THEMES AND TIME USE BY PARTICIPANTS IN GENERAL TEAM MEETINGS AT A PSYCHIATRIC DAY HOSPITAL[1]

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This naturalistic study was realized through observation and aimed to characterize general staff meetings held at a day hospital regarding theme and the professionals' participation in the use of time. We observed 21 meetings, during which 144 announcements were made and 46 issues were discussed, with greater participation in discussions by fixed team members. In 18 of these meetings, the discussed themes corresponded to daily situations registered during the weeks preceding the meetings. Our findings reveal that these meetings are inserted in the service on a regular basis. Power relations and differences in experience and technical knowledge between the different professionals seem to contribute to the higher or lower number of announcements and issues presented. As this space favors exchanges, we suggest these meetings to be used in other health services working with assistance teams.

DESCRIPTORS: patient care team; day care; psychiatry; mental health

TEMAS Y UTILIZACIÓN DEL TIEMPO POR LOS PARTICIPANTES DE REUNIONES DEL EQUIPO GENERAL EN UN HOSPITAL DÍA PSIQUIÁTRICO

La finalidad de este estudio, configurado como una investigación naturalística conducida mediante observación, fue la de caracterizar las reuniones del equipo general de un hospital día respecto a la temática y la participación de los profesionales en la utilización del tiempo. Fueron comunicados 144 avisos y discutidos 46 asuntos en 21 reuniones observadas, con mayor participación del equipo fijo en las discusiones. En 18 de las reuniones estudiadas, los temas discutidos correspondieron a las situaciones diarias registradas durante las semanas antecedentes a las mismas. Los hallazgos muestran que estas reuniones están insertadas regularmente en el servicio. Las relaciones de poder y las diferencias de experiencia y conocimientos técnicos entre los diversos profesionales parecieron contribuir para la mayor o menor colocación de avisos y asuntos. Como son un espacio que favorece cambios, sugerimos la utilización de estas reuniones en otros servicios de salud que trabajen con equipos de atención.

DESCRIPTORES: grupo de atención al paciente; cuidados diurnos; psiquiatría; salud mental

TEMAS E UTILIZAÇÃO DO TEMPO PELOS PARTICIPANTES DE REUNIÕES DE EQUIPE GERAL EM UM HOSPITAL-DIA PSIQUIÁTRICO

O presente estudo, configurado como pesquisa naturalística, conduzida pela observação, teve como objetivo caracterizar as reuniões de equipe geral de um hospital-dia quanto à temática e à participação dos profissionais na utilização do tempo. Foram comunicados 144 avisos e discutidos 46 assuntos em 21 reuniões observadas, com participação maior da equipe fixa nas discussões. Em 18 das reuniões estudadas, houve correspondência entre os temas discutidos e as situações diárias registradas nas semanas que antecederam as mesmas. Os achados mostram que essas reuniões estão inseridas regularmente no serviço. As relações de poder e as diferenças de experiência e conhecimentos técnicos entre os diversos profissionais pareceram contribuir para a maior ou menor colocação de avisos e assuntos. Por ser um espaço favorecedor de trocas, sugere-se a utilização dessas reuniões em outros serviços de saúde que trabalhem com equipes de assistência.

DESCRITORES: equipe de assistência ao paciente; assistência diurna; psiquiatria; saúde mental

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INTRODUCTION

Psychiatric treatments have historically gone through different approaches, ranging from mystic-religious, moral and biological ones to, more recently, approaches attempting to offer a more humanitarian care to patients. Several models are found in current practice, which result from the reforms implemented in mental health policies. The available proposals include partial hospitalization, in Day Hospitals.

The Day Hospital (DH) studied here attends 16 users older than 15 in a psychiatric semi-hospitalization regime. It functions every day, from Monday to Friday, between 7:30 and 16 hours. Programmed activities are offered, such as operational groups, social therapies, family interviews and meetings, individual psychotherapy, occupational therapy, physical activities, recreational activities, educational meetings, community meetings, besides activities volunteers developed at the service (choir and yoga). Furthermore, immediate post-discharge outpatient care is offered during three months, as well as a weekly long-term care group to improve the social integration of patients who left the service.

As this is a university service, besides care, the service is also directed at teaching and research, with in-service training for professionals from areas related to Mental Health who take their training period on site. This configures two groups, one fixed and another floating, each with characteristic properties[1]. The first consists of the professionals from the permanent work team, while the second is composed of graduated professionals who attend the service to comply with requisites from specific graduate programs in Mental Health and, occasionally, undergraduate students.

Since 1974, the two groups participate in a meeting known as "general team meeting" (GTM), to address administrative subjects, interpersonal relations and conduct involving patients. Among the specific objectives of these meetings, the following stand out: visualizing and assessing teamwork; addressing emerging conflicts; promoting further integration between the fixed team and trainees; establishing exchanges between both groups; discussing conducts with the participation of a larger number of service professionals and assessing the traineeships with the presence of all DH professionals.

Since 1987, in turn, the fixed team has participated in the "fixed team meeting" (FTM), to continuously reflect on their practice, discuss bureaucratic and administrative issues and address conflicts among sectors. Thus, the team is strengthened as a group that maintains the service.

In 1992, the "community meeting" (CM) was created, which is open to members of the DH and aims to favor the community's organization; bring patients, fixed team and trainees closer together; promote the relief of tensions among the groups and seek a more social and collective dimension for private issues[2].

These three meetings constitute the axis that sustains the service, and the evolution of the work proposal highly depends on them[2]. The GTM is an activity that has been maintained at this institution for more than two decades, offering a space for teaching-learning. It seems to be a space for democratic exchanges among participants. This hypothesis gave rise to the interest in researching on the GTM.

Studying the GTM is a complex task, as some variables are hard to control, such as each member's individual aspects for example, the situations the group is experiencing, considering aspects of the institution, society and the interaction between professionals and clients. Thus, this study aimed to characterize the GTM in terms of themes and participants' time use in a given period.

METHOD

The strategy chosen for this study was natural research, that is, the investigation of the phenomenon within and in relation to the natural context it occurs in. In this kind of research, the examined environment (naturally occurring event, program, community, relationship or interaction) does not have a course that is predetermined and established by or for the researcher[3].

Characterization of study situation

The GTM were held every week, took one hour and were coordinated by a fixed or floating team member. The first 10 minutes were used to give notices and choose the themes for discussion in the remaining

time. The team had agreed to limit the number of topics to three per meeting, so as to make possible discussions.

Eleven professionals were part of the fixed team: two psychiatric faculty members, one assistant psychiatrist, two nurses, one social worker, one occupational therapist, one recreationist, two nursing aids and one administrative aid. There were eight trainees: three resident physicians, three specialization course students (psychology, social service, occupational therapy), one postdoctoral student in mental health (social worker) and one undergraduate student (occupational therapy). Professionals from other services and institutions who were occasionally present during GTM were identified as visitors.

Data collection and analysis

The procedure used was non-participant observation[4] of 21 meetings held during a six-month period. In this research, the observer had contact with the GTM but did not take part and remained an outsider, witnessing the facts without participating in them, without getting involved in the situations, that is, being more of a spectator. The observation was ordered and directed to the established goal, using a systemized protocol to collect data, which had been defined and tested in the pilot phase of the study. The records permitted focusing on the content (what the group was saying) and the communication process (who was speaking and how much)[3-5].

The observers were the first author of this study and a psychologist, both of whom used to be trainees at the DH before the data collection period. Their training took place in the construction phase of the data collection instrument, and a minimum agreement of 80% was obtained between the obtained records. For each GTM, the protocol was used, which included notices, subjects, the member (previously defined individual two-letter code) and the duration of the person's talk.

To record notices and subjects, theme categories[6] were established, extracted from the material recorded in minutes of 44 GTM that took place during the year before data collection, and tested in the pilot phase. The themes related to the notices and subjects were defined as follows: **service routines and functioning** (R) - activities, times, explanations and clarifications about functioning and occasional changes in the routine (such as strikes, holidays); **physical structure** (PS) - maintenance and modifications in the physical structure (installations), building or environment; **patients** (P) - indication for treatment, adherence, evolution, management and conduct with the users; **trainees** (T) - start and end of traineeships, evaluations, relationships between trainees and between them and the fixed theme and their specific difficulties; **scientific activities** (SCA) - participation of DH professionals in scientific events (congresses, symposia, conferences, courses), publications and studies about the DH; **social activities** (SA) - parties, get togethers, encounters, cocktails, trips, shows by team members with or without users and with or without the community; **visitors** (V) - reception and organization of the service for visitors; **attendance** (A) - trainees' and fixed team members' attendance at meetings and DH activities (absences, delays, holidays); **fixed team** (FxT) - temporary or permanent absence of fixed team members (health leaves, leaves of absence, retirements and resignations). These categories were used to register the data collected from the 21 GTM.

In order to establish a relation between the daily service reality and the GTM, two team members registered the situations that happened during the period between one meeting and the next. The material registered in this way was submitted to thematic content analysis[6], based on the previously defined notices and subjects.

The research project was defined by the Institutional Review Board of the institution the DH is inserted in. The team members were asked to give their informed consent during a general service meeting, which was recorded in the minutes.

To analyze the findings, the theoretical reference framework of individual, group and organizational psychodynamics was used[5,7-9].

RESULTS

Notices and subjects

In the study period, 144 notices were communicated, 10 (6.94%) of which were transformed into subjects. According to Table 1, GTM participants

more frequently gave notices in the categories **attendance and routines**, corresponding to 101 (70.1%) of the total. Trainees produced 18 (12.5%) notices and fixed team members 126 (87.5%).

Table 1 - Distribution of Notices in GTM at a DH, according to categories, informants and notices transformed into subjects

Categorias	Fixed Team		Trainees		Transformed into Subjects		Total	
	f	%	F	%	f	%	f	%
Attendance	70	55.5	10	55.5	0	0	80	55.5
Routines	20	15.9	1	5.6	2	20	21	14.6
Social Activities	11	8.8	1	5.6	3	30	12	8.3
Scientific Activities	7	5.5	4	22.2	3	30	7	7.6
Physical Structure	8	6.3	0	0	0	0	8	5.6
Trainees	4	3.2	2	11.1	0	0	6	4.2
Patients	3	2.4	0	0	2	20	3	2.1
Visits	3	2.4	0	0	0	0	3	2.1
Total	**126**	**100**	**18**	**100**	**10**	**100**	**144**	**100**

Table 2 - Distribution of Subjects in GTM at a DH, per categories and proposing subjects

Category	Fixed team		Trainees		Total	
	f	%	F	%	f	%
Routines	9	25	3	30	12	26.1
Patients	6	16.7	4	40	10	21.7
Social Activities	8	22.2	0	0	8	17.4
Trainees	5	13.9	2	20	7	15.2
Scientific Activities	5	13.9	0	0	5	10.8
Fixed Team	1	2.8	1	10	2	4.4
Physical Structure	2	5.5	0	0	2	4.4
Total	**36**	**100**	**10**	**100**	**46**	**100**

Table 2 presents the subjects that came up in the meetings and their distribution according to categories and proposing subjects. It is observed that the predominant subjects were related to administration and conduct involving users, in the categories **routines**, **patients**, **social activities** and **physical structure,** totaling 32 (69.5%) of the 46 themes that were discussed. The subjects related to the professionals, teaching and research, represented by the categories **trainees**, **scientific activities** and **fixed team,** corresponded to 14 (30.5%) of the total. Fixed team members proposed 36 subjects (78.3%) and trainees 10 (21.7%).

Comparison between meeting records and daily DH records

The records made during the weeks before each of the GTM are presented in Tabel 3 and were compared with data from Tables 1 and 2.

Table 3 - Distribution of notice and subject categories* during GTM at a DH in comparison with daily service situation records

GTM	Notices	Subjects	Daily Situations
02	SCA; PS; T; A	SCA; R; FxT	SCA; R; FxT; PS; V; P; SA
03	P; R; PS; SA; SCA; T; A	P; R	P; R; PS; SA; SCA; T; FxT; V
04	R; PS; SCA; T; V; A	R; PS; SCA	R; PS; SCA; T; P; FxT
05	R; P; A	R; P	R; P; PS; SCA; FxT; V; T
06	FxT; R; V; A	FxT; T; SA	FxT; T; SA; R; V; SCA; P
07	SA; SCA; R	SA; SCA; P	SA; SCA; P; R; FxT; T; V
08	SA; A; PS	P; R	P; R; SA; V
09	R; PS; SCA; T; A	R	R; PS; SCA; T; SA; V; P; FxT
10	R; FxT; V; A	P; T	P; T; R; FxT; V; SCA
11	—	SCA	SCA; R; PS; FxT; SA; P; T; V
12	SCA; T; SA; A	SA; P	SCA; T; R; V
13	SA; R; A	SA; P; T	SA; P; R; FxT; V
14	R; A	PS; SA	PS; SA; R; FxT; P; V
15	R; SA; A	T	R; P; FxT
16	T; PS; R; SA; A	T; P	T; PS; R; SA; V
17	R; A	T	T; R; FxT; P
18	R; SA; T; A	R; SA	R; SA; T; V; PS; FxT
19	R; P; SCA; SA; A	R	R; P; T; V; PS; FxT
20	R; SCA; A	R	R; P; SA; FxT
21	R; SCA; A	R; P	R; P; SCA; V; T; FxT

* Category description: R - service routines and functioning; PS - physical structure; P - patients; T - trainees; SCA - scientific activities; SA - social activities; V - visitors; A - attendance; FxT - fixed team.

Daily service situations were recorded for analysis as from the second GTM. Total or partial correspondence was observed between the discussed subjects and the daily situations registered at the service, in 18 of the 20 weeks under study. The category **fixed team** was listed 17 times in daily service records and appeared once as notice and twice as subjects during the meetings. The theme **trainees** appeared 14 times in daily service records and nine times in GTM. **Visits** were mentioned 14 times in daily notes and as notices in three GTM.

Participation

The duration of each GTM ranged from 49 to 67 minutes and 30 seconds, with a mean time of 58 minutes. The mean silence per meeting was 42 seconds. In only one meeting, there was silence for 5 minutes.

As to usage time, the team members' verbal participation was distributed as shown in Figure 1.

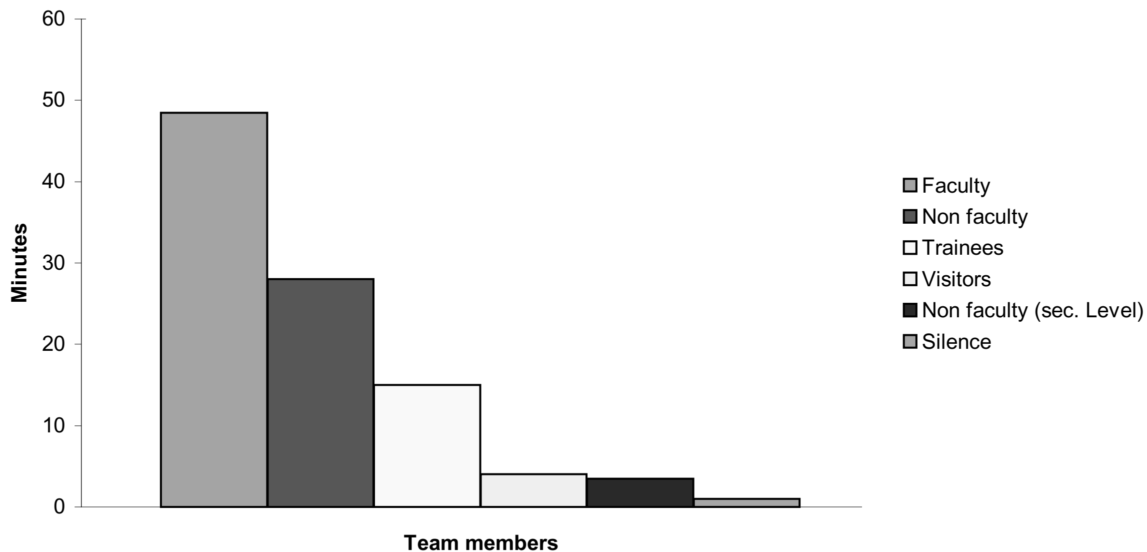

Figure 1 - Verbal participation of GTM members from a DH according to time occupation during meetings

The verbal participation of the DH's interdisciplinary team members in the study period, in view of the time occupied in the choice and the discussion of the themes, in Figure 1, shows that the faculty members talked most. They occupied 48.5% of total time during the 21 GTM, that is, almost half of the meeting time. The other participants used 50.5% of the time, distributed as follows: non faculty higher education level 28%; non faculty secondary level 3.5%; trainees 15%; visitors 4%. Silence corresponded to 1%.

Non-faculty employees with higher-level functions proposed 20 (43.5%) of the subjects discussed in the meetings during the study period, followed by the faculty members with 16 (34.8%) and trainees with 10 (21.7%) subjects. The subjects proposed by the trainees were all chosen by the resident physicians.

DISCUSSION

The importance of the general team meetings for the DH can be observed through the information presented in a retrospective survey, covering a ten-year period, which registered minute transcripts of 437 GTM, that is, an average of approximately 43 GTM per year[10]. This is a considerable number if one considers holidays. During the six months of this research, 21 meetings were observed, that is, almost one meeting for every week under study. These data show that the DH team values these meetings, which can be a sign that the space they offer is well-used.

The equivalence between the categories of notices and subjects and the possibility of using them to categorize the daily situations from the weeks before each GTM permits concluding that there is a constant circulation of information at the service, apparently in accordance with the meeting's objectives. The correspondence between the daily situations and the subjects discussed in 18 of the 20 meetings that were assessed (Table 3) allows us to infer that these results indicate that the service context was examined during these meetings.

The notice and subject categories appeared more frequently in the records of daily DH situations than in the corresponding GTM (Table 3). This is understandable, as both the time and the number of subjects are limited during the meetings. However, the findings related to the categories **fixed team, trainees** and **visits** cannot be ignored. As to the low frequency of the **visits** category during the meetings (Tables 1 and 2), as the team is accustomed to this routine, members may not feel the need to discuss this theme.

The low frequency of subjects related to **trainees** and the **fixed team** during GTM (Tables 1 and 2), may be justified by the hypothesis that the existence of weekly fixed team meetings (FTM) makes it easier for the fixed professionals to leave some specific themes for discussion during this meeting. The FTM seems to make it easier not to account for all problems inherent in interdisciplinary work, like that of the team in question, in the face of the trainees. Hence, the general objective of the GTM, which is to

facilitate the articulation between the trainees and the fixed team, addressing subjects related to the interpersonal relationships among its components, would not be fully contemplated.

When considering problems related to interdisciplinary team work, literature[11] evidences other factors that can also be related with the results of this research: 1. the need for further clarification of roles and the distribution of functions among team members; 2. interpersonal communication with problems; 3. hierarchical differences marking relations; 4. the occurrence of in-service training; and 5. each member's time at the institution.

The trainees participated verbally, occupying 15% of meeting time (Figure 1). This timid participation in the GTM under study can reflect their lack of experience, making them assume a secondary role in the choice and discussion of themes. The fact that their professional identities are still under construction can favor their expressions of insecurity and persecutiveness.

The therapeutic community environment favors greater exposure of learners, so that their weaknesses become more evident. The young make efforts in the search for knowledge and identification with their supervisors, seeking in them a professional model they want to be in the future. Sometimes, they end up behaving like children that wait for their parents' directions, which makes the group function at the level of the basic dependence assumption[12]. Hence, more experienced professionals are expected to assume the role of facilitators in the trainees' development, serving as a model and looking over them more carefully and containedly, so as to favor their integration and learning. If not, frustration, persecutiveness, envy and the feeling of inadequacy can make it easier for these young people to adopt a posture in which they silently alienate themselves at the institution or even end up implementing actions that sabotage service tasks.

Therefore, the fact that the DH trainees are experiencing a very special moment in their professional training cannot be underestimated. Their previous learning at college institutions was centered on the bi-personal relation. Interdisciplinary team work in the therapeutic community model presupposed a plural dimension in the therapeutic relation. Clients are no longer "mine" but become "ours". In a parallel way, the new Curricular Guidelines of undergraduate courses have attempted to privilege professionals' more humanistic education, stimulating them to assume a more critical and reflexive posture and enabling them to attend to local and regional demands, with the social commitment to make changes[13].

The search for cohesion in the professional group of any interdisciplinary team and the need for a space to reflect on direct practice involving users has been a consensus in specialized literature. Therefore, systematic meetings of team professionals emerge as a resource to facilitate the integration among different ways of thinking and acting. The discussions are implemented so as to review concepts, postures, attitudes, conducts; provide for innovations in practice; address emerging conflicts and facilitate interpersonal relationships among team members and between them and users. As they contrast with verticalized hierarchical decisions, at any institution, team meetings facilitate the democratic distribution of authority to perform the tasks[5,7].

Institutions or organizations can function according to the requisite or *paranogenesis* model[7]. Requisite institutions have a functional administrative structure, that is, authority and responsibility combine. *Paranogenic* institutions end up molding behaviors that lead to mistrust, envy, rivalry, anxiety and hostilities, making interpersonal relations difficult, even when individual good will exists.

The DH's characteristics and functioning of the GTM seem to favor *paranogenesis*. There seems to be an attempt to control the *paranogenesis* by establishing democracy in the GTM. However, as a political system, democracy works better in the social regulation of open societies. As a limited social organization, that is, with a restricted number of delimitations and specific primary tasks, the GTM requires a functional leadership. The functional decision involves the possibility of group discussions and decision making among leaders from a specific hierarchical level. Authority can be delegated to any of the involved groups, but the leaders who hold the legitimate power (authorities) are still responsible. This can make the functional organization seem democratic when, in fact, it corresponds to the functional principles of the social organization[5,7].

In view of the professional category of the components of the DH team's two groups, that is, the fixed and the floating, it could be observed that the physicians prevailed in the occupation of time and choice of themes for discussion during the GTM. Among the trainees, the resident physicians proposed

ten (21.7% - Table 2) out of 46 subjects. Medical faculty members talked most, occupied almost half of the meeting time (Figure 1) and suggested 16 (34.8% - Table 2) discussion themes. Their responsibility for teaching and research, the structural administrative concerns of the institution the service is inserted in (University) and the necessary worries with the care population can favor the hierarchization and fixed determination of the leadership function and the consequent legitimate power. Thus, delivering care, teaching, serving as a model, administering and also developing research are functions that end up facilitating or pressuring members from this group to participate more in the GTM. This makes it possible to infer that, in the theme under study, there are knowledge and power differences. What power is concerned, it seems that, like in most university hospital services, the medical model is hegemonic[14-15]. Hence, DH physicians appear as the group with authority over the service, that is, which assumes responsibility and functional leadership[5,7].

Daily contact with the problems created by illness and consequent losses tends to create defensive behaviors in the care team. The medical professional's often omnipotent posture can appear as the dislocation of tensions to the auxiliary staff or clients. This ends up stimulating dependence in them, which is facilitated by the regression conducted by the disease itself. However, this dependence can increase demands, frustrations and ingratitude or persecutory situations among people receiving care as well as among auxiliary technicians. Another possible attitude is identification with the problem the institution intends to solve, which can make it acquire the same structure and meaning. In the case of a mental health service, this can segregate and alienate its users, while it actually aims to reintegrate them[9].

A hospital, as an institution the client can turn to in case of a disease or problem that affects his/her integrity, essentially aims to provide favorable conditions for his/her rehabilitation. However, sometimes, it ends up structuring itself according to health and administrative professionals' convenience, which are frequently opposed to users' needs. The institutions repeat life, that is, its dynamic nature and the presence of conflict are immanent. The universal character of the tendency towards the institutionalization of human groups, the progressive distancing of the group's original objectives to the extent that its institutionalizing process occurs and the conquest or maintenance of "power states", appear as characteristics of any human grouping, that is, groups are always power-seeking instruments, which is inherent in the human condition[7-8].

Another justification for the differences observed in the team members' verbal participation (Tables 1 and 2, Figure 1) could be the fact that the team includes professionals with different educations, qualifications and affiliations with the institution, interacting in a university service. Fixed team members have different education levels, while the difference among trainees refers to the models they have learned. The heterogeneous composition of the team can facilitate disagreement and knowledge shock. These differences and their developments, in turn, derive from the division of human sciences, which tend to seek refuge in their small intellectual feuds[14,16].

Besides presenting technical differences in terms of knowledge and attributions, the specialties that make up a team can receive an unequal treatment within the group itself. This ends up making possible a climate of tension among team members (each of whom has his/her own knowledge and autonomy), characterizing the team as a "grouping" (juxtaposed actions and grouping of professionals) or "integration" (articulated actions and interaction among professionals). This evidences that the reciprocity between work and interaction is essential for teamwork, with communication among professionals as its support base[14,16].

In the meetings observed at the DH, the team members' different participations can reflect these and other defense mechanisms aroused by knowledge and power relations. These aspects deserve assessment through the inclusion of institutional supervision into the routine of a service like the one studied here. Institutional psychology can be an effective therapeutic approach when applied at health institutions[8-9,14].

During the study period, the DH team did not directly discuss themes related to feelings of frustration or helplessness in the face of practice with patients in mental suffering, which sometimes creates anguish. No mention was made of seeking external supervision for the professionals. This does not differ from findings in a study about nursing practice at psychiatric day hospitals in the State of São Paulo, which observed the occurrence of supervision in only three (20%) of the 15 services that were examined[17].

For the effective functioning of a health team, its components' objectives must be shared,

clear, understood and accepted, preferably by everybody. In case of individual goals, these must be compatible with the group's[5,11,15]. The motivation to perform the task must be nourished constantly. This is found in the exchange itself with users and other team components, where each member can feel that the satisfaction with the realization of his/her task rests in participation and in being able to extract the enrichment of learning from shared therapeutic experiences. The team's common objectives seemed to be in conformity during this DH's general team meetings, although the individual objectives and motivation of group members were not assessed.

In view of the service characteristics and different professional groups composing the (fixed and floating) teams, the meetings under study favor a space for constant teaching-learning. According to the observations in this study, the meetings seem to be structured as a space for encounter and possible integration among professionals. The dynamics of their functioning inserts the GTM into the service as a part of its structure, of its support base, needed for the existence itself and continuation of the DH's activities.

It is known that attending people experiencing emotional suffering is a hard and painful task that mobilizes the most diverse feelings in professionals. Therefore, the climate of reliability that can be created on the basis of team meetings, which is not immune to conflicts, is facilitated by the professionals' and trainees' increased creativity and pleasure in the realization of tasks. If this occurs, users, in turn, detect the spontaneity produced like this and can internalize the experienced model and seek less strict forms of relating. This favors the construction of a space of continuous improvement in mental health practice.

Like any health service, the DH is inserted in a society and, therefore, subject to its expectations and demands (macro-social context). These can interfere in team members' relationships or behaviors. The GTM's functioning, in turn, ends up reflecting these situations. Would the subjects discussed during the meetings be independent from external variables and would they repeat themselves over time? Would they be different at other times? These questions remain open.

FINAL CONSIDERATIONS

This study about general team meetings at this DH made it possible to identify them as a component part of the service and to understand them better by examining their functioning. Based on the presented results, their use is suggested in interdisciplinary mental health team practice in "therapeutic communities", whether directed at teaching, research or care.

The inquiries aroused by this research, in combination with the presented results, stimulate future research on interdisciplinary team meetings, whether at this DH or at any other health institution.

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