:	13:	0:	0:	0:	19:	0:	20

HASH NUMBER	158
RECORD NUMBER	1/159
DATE	25/06/85
VENUE	1A
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	2														2
3 .AGREES	3			2	5			3	2						15
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	3			2	4			2	3						14
6 .GIVES ORIENTATION	2			2	6			1							11
7. ASKS FOR ORIENTATION	1				1			2	2						6
8 .ASKS FOR OPINION	1			1	2										4
9 .ASKS FOR SUGGESTION	2				3			3	2						10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	18:	0:	0:	7:	21:	0:	0:	11:	9:	0:	0:	0:	0:	0:	0

HASH NUMBER	159
RECORD NUMBER	3/160
DATE	02/07/85
VENUE	1A
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	5
PAPERS CIRCULATED	1
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4			2	3		4	2				2		2	19
4 .GIVES SUGGESTION	2							1						1	4
5 .GIVES OPINION	3				1		2	3						2	11
6 .GIVES ORIENTATION	2				4		1	2				3		2	14
7. ASKS FOR ORIENTATION	4				1							1	3		9
8 .ASKS FOR OPINION	2		2					1							5
9 .ASKS FOR SUGGESTION	2		1	3			2	2				3		1	14
10.DISAGREES	1			1				1				1	1		5
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1		2												3
	21:	0:	0:	8:	12:	0:	0:	9:	12:	0:	0:	0:	10:	0:	12

HASH NUMBER	160
RECORD NUMBER	1/161
DATE	09/07/85
VENUE	1A
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	0
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1			2				1							4
2 .SHOWS TENSION RELEASE	2			1	1			1	2			2			9
3 .AGREES	3			2	3			1	3				3		15
4 .GIVES SUGGESTION	3			3	1										7
5 .GIVES OPINION	4			5	2		3	2				2			18
6 .GIVES ORIENTATION	1			3	5		2	2				1			14
7. ASKS FOR ORIENTATION	2			2	1		1								6
8 .ASKS FOR OPINION				1											1
9 .ASKS FOR SUGGESTION	3			1	2			1				2			9
10.DISAGREES	2			2	1			2							7
11.SHOWS TENSION	1				1										2
12.SHOWS ANTAGONISM															0
	22:	0:	0:	22:	17:	0:	0:	10:	11:	0:	0:	0:	10:	0:	0

HASH NUMBER	161
RECORD NUMBER	1/162
DATE	16/07/85
VENUE	1A
TIME	30
INITIATOR	PSYCHOLOGIST -D
CASES ACTIONED	2
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY									1						1
2 .SHOWS TENSION RELEASE				1				1	2				1		5
3 .AGREES				3	4			1	1				2		11
4 .GIVES SUGGESTION				1											1
5 .GIVES OPINION				6	7			2	3				4		22
6 .GIVES ORIENTATION				1	5			1	2				3		12
7. ASKS FOR ORIENTATION			2					1							3
8 .ASKS FOR OPINION													1		1
9 .ASKS FOR SUGGESTION				2	3		1	2				4			12
10.DISAGREES			2									1			3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0	0	0	16	21	0	0	6	12	0	0	0	16	0	0

HASH NUMBER	162
RECORD NUMBER	1/163
DATE	23/07/85
VENUE	1A
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2			3	4			2	2			3			16
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	5			3	2			2	1			2			15
6 .GIVES ORIENTATION	2			2	3			4							11
7. ASKS FOR ORIENTATION	3														3
8 .ASKS FOR OPINION	2			2	1										5
9 .ASKS FOR SUGGESTION	1				3			1				2			7
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	17	0	0	10	13	0	0	9	3	0	0	0	7	0	0

HASH NUMBER	163
RECORD NUMBER	1/164
DATE	30/07/85
VENUE	1A
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	6
PAPERS CIRCULATED	1
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4			2	3	2	3	1					2	2	21
4 .GIVES SUGGESTION	3			1											4
5 .GIVES OPINION	6			6	4		3	1	2				1	1	24
6 .GIVES ORIENTATION	2			3	6		1	2	1				3	1	19
7. ASKS FOR ORIENTATION	4			2	3		1		1				1	2	14
8 .ASKS FOR OPINION	5			3	1		1		2				2		14
9 .ASKS FOR SUGGESTION	4			3	4		2	3	2				4	1	23
10.DISAGREES	2			2	1				1					1	7
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM				1											1
	30	0	0	23	22	0	10	9	12	0	0	0	13	0	8

HASH NUMBER	164
RECORD NUMBER	1/165
DATE	06/08/85
VENUE	1A
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.T.
NO. NON-ACTIVE PARTICIPANTS	2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2			1	1										4
2 .SHOWS TENSION RELEASE	3			4	3			2					2		14
3 .AGREES	5			3	4			3	2				2		19
4 .GIVES SUGGESTION				1											1
5 .GIVES OPINION	5			6	3			4	1				3		22
6 .GIVES ORIENTATION				1	5			1	2				2	1	12
7. ASKS FOR ORIENTATION	1								1				1		3
8 .ASKS FOR OPINION	4			2											6
9 .ASKS FOR SUGGESTION	2			4	1								2		9
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	22	0	0	22	17	0	0	10	6	0	0	0	12	0	1

HASH NUMBER	165
RECORD NUMBER	1/166
DATE	13/08/85
VENUE	1A
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4			5	2		3	3				1			18
4 .GIVES SUGGESTION	2			3								1	1		7
5 .GIVES OPINION	4			3	3		2	1				3			16
6 .GIVES ORIENTATION	2				6			1	2			3			14
7. ASKS FOR ORIENTATION	1												1		2
8 .ASKS FOR OPINION	1			2				1							4
9 .ASKS FOR SUGGESTION	2			4				1							7
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	16	0	0	13	15	0	0	8	6	0	0	0	8	0	2

HASH NUMBER	166
RECORD NUMBER	1/167
DATE	20/08/85
VENUE	1A
TIME	35
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	3
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2			1	2										5
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	3			5	2				2						12
6 .GIVES ORIENTATION	1			2	4			1	2			3			13
7. ASKS FOR ORIENTATION	2														2
8 .ASKS FOR OPINION	2			2											4
9 .ASKS FOR SUGGESTION	4			5	3			1	1			2			16
10.DISAGREES	3			4	1				1						9
11.SHOWS TENSION	2			2	1			1	1			1			8
12.SHOWS ANTAGONISM	3			2				1							6
	23	0	0	23	13	0	0	3	8	0	0	6	0	0	

HASH NUMBER	167
RECORD NUMBER	1/168
DATE	03/09/85
VENUE	2A
TIME	20
INITIATOR	SISTER
CASES ACTIONED	1
NO. CASES	3
PAPERS CIRCULATED	0
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES			3	4				1			2	3			13
4 .GIVES SUGGESTION			2	3				1			3	3			12
5 .GIVES OPINION			3	1							1				5
6 .GIVES ORIENTATION				4				2			1	1			8
7. ASKS FOR ORIENTATION			2					1							3
8 .ASKS FOR OPINION			1												1
9 .ASKS FOR SUGGESTION			2	5				1			2	1			11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	0:	0:	13:	17:	0:	0:	0:	6:	0:	0:	9:	8:	0:	0

HASH NUMBER	168
RECORD NUMBER	1/169
DATE	10/09/85
VENUE	2A
TIME	25
INITIATOR	SISITER
CASES ACTIONED	1
NO. CASES	3
PAPERS CIRCULATED	0
NO. PARTS	5
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES			3	2		1		1				3			10
4 .GIVES SUGGESTION			2	1											3
5 .GIVES OPINION			4	3		2		2			4				15
6 .GIVES ORIENTATION				5											5
7. ASKS FOR ORIENTATION			1			3		1			1				6
8 .ASKS FOR OPINION			3	2		1					2				8
9 .ASKS FOR SUGGESTION			4	1		2		1			3				11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	0:	0:	17:	14:	0:	9:	0:	5:	0:	0:	0:	13:	0:	0

HASH NUMBER	169
RECORD NUMBER	1/170
DATE	17/09/85
VENUE	2A
TIME	45
INITIATOR	SOC/WORKER
CASES ACTIONED	3
NO. CASES	4
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2			1	1				1	2			1		8
3 .AGREES	2				2				1	1			2		8
4 .GIVES SUGGESTION	2		1												3
5 .GIVES OPINION	4		3	2					1	3			2		15
6 .GIVES ORIENTATION				3						4			1		8
7. ASKS FOR ORIENTATION	2			1	1										4
8 .ASKS FOR OPINION	3			2						2					7
9 .ASKS FOR SUGGESTION	1								1					1	3
10.DISAGREES					1										1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	0:	17:	0:	8:	10:	0:	0:	4:	12:	0:	0:	0:	7:	0:	0

HASH NUMBER	170
RECORD NUMBER	1/171
DATE	24/09/85
VENUE	2A
TIME	30
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	3
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2			1											3
2 .SHOWS TENSION RELEASE	3			2	2			1	1	1			2		11
3 .AGREES	3			2	2			2	3				4		16
4 .GIVES SUGGESTION	2			3	1										6
5 .GIVES OPINION	4			2	3			1	2				2		14
6 .GIVES ORIENTATION				2	4				1				2		9
7. ASKS FOR ORIENTATION	1							1							2
8 .ASKS FOR OPINION	2			3	1										6
9 .ASKS FOR SUGGESTION				1					1				1		3
10.DISAGREES				1											1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	17:	0:	0:	16:	14:	0:	0:	5:	8:	0:	0:	0:	11:	0:	0

HASH NUMBER 171
RECORD NUMBER 1/172
DATE 08/10/86
VENUE 4
TIME 80
INITIATOR CONSULTANT
CASES ACTIONED 3
NO. CASES 28
PAPERS CIRCULATED 0
NO. PARTS 10
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1								1						2
2 .SHOWS TENSION RELEASE	3				4		2	1	2			1	2	2	17
3 .AGREES	4	1			3		2	3	2				1		16
4 .GIVES SUGGESTION	3	1													4
5 .GIVES OPINION	5	2				1							1		9
6 .GIVES ORIENTATION					5				1				2	3	11
7. ASKS FOR ORIENTATION	1						1								2
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION					3		1						1		5
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	18	4	0	0	16	0	6	4	6	0	1	6	6	0	0

HASH NUMBER 172
RECORD NUMBER 1/173
DATE 08/10/86
VENUE 1
TIME 60
INITIATOR CONSULTANT
CASES ACTIONED 5
NO. CASES 28
PAPERS CIRCULATED 0
NO. PARTS 8
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	2				1	1		1							5
3 .AGREES	2				2	3	1					1	1	2	12
4 .GIVES SUGGESTION	4				1				1						6
5 .GIVES OPINION	6				3	2						2			13
6 .GIVES ORIENTATION					4				1				1		6
7. ASKS FOR ORIENTATION	1														1
8 .ASKS FOR OPINION															0
9 .ASKS FOR SUGGESTION					1	2						2	1		6
10.DISAGREES					1										1
11.SHOWS TENSION					1										1
12.SHOWS ANTAGONISM	1				1										2
	16	0	0	10	13	0	1	2	1	0	1	5	4	0	0

HASH NUMBER	173
RECORD NUMBER	1/174
DATE	15/10/85
VENUE	1
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1	1			1				1				1	1	6
2 .SHOWS TENSION RELEASE	2		1												3
3 .AGREES	3	4			5				1	2			2	3	21
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	6	2				1								1	10
6 .GIVES ORIENTATION		1			4			1	1				1		8
7. ASKS FOR ORIENTATION						2					1		1		4
8 .ASKS FOR OPINION	1	1											1		3
9 .ASKS FOR SUGGESTION	1	2			3	1	1				2	1			11
10.DISAGREES								1							1
11.SHOWS TENSION								1							1
12.SHOWS ANTAGONISM		1													1
	17	13	0	0	14	0	4	3	5	0	2	6	8	0	0

HASH NUMBER	174
RECORD NUMBER	1/175
DATE	22/10/85
VENUE	1
TIME	65
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3	3			2			1	1			1	1		12
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	6	3			2		1					1			13
6 .GIVES ORIENTATION		1			5			1				1	2	1	11
7. ASKS FOR ORIENTATION	3										1				4
8 .ASKS FOR OPINION					2							2	2		6
9 .ASKS FOR SUGGESTION					4		2				1	2	3		12
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	16	7	0	0	15	0	4	2	0	0	3	7	8	0	0

HASH NUMBER	175
RECORD NUMBER	1/176
DATE	29/10/85
VENUE	1
TIME	120
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2														2
2 .SHOWS TENSION RELEASE	3				2				2			1			8
3 .AGREES	3	2		5		2					1	2	4		19
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	5	2													7
6 .GIVES ORIENTATION					6				1				3	3	13
7. ASKS FOR ORIENTATION	4	2													6
8 .ASKS FOR OPINION	1	1													2
9 .ASKS FOR SUGGESTION		1			3			1					2	3	10
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	23:	8:	0:	0:	16:	0:	3:	0:	3:	0:	1:	8:	10:	0:	0

HASH NUMBER	176
RECORD NUMBER	1/177
DATE	05/11/85
VENUE	1C
TIME	60
INITIATOR	CONSULTANT 2
CASES ACTIONED	4
NO. CASES	30
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2											1			3
2 .SHOWS TENSION RELEASE	3	2			2		1	1			2	1			12
3 .AGREES	4	3			4		1	1		2	2		3		20
4 .GIVES SUGGESTION	5	2													7
5 .GIVES OPINION	6	1			2				1						10
6 .GIVES ORIENTATION					7						3	1			11
7. ASKS FOR ORIENTATION	4														4
8 .ASKS FOR OPINION	1	2		2					3			1			9
9 .ASKS FOR SUGGESTION	2	1			4	2					2	1			12
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	27:	11:	0:	0:	21:	0:	4:	2:	0:	6:	0:	9:	8:	0:	0

HASH NUMBER 177
RECORD NUMBER 1/178
DATE 12/11/85
VENUE 1C
TIME 60
INITIATOR CONSULTANT C
CASES ACTIONED 5
NO. CASES 29
PAPERS CIRCULATED 0
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4				4	2	1		2	1	1	2			17
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	6				3				1			1			11
6 .GIVES ORIENTATION	2				6										8
7. ASKS FOR ORIENTATION									1			1			2
8 .ASKS FOR OPINION	2					1									3
9 .ASKS FOR SUGGESTION				4		3	1				2	2			12
10.DISAGREES	2														2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1								1						2
	22:	0:	0:	0:	17:	0:	6:	2:	0:	5:	1:	3:	6:	0:	0

HASH NUMBER 178
RECORD NUMBER 1/179
DATE 19/11/85
VENUE 1C
TIME 85
INITIATOR CONSULTANT C
CASES ACTIONED 5
NO. CASES 29
PAPERS CIRCULATED 0
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 2

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4	2			4			1	1		2	1	3	2	20
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	5				1					1			1		8
6 .GIVES ORIENTATION	2	1			7						1				11
7. ASKS FOR ORIENTATION							2						1		3
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION					3		4	1			1	2			11
10.DISAGREES	1														1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	17:	3:	0:	0:	15:	0:	7:	2:	0:	3:	3:	6:	3:	0:	0

HASH NUMBER	179
RECORD NUMBER	1/180
DATE	26/11/85
VENUE	1C
TIME	90
INITIATOR	CONSULTANT C
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	2

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2				1				1						4
2 .SHOWS TENSION RELEASE		2							1						3
3 .AGREES	4	1			3		2	1	1	1	1	2	1		17
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	8	4							1						13
6 .GIVES ORIENTATION	2				5		1			1	3	1			13
7. ASKS FOR ORIENTATION	1							2							3
8 .ASKS FOR OPINION				2											2
9 .ASKS FOR SUGGESTION				4					1	1					6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21:	7:	0:	0:	15:	0:	3:	1:	6:	2:	3:	5:	2:	0:	0

HASH NUMBER	180
RECORD NUMBER	1/181
DATE	10/12/85
VENUE	1C
TIME	65
INITIATOR	CONSULTANT C
CASES ACTIONED	6
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY		2				1									3
2 .SHOWS TENSION RELEASE	3		1			1		1		1			1	1	9
3 .AGREES	5	4			5		3			3			3	3	26
4 .GIVES SUGGESTION	4														4
5 .GIVES OPINION	3	4			2				1		2	3			15
6 .GIVES ORIENTATION					4			1		1			1		7
7. ASKS FOR ORIENTATION							1								1
8 .ASKS FOR OPINION	2											2			4
9 .ASKS FOR SUGGESTION				2											2
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	17:	11:	0:	0:	15:	0:	6:	0:	6:	0:	0:	7:	9:	0:	0

HASH NUMBER 181
RECORD NUMBER 1/182
DATE 17/12/85
VENUE 1C
TIME 110
INITIATOR CONSULTANT C
CASES ACTIONED 6
NO. CASES 29
PAPERS CIRCULATED 1
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 0

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3	14			13			11	11		21	11	11		16
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	6	14			13			11			31		21	31	22
6 .GIVES ORIENTATION	2	11			51										8
7. ASKS FOR ORIENTATION	2														2
8 .ASKS FOR OPINION	1									11					2
9 .ASKS FOR SUGGESTION	1				31	12				21		11	11		10
10.DISAGREES		12											11		4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21:	11:	0:	0:	14:	0:	4:	1:	0:	8:	1:	3:	6:	0:	0

HASH NUMBER 182
RECORD NUMBER 3/183
DATE 03/04/85
VENUE 4
TIME 140
INITIATOR CONSULTANT
CASES ACTIONED 5
NO. CASES 32
PAPERS CIRCULATED 0
NO. PARTS 10
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1			11	21										4
2 .SHOWS TENSION RELEASE	2			11	21		31		11			11	11		11
3 .AGREES	5			12	13		11			11		11			13
4 .GIVES SUGGESTION	4							11							5
5 .GIVES OPINION	6			13	12			11							12
6 .GIVES ORIENTATION		11		12	15					21		11			11
7. ASKS FOR ORIENTATION												11	11		2
8 .ASKS FOR OPINION											11				1
9 .ASKS FOR SUGGESTION	1				13		12					21	31		11
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	20:	0:	0:	9:	17:	0:	7:	1:	4:	1:	3:	3:	5:	0:	0

HASH NUMBER	183
RECORD NUMBER	3/184
DATE	10/04/85
VENUE	4
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	29
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2			1	1										4
3 .AGREES	1			1	3		2	1	1	1	2	3	1		15
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	2			1					1		1		1		5
6 .GIVES ORIENTATION	1				3										4
7. ASKS FOR ORIENTATION	1								1	1		2			4
8 .ASKS FOR OPINION					2							1	1		4
9 .ASKS FOR SUGGESTION	1				4							2			7
10.DISAGREES				1											1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	14:	0:	0:	4:	13:	0:	2:	1:	0:	3:	2:	5:	6:	0:	0

HASH NUMBER	184
RECORD NUMBER	3/185
DATE	17/04/85
VENUE	4
TIME	145
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	29
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2	1			2		1	1	1		1	2	1		12
4 .GIVES SUGGESTION															0
5 .GIVES OPINION	5														5
6 .GIVES ORIENTATION	1	2			4						2	1			10
7. ASKS FOR ORIENTATION	1					1			2						4
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION					3			1			3				8
10.DISAGREES				2		1						1			4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	11:	3:	0:	0:	11:	0:	3:	1:	4:	0:	1:	7:	3:	0:	0

HASH NUMBER	185
RECORD NUMBER	3/186
DATE	24/04/85
VENUE	4
TIME	160
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	30
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1			1	2										4
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3			7		2		1	3		2	5	4		27
4 .GIVES SUGGESTION	6										1				7
5 .GIVES OPINION	5			2	1										8
6 .GIVES ORIENTATION				3	3				1				2	1	10
7. ASKS FOR ORIENTATION	1													2	3
8 .ASKS FOR OPINION	2					1									3
9 .ASKS FOR SUGGESTION				1	2						1		2		6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	18	0	0	7	15	0	3	1	4	0	3	6	8	0	3

HASH NUMBER	186
RECORD NUMBER	3/187
DATE	01/05/86
VENUE	4
TIME	145
INITIATOR	CONSULTANT
CASES ACTIONED	6
NO. CASES	29
PAPERS CIRCULATED	0
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4			2	1			2		2		2	3	1	17
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	4			1	2		1					2			10
6 .GIVES ORIENTATION				1	3				1				2		7
7. ASKS FOR ORIENTATION	2							1							3
8 .ASKS FOR OPINION	4				2				2			1	1		10
9 .ASKS FOR SUGGESTION					5							2	3		10
10.DISAGREES	2			1					1						4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	21	0	0	5	13	0	3	2	5	0	2	8	7	0	0

HASH NUMBER	187
RECORD NUMBER	3/188
DATE	15/05/85
VENUE	4
TIME	45
INITIATOR	CONSULTANT
CASES ACTIONED	1
NO. CASES	25
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2			1	2										5
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4				1		2	1		2	1	4	2		17
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	3			2									3		8
6 .GIVES ORIENTATION	1				4										5
7. ASKS FOR ORIENTATION	2						1		1	2	1				7
8 .ASKS FOR OPINION	3														3
9 .ASKS FOR SUGGESTION	1				2										3
10.DISAGREES	2				1				1						4
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	19:	0:	0:	3:	10:	0:	2:	2:	0:	4:	3:	5:	5:	0:	0

HASH NUMBER	188
RECORD NUMBER	3/189
DATE	15/05/85
VENUE	4
TIME	180
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2			1	1		2	1		1		3	2	1	14
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	2			1	2										5
6 .GIVES ORIENTATION	2			2	3							1			8
7. ASKS FOR ORIENTATION									1						1
8 .ASKS FOR OPINION						1									1
9 .ASKS FOR SUGGESTION				2						1		3			6
10.DISAGREES	1														1
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	2														2
	14:	0:	0:	4:	8:	0:	3:	1:	0:	2:	4:	2:	5:	0:	0

HASH NUMBER 189
RECORD NUMBER 1/190
DATE 16/ 1/85
VENUE 1C
TIME 130
INITIATOR CONSULTANT
CASES ACTIONED 8
NO. CASES 30
PAPERS CIRCULATED 1
NO. PARTS 12
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	2	1		1	3		1	2		1	1	1	3	2	18
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	2			1						1		2		1	7
6 .GIVES ORIENTATION		2		2	4						1		3		12
7. ASKS FOR ORIENTATION	4									1		2	1		8
8 .ASKS FOR OPINION	2										1				3
9 .ASKS FOR SUGGESTION	2				3										5
10.DISAGREES	3														3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	21:	3:	0:	3:	11:	0:	1:	2:	3:	2:	2:	7:	6:	1:	0

HASH NUMBER 190
RECORD NUMBER 1/191
DATE 15/01/85
VENUE 2C
TIME 90
INITIATOR CONSULTANT
CASES ACTIONED 4
NO. CASES 30
PAPERS CIRCULATED 1
NO. PARTS 8
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY		2			1		1		1						5
2 .SHOWS TENSION RELEASE									1	1	2		1		4
3 .AGREES	4	1	1			4						1	1		10
4 .GIVES SUGGESTION	6														6
5 .GIVES OPINION	6				2										8
6 .GIVES ORIENTATION					3				2			1	1		7
7. ASKS FOR ORIENTATION					1	1	2					2			5
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION		2			3				1						6
10.DISAGREES															0
11.SHOWS TENSION							1								1
12.SHOWS ANTAGONISM	2														2
	19:	5:	0:	0:	14:	0:	3:	1:	5:	0:	3:	1:	4:	0:	0

HASH NUMBER	191
RECORD NUMBER	1/192
DATE	22/01/85
VENUE	2C
TIME	95
INITIATOR	CONSULTANT
CASES ACTIONED	2
NO. CASES	28
PAPERS CIRCULATED	1
NO. PARTS	8
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	3			1	2		1		2				1	1	11
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	4			2	1										7
6 .GIVES ORIENTATION					1										1
7. ASKS FOR ORIENTATION	1														1
8 .ASKS FOR OPINION	2				1								2		5
9 .ASKS FOR SUGGESTION	2			3				1			1	2	3		12
10.DISAGREES	2			1	3		2		4				1		13
11.SHOWS TENSION					2				3				1		6
12.SHOWS ANTAGONISM	2								1				2		5
	19:	0:	0:	4:	13:	0:	3:	0:	11:	0:	1:	3:	10:	0:	0

HASH NUMBER	192
RECORD NUMBER	1/193
DATE	02/07/85
VENUE	2B
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	26
PAPERS CIRCULATED	1
NO. PARTS	9
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1								1						2
3 .AGREES	2			1	6		2	1	3		1	2	3		21
4 .GIVES SUGGESTION	4				1				2						7
5 .GIVES OPINION	2			1				1			1	4	1		10
6 .GIVES ORIENTATION				2											2
7. ASKS FOR ORIENTATION	1										1				2
8 .ASKS FOR OPINION	2						1								3
9 .ASKS FOR SUGGESTION				2			3		2		1	2	1		11
10.DISAGREES	2														2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	14:	0:	0:	2:	11:	0:	3:	5:	8:	0:	3:	9:	5:	0:	0

HASH NUMBER 193
RECORD NUMBER 1/194
DATE 11/07/85
VENUE 2B
TIME 45
INITIATOR CONSULTANT
CASES ACTIONED 2
NO. CASES 26
PAPERS CIRCULATED 1
NO. PARTS 7
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1				2			1			1				5
2 .SHOWS TENSION RELEASE	3				2		1	1		2			1		10
3 .AGREES	3				2						1		2		8
4 .GIVES SUGGESTION															0
5 .GIVES OPINION	3				1										4
6 .GIVES ORIENTATION					3		1	2	1			2			9
7. ASKS FOR ORIENTATION											1				1
8 .ASKS FOR OPINION	2								1						3
9 .ASKS FOR SUGGESTION					4			1							5
10.DISAGREES	1											1			2
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM	1														1
	14:	0:	0:	0:	14:	0:	3:	4:	4:	0:	3:	6:	0:	0:	0

HASH NUMBER 194
RECORD NUMBER 1/195
DATE 18/07/85
VENUE 2B
TIME 60
INITIATOR CONSULTANT
CASES ACTIONED 2
NO. CASES 26
PAPERS CIRCULATED 1
NO. PARTS 6
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	1														1
2 .SHOWS TENSION RELEASE	2														2
3 .AGREES	2				3			1			1	1	1		9
4 .GIVES SUGGESTION	2														2
5 .GIVES OPINION	3				1			2				2			8
6 .GIVES ORIENTATION	1				2		1					1			5
7. ASKS FOR ORIENTATION							1								1
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	2				1						1	2			6
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	14:	0:	0:	0:	7:	0:	5:	0:	0:	1:	2:	6:	0:	0:	0

HASH NUMBER	195
RECORD NUMBER	1/196
DATE	25/07/85
VENUE	2B
TIME	90
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	26
PAPERS CIRCULATED	1
NO. PARTS	6
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE	1				1				1						3
3 .AGREES	2				3			1	2		1	1			10
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	3				2				1			1			7
6 .GIVES ORIENTATION	2				3										5
7. ASKS FOR ORIENTATION	1						1			1		2			5
8 .ASKS FOR OPINION					2				1		1				4
9 .ASKS FOR SUGGESTION	1				2				2			1			6
10.DISAGREES					1				1		1				3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	11:	0:	0:	0:	14:	0:	2:	0:	9:	0:	5:	3:	0:	0:	0

HASH NUMBER	196
RECORD NUMBER	1/197
DATE	03/09/85
VENUE	2B
TIME	80
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	25
PAPERS CIRCULATED	1
NO. PARTS	7
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4				4			2	1	2		1	1		15
4 .GIVES SUGGESTION	1														1
5 .GIVES OPINION	3				2				1				2		8
6 .GIVES ORIENTATION	2				1							1			4
7. ASKS FOR ORIENTATION													2		2
8 .ASKS FOR OPINION	2								1						3
9 .ASKS FOR SUGGESTION					2							1	1		4
10.DISAGREES	1				1								1		3
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	13:	0:	0:	0:	10:	0:	2:	1:	4:	0:	0:	3:	7:	0:	0

HASH NUMBER 197
RECORD NUMBER 1/198
DATE 10/09/85
VENUE 2B
TIME 125
INITIATOR CONSULTANT
CASES ACTIONED 8
NO. CASES 26
PAPERS CIRCULATED 0
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY	2				1			1							4
2 .SHOWS TENSION RELEASE	3			2		2			1	1	1				10
3 .AGREES	4		2	3						2					11
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	3			1	1						2	2			9
6 .GIVES ORIENTATION				3	2							1			6
7. ASKS FOR ORIENTATION	1									1					2
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	2			2						1		2			7
10.DISAGREES															0
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM									1						1
	21:	0:	0:	6:	11:	0:	2:	1:	0:	2:	5:	3:	5:	0:	0

HASH NUMBER 198
RECORD NUMBER 1/199
DATE 24/09/85
VENUE 2B
TIME 85
INITIATOR CONSULTANT
CASES ACTIONED 2
NO. CASES 26
PAPERS CIRCULATED 0
NO. PARTS 9
RELATIVES PRESENT .F.
PATIENTS PRESENT .F.
NO. NON-ACTIVE PARTICIPANTS 1

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE															0
3 .AGREES	4			2		1	2		1	1	3	2			16
4 .GIVES SUGGESTION	2			1											3
5 .GIVES OPINION	6			1											7
6 .GIVES ORIENTATION	4			1											5
7. ASKS FOR ORIENTATION															0
8 .ASKS FOR OPINION	1			2				2			1				6
9 .ASKS FOR SUGGESTION				1	3					2		1			7
10.DISAGREES	1														1
11.SHOWS TENSION						1					1				2
12.SHOWS ANTAGONISM	2														2
	20:	0:	0:	2:	9:	0:	2:	2:	3:	0:	4:	4:	3:	0:	0

HASH NUMBER	199
RECORD NUMBER	1/200
DATE	01/10/85
VENUE	2B
TIME	128
INITIATOR	CONSULTANT
CASES ACTIONED	3
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	10
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY	2				1		1				1				5
2 .SHOWS TENSION RELEASE	2			1	1			1	1		2		1	1	10
3 .AGREES	3	1		1		2		1	2		3	1	4	2	20
4 .GIVES SUGGESTION	5														5
5 .GIVES OPINION	6														6
6 .GIVES ORIENTATION					3		1			2		3	1		10
7. ASKS FOR ORIENTATION	1					1				1					3
8 .ASKS FOR OPINION	1			1						1		2			5
9 .ASKS FOR SUGGESTION	2			3	1						1	2	1		10
10.DISAGREES				2						1	1	1			5
11.SHOWS TENSION															0
12.SHOWS ANTAGONISM															0
	22:	1:	0:	5:	11:	0:	4:	4:	0:	11:	3:	10:	8:	0:	0

HASH NUMBER	200
RECORD NUMBER	1/141
DATE	10/01/85
VENUE	2
TIME	60
INITIATOR	CONSULTANT
CASES ACTIONED	4
NO. CASES	28
PAPERS CIRCULATED	0
NO. PARTS	11
RELATIVES PRESENT	.F.
PATIENTS PRESENT	.F.
NO. NON-ACTIVE PARTICIPANTS	1

	A	/B	/C	/D	/E	/F	/G	/H	/I	/J	/K	/L	/M	/N	
1 .SHOWS SOLIDARITY															0
2 .SHOWS TENSION RELEASE		1			1				1						3
3 .AGREES		1	1			2		2	1	1	1		1		11
4 .GIVES SUGGESTION	3														3
5 .GIVES OPINION	1	1													2
6 .GIVES ORIENTATION	1				1										2
7. ASKS FOR ORIENTATION		1	1		2				1						5
8 .ASKS FOR OPINION	1														1
9 .ASKS FOR SUGGESTION	1								1	1					3
10.DISAGREES											1				1
11.SHOWS TENSION									1						1
12.SHOWS ANTAGONISM															0
	8:	4:	1:	0:	6:	0:	2:	2:	1:	4:	2:	1:	1:	0:	0

APPENDIX 10

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

PAGE NO. 00001 ALL CONFERENCES

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/ 1				
** SUBTOTAL **	40.23	13.40	420	
* CONFERENCE NUMBER 1/ 2				
** SUBTOTAL **	109.79	27.44	1140	
* CONFERENCE NUMBER 1/ 3				
** SUBTOTAL **	72.47	24.15	780	
* CONFERENCE NUMBER 1/ 4				
** SUBTOTAL **	89.77	29.92	950	
* CONFERENCE NUMBER 1/ 5				
** SUBTOTAL **	111.41	22.28	1140	XXC
* CONFERENCE NUMBER 1/ 6				
** SUBTOTAL **	74.73	12.45	760	
* CONFERENCE NUMBER 1/ 7				
** SUBTOTAL **	74.79	14.95	750	
* CONFERENCE NUMBER 1/ 8				
** SUBTOTAL **	74.28	18.57	770	
* CONFERENCE NUMBER 1/ 9				
** SUBTOTAL **	47.83	15.94	495	
* CONFERENCE NUMBER 1/ 10				
** SUBTOTAL **	104.01	34.66	1080	XXC

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/ 11				
** SUBTOTAL **	122.55	40.84	1320	
* CONFERENCE NUMBER 1/ 12				
** SUBTOTAL **	67.74	13.54	675	
* CONFERENCE NUMBER 1/ 13				
** SUBTOTAL **	64.80	21.59	650	
* CONFERENCE NUMBER 1/ 14				
** SUBTOTAL **	84.81	21.20	880	
* CONFERENCE NUMBER 1/ 15				
** SUBTOTAL **	25.55	8.51	240	XXC
* CONFERENCE NUMBER 1/ 16				
** SUBTOTAL **	58.17	9.69	585	
* CONFERENCE NUMBER 1/ 17				
** SUBTOTAL **	48.67	16.22	495	
* CONFERENCE NUMBER 1/ 18				
** SUBTOTAL **	37.86	12.61	360	
* CONFERENCE NUMBER 1/ 19				
** SUBTOTAL **	81.71	40.85	880	
* CONFERENCE NUMBER 1/ 20				
** SUBTOTAL **	104.01	34.66	1080	XXC

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/ 21				
** SUBTOTAL **	54.92	18.30	540	
* CONFERENCE NUMBER 1/ 22				
** SUBTOTAL **	43.57	43.57	520	
* CONFERENCE NUMBER 1/ 23				
** SUBTOTAL **	65.37	16.34	660	
* CONFERENCE NUMBER 2/ 24				
** SUBTOTAL **	127.59	42.52	1320	
* CONFERENCE NUMBER 2/ 25				
** SUBTOTAL **	95.68	23.92	990	XXC
* CONFERENCE NUMBER 2/ 26				
** SUBTOTAL **	89.56	29.85	900	
* CONFERENCE NUMBER 2/ 27				
** SUBTOTAL **	90.84	18.16	900	
* CONFERENCE NUMBER 2/ 28				
** SUBTOTAL **	85.18	28.39	900	
* CONFERENCE NUMBER 2/ 29				
** SUBTOTAL **	75.87	25.28	760	
* CONFERENCE NUMBER 2/ 30				
** SUBTOTAL **	96.94	19.38	1000	XXC

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 2/ 31				
** SUBTOTAL **	28.81	14.40	360	XS
* CONFERENCE NUMBER 2/ 32				
** SUBTOTAL **	21.60	21.60	270	XS
* CONFERENCE NUMBER 2/ 33				
** SUBTOTAL **	14.49	14.49	175	XS
* CONFERENCE NUMBER 2/ 34				
** SUBTOTAL **	16.79	8.39	210	XS
* CONFERENCE NUMBER 2/ 35				
** SUBTOTAL **	21.60	21.60	270	XS
* CONFERENCE NUMBER 2/ 37				
** SUBTOTAL **	17.74	8.87	240	XS
* CONFERENCE NUMBER 2/ 38				
** SUBTOTAL **	14.40	14.40	180	XS
* CONFERENCE NUMBER 2/ 40				
** SUBTOTAL **	109.86	21.97	1080	
* CONFERENCE NUMBER 2/ 41				
** SUBTOTAL **	74.84	14.96	720	
* CONFERENCE NUMBER 2/ 42				
** SUBTOTAL **	109.86	27.46	1080	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 2/ 43				
** SUBTOTAL **	60.56	20.18	600	
* CONFERENCE NUMBER 2/ 44				
** SUBTOTAL **	68.64	22.87	675	
* CONFERENCE NUMBER 2/ 45				
** SUBTOTAL **	73.22	14.64	720	XXC
* CONFERENCE NUMBER 2/ 46				
** SUBTOTAL **	121.14	30.28	1200	
* CONFERENCE NUMBER 2/ 47				
** SUBTOTAL **	80.34	26.77	810	
* CONFERENCE NUMBER 2/ 48				
** SUBTOTAL **	47.92	23.96	480	
* CONFERENCE NUMBER 2/ 49				
** SUBTOTAL **	67.86	16.96	680	
* CONFERENCE NUMBER 1/ 50				XXC
** SUBTOTAL **	99.81	33.26	1040	
* CONFERENCE NUMBER 1/ 51				
** SUBTOTAL **	69.38	34.69	650	
* CONFERENCE NUMBER 1/ 52				
** SUBTOTAL **	136.12	34.03	1440	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME
* CONFERENCE NUMBER 1/ 53			
** SUBTOTAL **	110.43	22.08	1188
* CONFERENCE NUMBER 1/ 54			
** SUBTOTAL **	74.11	18.52	792
* CONFERENCE NUMBER 1/ 55			
** SUBTOTAL **	51.20	25.60	675
* CONFERENCE NUMBER 1/ 56			
** SUBTOTAL **	55.75	55.75	650
* CONFERENCE NUMBER 1/ 57			
** SUBTOTAL **	71.51	35.75	720 XXC
* CONFERENCE NUMBER 1/ 58			
** SUBTOTAL **	96.11	16.01	950
* CONFERENCE NUMBER 1/ 59			
** SUBTOTAL **	102.75	25.68	1045
* CONFERENCE NUMBER 1/ 60			
** SUBTOTAL **	83.33	16.66	880
* CONFERENCE NUMBER 1/ 61			
** SUBTOTAL **	102.75	25.68	1045
* CONFERENCE NUMBER 1/ 62			
** SUBTOTAL **	10.12	2.53	125 XS

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME
* CONFERENCE NUMBER 1/ 63			
** SUBTOTAL **	9.59	2.39	120 XS
* CONFERENCE NUMBER 1/ 64			
** SUBTOTAL **	11.98	2.39	150 XS
* CONFERENCE NUMBER 1/ 65			
** SUBTOTAL **	11.98	3.99	150 XS
* CONFERENCE NUMBER 1/ 66			
** SUBTOTAL **	11.98	5.99	150 XS
* CONFERENCE NUMBER 1/ 67			
** SUBTOTAL **	14.40	14.40	180 XS
* CONFERENCE NUMBER 1/ 69			
** SUBTOTAL **	10.66	5.33	140 XS
* CONFERENCE NUMBER 1/ 70			
** SUBTOTAL **	11.98	2.99	150 XS
* CONFERENCE NUMBER 1/ 71			
** SUBTOTAL **	8.10	8.10	100 XS
* CONFERENCE NUMBER 1/ 73			
** SUBTOTAL **	16.79	3.35	210 XS
* CONFERENCE NUMBER 1/ 74			
** SUBTOTAL **	11.98	3.99	150 XS

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/ 75				
** SUBTOTAL **	9.59	4.79	120	XS
* CONFERENCE NUMBER 1/ 76				
** SUBTOTAL **	11.98	11.98	150	XS
* CONFERENCE NUMBER 1/ 77				
** SUBTOTAL **	114.42	38.13	1125	XXC
* CONFERENCE NUMBER 1/ 78				
** SUBTOTAL **	100.96	50.48	1000	
* CONFERENCE NUMBER 1/ 79				
** SUBTOTAL **	87.85	29.28	880	
* CONFERENCE NUMBER 1/ 80				
** SUBTOTAL **	68.64	17.16	675	
* CONFERENCE NUMBER 1/ 81				
** SUBTOTAL **	71.88	14.37	720	XXC
* CONFERENCE NUMBER 1/ 82				
** SUBTOTAL **	75.87	18.96	760	
* CONFERENCE NUMBER 1/ 83				
** SUBTOTAL **	47.92	23.96	480	
* CONFERENCE NUMBER 1/ 84				
** SUBTOTAL **	96.12	48.06	945	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/ 85				
** SUBTOTAL **	76.72	25.57	810	
* CONFERENCE NUMBER 1/ 86				
** SUBTOTAL **	91.56	45.78	900	XXC
* CONFERENCE NUMBER 1/ 87				
** SUBTOTAL **	86.96	43.48	855	
* CONFERENCE NUMBER 1/ 88				
** SUBTOTAL **	116.94	29.23	1210	
* CONFERENCE NUMBER 1/ 89				
** SUBTOTAL **	86.96	28.98	855	
* CONFERENCE NUMBER 1/ 90				
** SUBTOTAL **	47.92	11.98	480	
* CONFERENCE NUMBER 1/ 91				
** SUBTOTAL **	50.29	25.14	600	
* CONFERENCE NUMBER 1/ 92				
** SUBTOTAL **	40.24	40.24	480	
* CONFERENCE NUMBER 1/ 93				
** SUBTOTAL **	70.90	35.45	680	XXC
* CONFERENCE NUMBER 3/ 94				
** SUBTOTAL **	68.64	34.32	675	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME
* CONFERENCE NUMBER 3/ 95			
** SUBTOTAL **	82.38	27.45	810
* CONFERENCE NUMBER 3/ 96			
** SUBTOTAL **	47.92	47.92	480
* CONFERENCE NUMBER 3/ 97			
** SUBTOTAL **	54.92	10.98	540 XXC
* CONFERENCE NUMBER 3/ 98			
** SUBTOTAL **	59.89	29.94	600
* CONFERENCE NUMBER 3/ 99			
** SUBTOTAL **	111.91	55.95	1080
* CONFERENCE NUMBER 4/100			
** SUBTOTAL **	1.93	0.64	22
* CONFERENCE NUMBER 4/101			
** SUBTOTAL **	92.07	23.01	950 XXC
* CONFERENCE NUMBER 4/102			
** SUBTOTAL **	69.79	17.44	680
* CONFERENCE NUMBER 4/103			
** SUBTOTAL **	72.05	24.01	760
* CONFERENCE NUMBER 4/104			
** SUBTOTAL **	89.72	17.94	882

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 4/105				
** SUBTOTAL **	66.74	22.24	640	
* CONFERENCE NUMBER 4/106				
** SUBTOTAL **	35.81	17.90	420	
* CONFERENCE NUMBER 1/107				
** SUBTOTAL **	47.75	23.87	560	
* CONFERENCE NUMBER 1/108				
** SUBTOTAL **	78.76	26.25	765	XXC
* CONFERENCE NUMBER 1/109				
** SUBTOTAL **	73.57	24.52	720	
* CONFERENCE NUMBER 1/110				
** SUBTOTAL **	116.31	29.07	1200	
* CONFERENCE NUMBER 1/111				
** SUBTOTAL **	146.88	48.95	1400	
* CONFERENCE NUMBER 1/112				
** SUBTOTAL **	87.85	29.28	880	
* CONFERENCE NUMBER 1/113				
** SUBTOTAL **	86.96	28.98	855	XXC
* CONFERENCE NUMBER 1/114				
** SUBTOTAL **	137.33	34.33	1350	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/115				
** SUBTOTAL **	44.85	22.42	420	
* CONFERENCE NUMBER 1/116				
** SUBTOTAL **	63.88	31.94	640	
* CONFERENCE NUMBER 1/117				
** SUBTOTAL **	35.93	35.93	360	
* CONFERENCE NUMBER 1/118				
** SUBTOTAL **	43.90	21.95	440	XXC
* CONFERENCE NUMBER 1/119				
** SUBTOTAL **	71.82	35.91	720	
* CONFERENCE NUMBER 1/120				
** SUBTOTAL **	102.19	20.43	960	
* CONFERENCE NUMBER 1/121				
** SUBTOTAL **	87.52	87.52	960	
* CONFERENCE NUMBER 1/122				
** SUBTOTAL **	53.53	53.53	640	
* CONFERENCE NUMBER 1/123				
** SUBTOTAL **	49.58	24.79	585	
* CONFERENCE NUMBER 1/124				
** SUBTOTAL **	87.78	43.89	1035	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 3/125				
** SUBTOTAL **	69.22	13.84	840	XXC
* CONFERENCE NUMBER 1/126				
** SUBTOTAL **	61.05	61.05	720	
* CONFERENCE NUMBER 3/127				
** SUBTOTAL **	54.92	13.73	540	
* CONFERENCE NUMBER 1/128				
** SUBTOTAL **	80.21	40.10	810	
* CONFERENCE NUMBER 3/129				
** SUBTOTAL **	117.70	29.42	1120	
* CONFERENCE NUMBER 3/130				
** SUBTOTAL **	69.57	34.78	720	XXC
* CONFERENCE NUMBER 3/131				
** SUBTOTAL **	113.24	37.74	1200	
* CONFERENCE NUMBER 3/132				
** SUBTOTAL **	43.49	14.49	420	
* CONFERENCE NUMBER 3/133				
** SUBTOTAL **	77.78	38.89	765	
* CONFERENCE NUMBER 1/134				
** SUBTOTAL **	73.92	36.96	720	

ALL CONFERENCES

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/135				
** SUBTOTAL **	50.06	12.51	480	xxc
* CONFERENCE NUMBER 1/136				
** SUBTOTAL **	158.21	79.10	1550	
* CONFERENCE NUMBER 2/137				
** SUBTOTAL **	51.52	25.76	480	
* CONFERENCE NUMBER 2/138				
** SUBTOTAL **	54.92	13.73	540	
* CONFERENCE NUMBER 2/139				
** SUBTOTAL **	130.54	26.10	1260	
* CONFERENCE NUMBER 1/140				
** SUBTOTAL **	18.07	18.07	225	
* CONFERENCE NUMBER 1/142				
** SUBTOTAL **	44.26	22.13	540	
* CONFERENCE NUMBER 1/144				
** SUBTOTAL **	14.74	14.74	180	
* CONFERENCE NUMBER 1/145				
** SUBTOTAL **	22.12	11.06	270	
* CONFERENCE NUMBER 2/148				
** SUBTOTAL **	37.53	18.76	420	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 2/149				
** SUBTOTAL **	28.14	28.14	315	XXC
* CONFERENCE NUMBER 1/150				
** SUBTOTAL **	44.01	11.00	375	
* CONFERENCE NUMBER 2/151				
** SUBTOTAL **	31.22	10.40	270	
* CONFERENCE NUMBER 2/152				
** SUBTOTAL **	20.81	6.93	180	
* CONFERENCE NUMBER 2/153				
** SUBTOTAL **	32.62	8.15	300	
* CONFERENCE NUMBER 1/154				
** SUBTOTAL **	44.77	14.92	420	
* CONFERENCE NUMBER 1/155				
** SUBTOTAL **	31.22	6.24	270	
* CONFERENCE NUMBER 1/156				
** SUBTOTAL **	21.54	7.17	180	
* CONFERENCE NUMBER 1/157				
** SUBTOTAL **	27.74	13.87	240	
* CONFERENCE NUMBER 1/158				
** SUBTOTAL **	20.81	6.93	180	

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME	
* CONFERENCE NUMBER 1/159				
** SUBTOTAL **	37.69	9.42	300	
* CONFERENCE NUMBER 3/160				
** SUBTOTAL **	31.22	10.40	270	
* CONFERENCE NUMBER 1/161				
** SUBTOTAL **	55.50	18.49	480	
* CONFERENCE NUMBER 1/162				
** SUBTOTAL **	13.47	6.73	150	
* CONFERENCE NUMBER 1/163				
** SUBTOTAL **	20.81	10.40	180	
* CONFERENCE NUMBER 1/164				
** SUBTOTAL **	92.23	23.05	840	
* CONFERENCE NUMBER 1/165				
** SUBTOTAL **	31.22	10.40	270	
* CONFERENCE NUMBER 1/166				
** SUBTOTAL **	20.81	5.20	180	
* CONFERENCE NUMBER 1/167				
** SUBTOTAL **	24.27	8.08	210	XS
* CONFERENCE NUMBER 1/168				
** SUBTOTAL **	9.15	9.15	100	XS

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME
* CONFERENCE NUMBER 1/169			
** SUBTOTAL **	11.05	11.05	125
* CONFERENCE NUMBER 1/170			
** SUBTOTAL **	25.46	8.48	270
* CONFERENCE NUMBER 1/171			
** SUBTOTAL **	20.81	6.93	180
* CONFERENCE NUMBER 1/172			
** SUBTOTAL **	73.22	24.40	720
* CONFERENCE NUMBER 1/173			
** SUBTOTAL **	55.95	11.19	540
* CONFERENCE NUMBER 1/174			
** SUBTOTAL **	82.38	27.45	810
* CONFERENCE NUMBER 1/175			
** SUBTOTAL **	53.36	26.68	520
* CONFERENCE NUMBER 1/176			
** SUBTOTAL **	100.14	25.03	960
* CONFERENCE NUMBER 1/177			
** SUBTOTAL **	50.49	12.62	480
* CONFERENCE NUMBER 1/178			
** SUBTOTAL **	47.92	9.58	480

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME
* CONFERENCE NUMBER 1/179			
** SUBTOTAL **	77.78	15.55	765
* CONFERENCE NUMBER 1/180			
** SUBTOTAL **	90.84	30.27	900
* CONFERENCE NUMBER 1/181			
** SUBTOTAL **	49.42	8.23	455
* CONFERENCE NUMBER 1/182			
** SUBTOTAL **	100.69	16.78	990
* CONFERENCE NUMBER 3/183			
** SUBTOTAL **	143.70	28.74	1400
* CONFERENCE NUMBER 3/184			
** SUBTOTAL **	88.58	44.29	855
* CONFERENCE NUMBER 3/185			
** SUBTOTAL **	132.75	66.37	1305
* CONFERENCE NUMBER 3/186			
** SUBTOTAL **	149.22	49.73	1440
* CONFERENCE NUMBER 3/187			
** SUBTOTAL **	135.23	22.53	1305
* CONFERENCE NUMBER 3/188			
** SUBTOTAL **	41.95	41.95	405

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME
* CONFERENCE NUMBER 3/189			
** SUBTOTAL **	167.87	55.95	1620
* CONFERENCE NUMBER 1/190			
** SUBTOTAL **	155.44	19.43	1560
* CONFERENCE NUMBER 1/191			
** SUBTOTAL **	82.38	20.59	810
* CONFERENCE NUMBER 1/192			
** SUBTOTAL **	80.89	40.44	760
* CONFERENCE NUMBER 1/193			
** SUBTOTAL **	55.95	18.64	540
* CONFERENCE NUMBER 1/194			
** SUBTOTAL **	32.97	16.48	315
* CONFERENCE NUMBER 1/195			
** SUBTOTAL **	39.12	19.56	360
* CONFERENCE NUMBER 1/196			
** SUBTOTAL **	58.67	14.66	540
* CONFERENCE NUMBER 1/197			
** SUBTOTAL **	57.98	19.32	560
* CONFERENCE NUMBER 1/198			
** SUBTOTAL **	116.56	14.57	1125

COST OF CONFERENCES BY STAFF NUMBER AND CONFERENCE

STAFF NUMBER	COST	COST PER ACTIONED CASE	TIME
* CONFERENCE NUMBER 1/199			
** SUBTOTAL **	79.23	39.61	765
* CONFERENCE NUMBER 1/200			
** SUBTOTAL **	134.32	44.77	1280
* CONFERENCE NUMBER 1/141			
** SUBTOTAL **	66.11	16.52	660
** TOTAL **	12717.81	4535.69	128454

APPENDIX 11

APPOINTMENT CARD

Appointment Card

Dear .....

Thank you for agreeing to be involved in the hospital discharge research project.

I will call to see you at home on.....

at.....

Please keep this card safely and compare this signature with the identity card which I will bring with me.

Signature Janet Stevens

Patient Number.....

APPENDIX 12

GERIATRIC SERVICES DISCHARGE FORMS

GERIATRIC UNIT DISCHARGE FORM

FULL NAME_____ D.O.B._____

CALLED_____

HOME ADDRESS_____

_____

_____

DISCHARGE ADDRESS_____

_____

NEXT OF KIN_____

NAME_____

ADDRESS_____

_____

_____

SERVICES ARRANGED_____

_____

_____

MEDICATION_____

_____

_____

SKIN CARE_____

_____

☐ CONTINENT

☐ INCONTINENT: AIDS USED

BOWEL CARE_____

_____

AIDS..... BED

CHAIR

WALKING

LIKES/DISLIKES_____

_____

_____

_____

GERIATRIC SERVICES.

DISCHARGE FORM. WARD.

NAME.....

ADDRESS.....

.....

AGE..... G.P.....

CONDITION OF PATIENT AND DIAGNOSIS AT DISCHARGE.....

.....

.....

.....

SERVICES INVOLVED/ARRANGED.....

.....

.....

.....

FAMILY SUPPORT.....

.....

.....

COMMENTS / MEDICATION . . ..

.....

.....

SIGNED.....

BEHAVIOUR PROBLEMS _____

_____

NEEDS HELP: DRESSING _____

FEEDING _____

WASHING _____

TOILETING _____

ALLERGIES _____

_____

_____

G.P. _____

CONSULTANT _____

HOSPITAL NUMBER _____

NEXT APPOINTMENT _____

DISCHARGED FROM _____

_____

Any problems or for details Please Contact: _____

_____

_____

_____

MEDICAL HISTORY – PAST

SOCIAL HISTORY/HOME CIRCUMSTANCES

MOBILITY

MEDICAL HISTORY – PRESENT

PAIN/WHAT PATIENTS/RELATIVES UNDERSTAND RE DIAGNOSIS

DAILY ACTIVITIES

	NORMAL PATTERN	PRESENT PATTERN
SLEEP		
BOWEL HABIT		
URINE		
DIET		
APPETITE		
HYGIENE ABILITY		
DRESSING ABILITY		
FEEDING ABILITY		
ORIENTATION		
COMMUNICATION		

CP14/23452

EXETER UNIT HEALTH VISITOR DISCHARGES

WARD .....

NAME ..... AGE .....

ADDRESS .....

.....

HOME TEL: .....

G.P. .....

DIAGNOSIS .....

MEDICATION .....

RELEVANT INFORMATION

DISTRICT NURSE ATTENDING YES/NO WEEKLY/DAILY

SIGNATURE .....

References

References

Page

Preface

1.	D.H.S.S. Cmnd.7615	Royal Commission on the National Health Service. Chairman Sir Alex Morrison. Ch.6 & 7. HMSO 1979.	14
2.	PARDOE P	Social Services Area Teams. Allen and Unwin. 1981.	15
3.	P.S.S.C.	Collaboration in Community Care - a discussion document. p. 24 to 31. HMSO 1978.	15
4.	D.H.S.S. Cmnd.5055 also HRC(73)3	Management arrangements for the Reorganised National Health Service HMSO 1972/4.	15
5.	D.H.S.S.	Care in Action - a handbook of Policies and Priorities for the Health and Social Services in England. HMSO 1981.	15
6.	D.H.S.S. HC(84)13	Management Arrangements for the National Health Service. Sir Roy Griffiths. 1984.	15
7.	D.H.S.S. Cmnd.9771	Primary Health Care - an agenda for discussion. HMSO April 1986.	15
8.	D.H.S.S.	National Health Service Act. HMSO 1977.	15
9.	D.H.S.S.	Progress in Partnership. HMSO 1986.	15
10.	HOME OFFICE et al. Cmnd.3707	Report of the Committee on Local Authority and Allied Socia Services 1968.	15
11.	HOME OFFICE et al.	Local Authority Social Services Act. HMSO 1970.	15

			Page
12.	ROWBOTTOM R et al.	Social Services Department Developing Patterns of Work and Organisation. Heinemann 1978.	15
13.	SCHON D	Beyond the Stable State. W.W. Norton. 1980.	15
		Chapter One	
14.	D.H.S.S. DA(86)13	Guidance Circular on Joint Planning and Collaboration. DHSS 1986.	19
		Chapter Two	
15.	FOX D	Fundamentals of Research in Nursing Appleton Century Crofts 4th Ed. 1982.	25
16.	POLIT D HUNGLER B	Nursing Research Lipcott Co., 2nd Ed. 1978.	25
17.	BALES F	Interaction Process Analysis. Addison Wesley. 1957.	25
18.	LALEAN S	The Study of Nursing Care. Royal College of Nursing. 2nd. Ed. 1981.	25
19.	GOLDSCHMIDT W	Ethnography of Encounters. Current Anthropology (Jrnl) Ch.13. pp 59-78. 1972.	26
20.	MARSHALL V.W	Team Function - in Macpherson AS et.al., A study to develop an evaluation of a psychological programme. Report P.R.402. Ministry of Health - Ontario. 1976.	26
21.	MARSH G.N.	Obstetric Audit in General Practice. British Medical Journal. 2: pp 1001-1006. 1977.	26
22.	BOZZONE V.	Team Approach Improves Quality. Journal of Advanced Nursing. Vol.49. pp 161-166. 1975.	26

			Page
23.	CHRISTENSEN K HINGLE J	Effectiveness of Team and Non Team in Public Health Nursing. Advanced Journal of Public Health. Vol.62 pp 183-490. 1972	27
24.	CUMBERLEGE J	Neighbourhood Nursing - A Focus for Care. DHSS. HMSO. 1986.	27
25.	KANE R.A.	Interprofessional Teamwork. Syracruse University Manpower Monograph No.8. 1975.	27
26.	PAYNE M	Working in Teams. B.A.S.W. 1982.	28
27.	WOODCOCK M	Team Development Manual. Gower Press. 1979.	28
28.	BRILL N.I.	Teamwork : Working Together in the Human Services. Lippincott. p.22. 1976.	29
29.	HUNT M	Possibilities and Problems in Interdisciplinary Teamwork, in Marshall et.al. B.A.S.W. p.13. 1979.	29
30.	DYER W.G.	Team Building : Issues and Alternatives. Addison Wesley. p.4. 1977.	29
31.	TUCKMAN B.W	Developmental Sequence in Small Groups. Psychological Bulletin, 63(6). pp.384-99. 1963.	30
32.	PAYNE M	Power, Authority and Responsibility in Social Services. Macmillan. 1979.	30
33.	HORSLEY S.D	Working in Teams, in Teamwork in the National Health Service. Occasional Paper No. 4. Unit for Continuing Education, Department of Community Medicine - University of Manchester. 1981.	31
34.	HORWITZ J.J	Team Practice and the Specialist. C.C. Thomas & Company (Amer). 1970.	31

			Page
35.	HANDY C	The Hawthorn Experiments in Understanding Organisations. Penguin. 1979.	32
36.	WEBB A.L & HOBDELL M	Co-ordination of Teamwork in the Health and Personal Social Services. Lonsdale et.al., 1980.	32
37.	THOMAS D.N. & WHARBURTON RW.	Community Work in a Social Service Department. National Institute for Social Work and Personal Social Services Council. London. 1979.	32

Chapter III

38.	D.H.S.S. HRC(74)32	Management Arrangements, Agency Arrangements and Extraterritorial Management. 1974.	38
39.	WILD D.W	In Working In Teams - A National Health Service Perspective. Occasional Paper 4. University of Manchester. 1981.	40
40.	D.H.S.S. HC(82)2	Determination of Region and District Orders: Transfer of Officers Regulations and Consequential Provision. 1982.	41
41.	WHITE D et.al.,	Options for Strengthening Unit Management. H.S.M.C. Birmingham University. Occasional Paper 44. 1982.	43
42.	KINGS FUND CENTRE	Unit Management in Context. Kings Fund Paper No. 31. March 1982.	43
43.	TITMUSS R.M	War and Social Policy in Essays on the Walfare State. Allen and Unwin. 1963.	44

			Page
44.	MINISTRY OF HEALTH Cmnd.1191.	Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services. HMSO. 1959.	45
45.	BUTRYM Z HORDER J	Health Doctors and Social Workers. Routledge & Kegan Paul. 1983.	49
46.	HEY A	Organising Teams - Alternative Patterns in Marshall et.al. Teamwork: for and against. B.A.S.W.A. 1979.	51
47.	ETZIONI A.ed.,	The Semi Professions and Their Organisation. New York Free Press. 1969.	51
48.	FRIEDSON E	Professional Dominance. Atherton Press Inc. New York. 1970.	51
49.	LEONARD P	Professionalisation, Community Action and Growth of Social Service Bureaucracies in Professionalisation and Social Change. ed. P Halnes. Sociological Review. Monograph 20. University of Keele. 1973.	51
50.	HICKS H.G	The Management of Organisations. Open University Press. 1972.	53
51.	WARR P WALL T	Work and Wellbeing. Penguin. 1978.	54
52.	GARRARD	On the Margin of the Impossible in Medical Social Work. No. 6. June 1966.	55
53.	HANNAY Dr.	The Sympton Iceberg - a study of Community Health. Routledge and Kegan Paul. ch.9. p.133. 1979.	57

			Page
54.	D.H.S.S. Cmnd.9663.	Report of the Committee of Enquiry into the Cost of the National Health Service. (Guilleband Report). HMSO. London. 1956.	58
55.	D.H.S.S. Cmnd.4040.	Royal Commission on Local Government in England. HMSO. London. 1969.	58
56.	D.H.S.S. Green Paper	The Future Structure of the National Health Service. HMSO. para.21. 1970.	58
57.	D.H.S.S. Welsh Office.	Patients First. HMSO. London. 1979.	60
58.	WISTOW G WEBB A	Patients First - One Step Backwards for Collaboration. Working Paper in Social Admin., Loughborough University. 1980.	60
59.	STOTEN B	The N.H.S. A Changing Climate in Jones K. ed. The Yearbook of Social Policy. Routledge and Kegan Paul. 1982.	60
60.	D.H.S.S.	Care in the Community. HMSO. 1981.	61
61.	SMITH J	The Big Match Replay in Health and Social Services Journal. 6.1.83 pp.22-24. 1983.	61
62.	WISTOW G FULLER S	Collaboration since Restructuring. Centre for Research Into Social Policy. National Association of Health Authorities. 1986.	61

Chapter Five

63.	WEBB A.L	Co-ordination Between Health and Social Services at Local Level Centre for Welfare Research. Vienna. 1980.	66

			Page
64.	SPITZER W.O ROBERTS R.F	Twelve Questions About Health Teams in Journal of Community Health. Human Sciences Press. Vol.16.1980	66
65.	WEICK K	Systematic Observational Methods in The Handbook of Social Psychology. ed. Lindzey and Aronson. Addison and Wesley. 1968.	81
66.	BYERLY E.L	The Nurse Research As Participant Observer in P.J. Brink ed., Prentice - Hall. 1976.	83
67.	KLECKA W.R et.al.,	Statistical Package for the Social Scientist. McGraw Hill. New York. 1975.	91
68.	CHAPLIN N.W editor	The Hospital and Health Services Year Book 1987. I.H.S.M. 1987.	97

Chapter Six

69.	CARTWRIGHT A	Life Before Death. Routledge and Kegan Paul. 1973.	197
70.	SKEET M	Home from Hospital. Research. Dan Mason Committee. 1971.	197
71.	ROBERTS I	The Discharged Patient - Are We Doing the Best? Nursing Mirror 1977. 145:12. pp.37-39.	198
72.	TURTON P	When the Team Doesn't Work. Nursing Times. p.23. March 1985.	198
73.	JUPP M SIMMS S	Discharge Planning - Going Home. Nursing Times. Oct 1. 1986. p.40-41.	198