The Effects on the Organisation of Hospital Visiting Teams

A Critique

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Hospital visiting teams, review bodies, and inquiries have become a fact of life in psychiatric settings in the Health Service. In the last 20 years or so there has been an intensification of efforts aimed at examining and evaluating psychiatric services. There can be no doubt that the purpose of the visits—to monitor and improve standards of care and to facilitate changes in service delivery—is a worthy and important one. Clearly, too, a great deal of expertise and energy goes into the visits. Descriptions of the range of visits and the arrangements involved, as reflected in the HAS Annual Report (1985–1986),[1] are impressive.

However, what do we know of the effects of these visits? There is little, if any, published information. No doubt there are numerous instances of visits that have had a constructive outcome, where the intervention of an outside team has been highly valued, and where helpful change has ensued. But we also know of instances in which they have had a less favourable outcome. In these cases, the team appears to have evoked strong feelings of threat in the organisation and has left behind a sense of chaos, with a deepened rather than a lessened resistance to change. The author has experienced three such visits in his work setting within the last four years, a full HAS visit, a specialist review body, and a follow-up to the first HAS visit. This is not to say that the visits had no benefit whatsoever: some important problems were accurately identified and in the case of the HAS visits there were some constructive consequences. However, the constructive aspects appeared to be outweighed by negative factors, by an overall sense in the organisation of not being understood and by an escalation of problems following the visits.

Participation as a staff member in the organisation being evaluated in these visits and reflections on events that occurred during and after them prompted questions in the author's mind. The main question was why these visits were so unsatisfactory, so disappointing and, in some ways, even damaging. Not having had the advantage of more positive experiences to go by, there was no standard of comparison, only the seemingly faulty processes that occurred in the visits. In turn, there was no immediate framework within which to put these observations. This seemed strange. The HAS, for example, has by now produced many reports, with detailed descriptions of the organisations studied and many words of advice on both minor matters and matters of far-reaching importance. Yet there has been very little attempt to look at the picture from the reverse perspective: how the institution or service views the visit, how staff deal with it, and which characteristics define the interaction of the visiting team and the organisation under scrutiny.

This paper attempts to redress the balance. In so doing it intersperses descriptions of the visits with systemic and psychodynamic observations, with the aim of understanding the interactional process of the visits, and, ultimately, of making recommendations for improving the service.

The overall visit in perspective

This description outlines the procedure of a typical HAS visit. There is usually a sense of considerable importance about the visit. Notification is usually issued some months in advance. The visit often starts with a large meeting with key staff of the organisation. The team stays a few weeks, during which time contact is made with departments, wards, and individual staff. At the end of the visit, there is usually a large meeting with staff in which the initial report is presented verbally. At this meeting, discussion about the report is discouraged. The printed report appears some weeks or months later. Comments are invited from the organisation. These usually take some time to collect but tend to make little impact on the reported findings. The final report is usually published jointly by the Health Authority and Local Authority concerned. It is circulated widely, with Regional and public access to it.

It is the report that carries the final weight of the visit. When published, it has the status of an official document and bears the stamp of authority. Because of this, its stated opinions can have far-reaching consequences. Reputations can be made or broken by it, responsibility, blame, and praise apportioned, units and services opened or shut.

The organisation and membership of the team

The quality of a visiting team must depend on its membership and organisation. From my knowledge, teams vary considerably in the extent to which they are organised as a team on arrival. Some appear cohesive, with the membership having been established some time ahead and/or members of the team having spent time together in preparation for their task. Others appear to be thrown together at the last minute. Rumours abound about the personnel involved and how so-and-so dropped out and someone else stepped in at the eleventh hour. Members of the organisation being

visited are both curious and anxious to receive information about the team and an advance sense of confusion about it does not inspire confidence.

The membership of the team, of course, varies from visit to visit. There is a popular, rather derogatory, impression of HAS members as being senior or retired Health Service staff who join the HAS to keep themselves occupied. If this impression is relevant to some individuals, it is unfair to others, as numerous, very active professional Health Service staff are included in visiting teams. The choice of membership according to profession sometimes seems arbitrary. As a clinical psychologist, I have been puzzled why some teams have psychology members and others do not. Advice from professional bodies, such as the British Psychological Society, is apparently sought in making the decisions, but even then the reasons for the decision are not always clear and do not necessarily tie in with the needs of the service. In the HAS visit in which my organisation was the recipient, complicated problems arose out of this discrepancy.

Another aspect of membership is the representation of theoretical viewpoints within the team and how these relate to ideological perspectives in the organisation under scrutiny. Are these closely matched or not? Should they be? In the review of a specialist unit in my District, major controversies were triggered off by the fact that the leader of the visiting team had a different theoretical approach from the Director of the specialist unit. Although the two approaches were not irreconcilable, the difference was seized on by some members of the organisation as an argument for devaluing the report of the review body.

The focus of the visit

The HAS started in 1969 as the Hospital Advisory Service, then changed in 1976 to the Health Advisory Sercice. In my experience, the two aspects, health and hospital, are open to confusion. This is an important issue, given that in many Districts the pattern of services is changing dramatically and that what were previously hospital-based services are becoming community-based services. The problems of these services are often problems of transition and organisational change. Any review must be clear about where its focus is directed and to what extent it is cognisant of the changes in service delivery.

In the set of HAS visits experienced by the author (a main visit and a follow-up visit), the first was conducted at a time that the psychiatric hospital was unequivocally the hub of the service, although developments in the community were beginning to take place. The team's findings related very largely to the hospital; scant attention was paid to the community. There were even some injunctions against the development of community services, because these were seen as draining the institution of resources. By the time of the follow-up visit, a retrenchment policy had been drawn up for the hospital and there were now urgent considerations about the direction of the service. This visit chose conspicuously to ignore this change—this was said in practically so many words at a meeting with staff—and concentrated on the same hospital-based issues considered in the initial visit. To be fair to the team, to have taken on board the new developments in a few crammed days would have been extremely difficult, but the skewed emphasis of the first visit was exaggerated by the even more skewed emphasis of the second, and left a distinct sense of unease about whether the team grasped the real problems of the service. The issue of the team's appreciation of the reality of a service is a crucial one, especially given the rapid degree of organisational change at present.

Judging from reports of visits to other Districts, different teams have different attitudes to changes of this sort. There are reports of teams which have strongly encouraged the closure of hospitals and the development of community facilities, while others appear to have accepted or reinforced the role of the hospital as the centre of the service. This makes comparison of reports from District to District very difficult, and raises questions about the consistency and coherence of policy informing HAS visits.

The context of the visit

The visit is very much an event from the outside. It is usually part of a wider programme of visits and staff in the organisations generally have little, if any, say about the visit: whether it is wanted, whether the timing is suitable, and who should be on the visiting team. Often, information about the membership of the team is given only at the start of the visit, probably because it has only been resolved at this late stage. The dates of the visit are also changeable. In the author's experience of an HAS follow-up visit, the date of the team's arrival changed several times within a three month period.

Events which occur from the outside in this way can arouse considerable anxiety in the recipients. There is a sense of having no control over the event. This in turn engenders feelings of helplessness and resentment. This is compounded by the sense of impending *judgement*. Try as one may to draw a different perspective of the visit, the fact remains that a group is coming to inspect. The dynamic is clear: one group inspects, the other is inspected. Even mature, responsible adults feel anxious in such a situation. The psychodynamics relate back to early fears of authority, to a parent–child constellation in which criticism and rebuke are anticipated.

Probably the more there is to hide in an organisation, the more anxiety there is about exposure. This may lead to defensive manoeuvres: trying to present the best possible impression, denying problems, resisting inquiry, blaming others. How much are visiting teams aware of such dynamics and, if they are, what can they do about them? My experience of visiting teams suggests either a limited awareness or inadequate techniques of dealing with organisational and individual anxiety and resistance. Some illustrations are given below.

Communication between team and organisation

In order to achieve effective collaboration between the visitors and the visited, communication is of the essence.

This is difficult to achieve in an atmosphere charged with anxiety and defensiveness. It requires considerable skill in communication which, however well-intentioned the team may be, it may not have within its resources. A glance at what happened at the start and the close of one HAS visit illustrated these difficulties.

The initial contact. The nature of the first contact between team and organisation must influence subsequent communication. At the start of the HAS visit (to a large psychiatric hospital) the team set up a preliminary meeting with all senior staff in the hospital (administration, consultants, nursing, and non-medical staff, comprising a group of approximately 30 people). The meeting took place in the boardroom of the hospital, dominated by a table in the centre of the room, the HAS team sitting at one end of the table and the hospital staff crammed in around the rest of the table.

The chairman of the team introduced himself and other members of the team, saying that he hoped this would be regarded as a friendly, helpful visit rather than an inquiry. A staff member commented that virtually the same had been said at the start of the last HAS visit some 10 years earlier, but that ultimately it had been regarded much more as an inquiry. There was no attempt by the team to discuss with the staff group the implications of this discrepancy for the present visit. Instead, the chairman asked the group to describe whatever problems members were now aware of in the organisation. The request was met with a tense and uncomfortable silence. Eventually, a staff member expressed the view that there were indeed problems, but that these were difficult to produce around the table in a meeting of this sort. The chairman noted that on HAS visits to other Districts, staff groups were able to do just this and that there must be particular difficulties in openly presenting problems in this organisation. This did little to reassure or mobilise the staff group and a sticky, defensive discussion ensued in which fragments of the organisational difficulties were grudgingly revealed. At the end of the meeting the chairman (who had immediately before participated in a similar visit to an adjacent and linked District) commented that the first visit should have taken place at this hospital, not the other District, because clearly this was where the problems were. Not surprisingly this was the start of a disturbing and controversial visit.

It is not difficult to see with hindsight what went wrong in that first meeting. This was an organisation with considerable problems, true, but one unused to discussing them as an overall group with a team of outsiders. Putting the staff in a large group and expecting them immediately to open up was a mistake in the first place. Group analytic studies have shown that large groups tend to create very high anxiety levels,[2] all the more so when there is a perceived threat from outside. The visiting team handled this by provocation which only reinforced the group's anxiety and resistance. Very possibly the visiting team itself was discomfited by the lack of flow in the meeting and unable to deal with its own unease in other than a critical manner. The exercise demonstrated a lack of awareness of the dynamics of large groups, particularly in institutional contexts, and resulted in a traumatic beginning to the visit.

The final contact. An even larger staff group (at least 60) was called to the team's feedback meeting prior to departure: a hall outside the hospital had to be hired. Members of the visiting team took turns in reading out comments based on their findings. The overall tone of the feedback was strongly critical. Some individuals or departments were singled out for praise, but most were criticised. Comments from the staff group were discouraged. However justified the criticisms, the *method* of feedback must again be questioned. The degree of exposure in such a large group was considerable, and the lack of redress incapacitating and infantilising.

A visit that had started off on a sour note ended with a bitter taste. In the process, the opportunity for goodwill and effective collaboration had been lost.

The reaction of the organisation

Most of the observations so far have focused on the approach of the visiting team and the sorts of responses this can elicit in the staff group. This section takes a closer look at the dynamics within the organisation itself and how these influence the visit.

The visit is, in my experience, preceded by a period of gathering uncertainty and anxiety in the organisation. As mentioned above, rumours abound about the visiting team and its membership. It is as if staff in the organisation are trying to predict aspects of the event in a way that would give them a greater sense of control.

Referring to a previous point, the anxiety is essentially about responsibility or blame. Each department, or profession, or even individual, probably believes that he/she/it is right. But at another level, there may be lurking fears of professional guilt and misconduct (ours is a profession/s in which perfection is impossible to achieve and we are ourselves often troubled by out imperfections), and of being found out. There is an alternation between what in the language of psycho-analysis is called *paranoid-schizoid position* and the *depressive position.*[3] In the former, the emphasis is on fears of attack and blame projected onto others. In the latter, there is a sense of personal responsibility for problems and difficulties, often leading to feelings of anxious and depressive guilt. The visiting team is likely to pick up the symptoms and defences arising from these organisational states of mind (as in the initial HAS meeting described above) but without recognising the source of these defences. Where the visiting team gives the organisation negative messages early on, this is likely to escalate the alternating process of guilt and blame.

In this atmosphere, blame starts focusing increasingly in the organisation on certain individuals and it is not long before they start being scapegoated. In reality, these people may before the visit have been seen as difficult, obstructive, or neglectful in the organisation, but in the context of a review or inquiry, the perception of their responsibility

becomes exaggerated and they are singled out in exclusion from other organisational dynamics. This ignores the more complex reality that these individuals are, like everyone else in the organisation, part of a system in which there is an elaborate set of interactions which reinforces interpersonal organisational behaviours. Even where staff recognise this interaction, it may be difficult in the context of the review, where questions are asked about *the* cause, *the* reason, *the* problem, *the* person, to sustain this point of view. Sometimes the sheer complexity of the systemic interaction is too difficult to hold in view, sometimes the wish to project blame too tempting, and regressive thinking sets in.

Polarisation then takes place: the goodies and the baddies are marshalled into place. This is reflected in staff groups becoming split and issues of loyalty or hostility to key figures in the organisation becoming paramount. The split between staff becomes a dynamic in itself. Observation of the visit of the review body to a specialist unit was that the splitting was beginning to occur before the visit and the actual visit tipped the dynamic over into rigid and destructive polarisation.

It is in this atmosphere that heroes and demons are created. It is as if the organisational dynamics yield to a mythology in which responsible figures, good and bad, but particularly bad, are elevated to massive proportions. The organisation becomes gripped by the myth and it is impossible, once established, to turn back and discover reality in its complex forms. In my experience, this is so powerful that the visiting team, who may have half-nurtured the myth, are themselves drawn further into it. Double messages abound about the objectivity of a team that yet becomes an essential part of the organisational dynamic.

This dramatic situation is an illustration of what may happen in less pronounced but nevertheless important other ways—the team being drawn into institutional politics. Organisations abound with strategies, lobbying, and gossiping, all of which is designed at the time of the visit to influence the opinions of the team. This is not to say that there is no honest feedback, that all criticism of others is unfounded, but to point out that it must be difficult to distinguish responsible feedback from self-interested criticism of others.

The report

Given the above background factors, the task of producing a report must be a daunting one. In my experience what emerges is a mixture of fact and distortion. The discrepancies can be glaring: on one page some very accurate observations and on another gross misrepresentations. The terms of reference in a report may in themselves create problems. These do not always tie up with terms of reference in the organisation. I have seen vital terms like *rehabilitation* and *therapy* used in totally different ways from the meaning ascribed to them in the organisation. This has required an enormous and time-consuming effort of clarification on both sides that could have been avoided had the use of terms been agreed at the outset. But perhaps the most difficult aspect of the report concerns the necessity for staff to respond to it when truth and distortion are so closely interwoven. Were the report essentially true or essentially false this would be easier to respond to.

The task of commenting on the report produces its own dynamics. In the case of the visits described above, individuals and staff groups reacted either with denigration of the team's comments or there seemed to be a reluctance to respond for fear of being seen as defensive. Of course, there were also reactions between the two extremes. But the task of producing and collating the organisation's response easily becomes imbued with conflict and ambivalence, often linking in with the conflicting patterns of truth and distortion contained in the report. How much the final amalgam of the team's report and the organisation's responses reflect reality must vary considerably from visit to visit.

The aftermath of the visits

The outcome of the two main visits described differed in interesting and important ways. What happened would probably be interpreted differently by different observers but the following are some of my impressions.

The original HAS visit initially aroused considerable anger, focusing on some obvious distortions in the report, and temporarily producing a unification of staff against the common enemy, the visiting team. There was a core of response that took the report seriously and responded as such, but this was counter-balanced by doubts about the team's credibility and attempts to discredit the report as lacking relevance. There were some changes in the service following the visit (e.g., changes in organisational structures, particularly on the management side, and staff changes). These might have been influenced by the report, but equally they could have been part of the natural tide of events in the Health Service. In fact, the significance of the report seemed to be swallowed up and lost in the welter of organisational life. By the time of the follow-up (three years later), the original visit seemed distant and unconnected. As mentioned above, the follow-up visit concentrated solely on hospital conditions when the main problems concerned the development of community services, and although some relevant aspects were dealt with, again the overall impression was that the team failed to grasp the reality of the present position.

In contrast to the eventual overall indifference to the HAS visits, the review of the specialist unit had a cataclysmic effect. The unit was closed and the leading staff member, who had been severely criticised by the report, went into fierce battle against the review body and his employing authority. Where the process of the review seemed to have kindled a split amongst staff, this split widened into a massive and dangerous gulf. A series of attacks and counter-attacks was instigated, with the atmosphere of a cruelly punishing review being played out again and again in the staff arena. At the time of writing (two years after the review), the controversies continue and the unit remains shut. Several people have felt damaged in the process.

An ironic postscript—I recently contacted a member of

the review team to discuss a professional matter unrelated to the review. She expressed surprise when I mentioned the exacerbation of problems in the unit following the visit. She said she was unaware of events following the review as she had not kept in contact with the team or the situation.

Further reflections

It has been difficult to write this paper without having constantly to check my own biases. I perceived the visits as essentially negative and while I have tried to give as accurate a record of events as possible, I am aware that my observational bias may have distorted the picture. I need to acknowledge this for several reasons. Firstly, I have no cause to doubt that the visiting teams were well-intentioned and put a lot of effort into their work. Secondly, many other HAS and similar visits have no doubt had more positive and successful outcomes than those I experienced and I would not want to detract from this. Thirdly, this paper is at pains to highlight the problems inherent in observations of complex organisations, and I would not want unthinkingly or uncritically to commit the very error that I attribute to others.

The latter point deserves elaboration. It is generally accepted in the field of social research that, in any observational study, the observer changes the situation which he is observing by the very act of observation. Therefore, he cannot claim to be seeing the situation in its 'pure' state. Where a team of observers is involved, there are the additional dynamics of the relationship within the team as well as outside the team and how this interaction affects the observational and feedback process.

In order to try to deal with this problem, to the extent that it is possible, it would seem important if not essential for any visiting team to have access to two inter-related approaches to the understanding of organisations: group dynamics (or group analysis) and systems theory. The former tends to be more cross-sectional in approach in looking at the motives that influence relationships in groups, as well as the anxiety and defence mechanisms that guide interpersonal behaviour in an organisational context, such as the work on social systems as a defence against anxiety.[4,5,6] The systems approach is more comprehensive in taking account of the overall system of the organisation, how the aims of the organisation are perceived, how component parts fit together, how interactions are shaped within the system, how different triggers spark off these interactions and what the value systems are that underlie all these actions.[7] The two approaches can either be used separately or combined flexibly in a way that makes sense of apparently deviant and complex organisational structures[8] and avoids simplistic notions which focus on individuals or other sub-components of the system in separation from their context. Such understanding would *of necessity* include the part played by the visiting team as observers of the system.

The above suggestions, emphasising group and systemic influences, may sound like ways of avoiding the question of individual responsibility within organisations. If this were the case it would be a mistake. Individual responsibility is a fact, all the more so in the present day NHS climate. But these approaches might yield a better understanding of the responsible individual in terms of the pressures and constraints on him, and the role and function that the system both consciously and unconsciously requires him to play.

If all this seems like a tall order, too ambitious a task to undertake for a visiting team, the consequences of *not understanding* the system should be borne in mind—the cost in manpower and time (both the team's and the organisation's), the cost of either an indifferent or a destructive outcome to the visit, and, particularly, the cost to individual staff members who may end up as casualties of the exercise.

Conceivably, the inclusion of a group dynamic or systemic approach (or both) would also help the team to establish as positive a working relationship as possible with the staff of the organisation. This refers back to an earlier part of the paper; it might, for example, have helped to avoid the kind of confrontational relationship that developed so quickly at the start of the HAS visit and which set the tone for the rest of the visit. The need to maximise collaboration and co-operation is obvious, but this might need knowledge and skills that exceed the usual resources of visiting teams.

A final point concerns the importance of the continuing evaluation of psychiatric services. The fact that this paper approaches the subject from a critical standpoint should in no way be seen to detract from an awareness of the need for external evaluation of the mental illness services. As Griffiths management establishes itself more firmly in the NHS, as questions about the quality of services and cost effectiveness are more widely voiced, and as changes in the direction of our services become more pressing, so the need for responsible and sympathetic evaluation increases. The plea for better, more informed, more sensitive methods of evaluation goes hand in glove with this recognition.

Recommendations

The overall recommendation is that the *frame of reference* of HAS and similar visits should be changed from a model resembling an *inquiry* to one resembling *consultation*. Such a change might naturally lead to the following changes of teamwork and procedure:

(1) The organisation being studied would be more involved in the planning and implementation of the visit. Instead of the visit being one of a series that is presented at a prescribed time to the organisation, the organisation would have a say in the timing of the visit, even deciding whether and when it wants it. This would help to increase co-operation and the sense of a collaborative venture.

(2) The visit would have a clear focus and team members would be selected in line with the task focus. The organisation would have a say both in defining the focus and in the choice of team members.

This would require staff of the organisation to do more preliminary work on the requirements of the visit and would enhance their involvement in the visit. It would also make the visiting team more

of a known entity and less a group of unfamiliar individuals struggling to get to grips with the organisation.

(3) Members of the visiting team would be chosen not so much—or not only—for their experience in the Health Service but for their skill in understanding organisational processes. If it is unrealistic to expect such expertise in all team members, each team could be accompanied or advised by an organisation consultant.

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The Marlborough Family Day Unit

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The Marlborough Family Day Unit has been in existence for 10 years. It is part of the Marlborough Family Service, a community-based psychiatric service for patients of all ages. Its location is the site of the former Marlborough Day Hospital in London NW8. The Day Unit was created in 1977 by Dr Alan Cooklin who is still the consultant in charge of the whole service. The reason for setting up such a unit was to experiment with new ways of dealing with what is now so fashionably termed 'multi-problem families'. These are families where one or more members have been in extensive contact with psychiatric and social services. Multiple hospitalisations, removal of children into care, and general chaotic behaviour are the presenting 'symptoms'. Such families have unrivalled skills in collecting agencies and professionals like flypaper and making it very difficult for anyone to leave the field given the enormous anxiety created all round.

Historical development

At the very beginning the Service encountered predictable difficulties. The Marlborough Day, as it was known locally, had been until then a somewhat controversial therapeutic community. The arrival of a new consultant signalled change: his idea was to admit whole families rather than just the 'identified' patient. A maximum of eight families started attending the Day Unit at the same time, five days a week for six hours a day. The day then consisted of community meetings, group activities, individual psychotherapy for some of the parents and child psychotherapy for some of the children. Patients were seen in three different contexts: as individuals within the therapeutic community (receiving group therapy); as members of families (receiving family therapy); and as individuals in their own right (receiving individual psychotherapy). The co-existence of three different models of how therapeutic change could be effected resulted in 'eclectic' practice combining a family systems approach with psychodynamic principles and group work.

Families usually stayed for about 18 months. This was in line with the then fashionable notion that change was a slow process and that patients needed to be allowed to 'grow' in their own time which meant 'slowly'. By 1981 we were ready to review our work and decided to shorten admission periods. This was based on the frequent observation that families had a tendency to settle down after initial difficulties and to become 'good members of the community', but that about one month before discharge they would act disturbed and go into a crisis. This observation led staff to cut down admission to one month only in the first instance, so as to keep up the pressure for change on families. The Day Unit no longer defined itself as a containing environment but rather a 'pressure cooker'. At the same time it was also