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Invited Keynote Address:
Joining Up Working

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Abstract

Terms for models of co-professional working are at times used interchangeably in policy documents, but definitions for 'named types' do exist. A classification framework is outlined, and discussed. The models that may be used are influenced by the structures within which staff work and the ease with which co-professional contact can be made. Integrated services will require to make decisions about the models they intend to foster, but resource limits will play a part. Options are discussed with reference to speech and language therapists and teachers working together, which provides a long-established and well-researched example, and the practical need for 'good enough' models of co-working is stressed.

Introduction

This introductory seminar is concerned with interprofessional and interagency working, and this paper specifically addresses seminar questions three, four and five about the effects of specific models of co-practice, the implications for practitioners and the ways in which schools need to reconfigure to include professionals from other agencies.

These issues are illustrated with reference to the work of speech and language therapists (SLTs) in schools in the United Kingdom as they seek to provide 'front-line delivery' of service. This is an illuminating example for several reasons. SLTs have already 'been around the block' with respect to their structural involvement in schools. Until 1974 therapists who provided services to schools were employed by education authorities. Since that date the vast majority have worked in the health service, and are now Allied Health Professionals (AHPs), regulated by the Health Professions Council. Their current involvement in schools is therefore an example of cross-sector or interagency working, where new structures are only now developing which aim to foster co-professional working.

SLTs' work in school has been subject to research and evaluation over time (for Scotland see Reid *et al*., 1996, and HMI, 1996; for England and Wales Law *et al*., 2000, 2002, and Lindsay *et al*., 2002, 2005a; for Northern Ireland NICCY, 2005). Their role is specifically discussed in relevant education acts and codes of practice across the UK.

SLTs are professionally committed to basing their services within schools and to planning jointly with education professionals (Gascoigne, 2006, p.17; RCSLT, 2005, p.25) to provide services as an integral part of a child's school life (RCSLT, 1996, p.54 currently being updated). Their focus on language and communication fits with the centrality of the language curriculum in schools, and large numbers of children have additional learning needs with a language and communication basis. As Forbes (2006) notes, a specific focus on SLT-education relationships has now been subsumed into wider policies of service integration. As these are being formulated it may be worth revisiting this relatively well-explored example to shed light on issues that affect interagency working between education and the other services in general, and health services in particular.

The paper therefore considers the variety of ways in which co-professional working can operate, how SLTs and teachers currently operate and why this is, and considers future options for integrated services.

Models of working together

It is worth considering what models of co-professional working are available. Several are described, usually defined from the perspectives of the professionals involved.

Terminology is problematic and terms are used differently across policy documents and within the literature. For example, 'multidisciplinary' appears in both *For Scotland's Children* (Scottish Executive, 2001) and *Every Child Matters* (DES, 2003) in what is probably a common usage to describe the situation where a number of different professionals are involved. *For Scotland's Children* lists education, social work and health staff (p.74) and then community education, mental health and housing management staff (p.85) as forming multidisciplinary teams. *Every Child Matters* uses 'multi-disciplinary' for co-working amongst education, social care and health services (p.60), and later amongst health visitors, nursery nurses and community development workers (p.93). However, *Supporting Children's Learning*: *The Code of Practice* (Scottish Executive, 2005, p.135) retains the term multidisciplinary for instances where professionals from different disciplines within the same agency work together, such as an SLT with a health visitor. Where the professionals come from different agencies the term 'interagency' is used, and by this definition a teacher and SLT working together would not be described as a multidisciplinary pairing.

'Collaboration' is another term that has received several definitions. Williams and Salmon (2002) use the term generically when discussing all aspects and styles of joint working practice. However, Kersner (1996) discussing SLTs in schools follows Conoley and Conoley (1982) in retaining 'collaboration' to describe situations where individuals join in an egalitarian partnership to achieve a mutually determined goal. Marvin (1990) uses the term to describe teachers and SLTs engaging in informal networking who have a shared responsibility for children and DiMeo, Merritt, and Culatta (1998) use collaboration only where there is trust, mutual respect and personal support, free and honest discussion and shared responsibility for planning.

Where terms are used differently and are also in common usage it is unlikely that their meanings can now be constrained - document-specific definitions and glossaries are probably the best that can be expected. However, it is worth attempting a

classification to consider and gain some clarity about dimensions considered relevant by those describing co-professional practice.

Writers have tended to classify models of co-professional working using four aspects: first, who works with a client to carry out planned activities, usually designed to meet health or learning targets; second, how egalitarian and third, how supportive are professional relationships, and last who agrees targets, here used as shorthand for any agreed end. These will be considered in turn in relation to professional working with school pupils, leaving aside for the moment considerations of how children and their families also are involved in agreeing and meeting targets.

Who works with the child

Professionals may work either directly with a child or indirectly, where learning activities are delivered by others (and so these terms are used from the professional's point of view). 'Others' can include professionals or assistants such as SLT assistants, classroom assistants or learning support assistants. Where implementation is through an assistant a professional retains responsibility and accountability for the assistant's performance: otherwise much responsibility for implementation lies with the professional undertaking the activities.

Egalitarian relationships

Some inequalities are formalised within job descriptions, such as that between a professional and an assistant or a professional and a manager. Here good relationships can be formed, but by definition not egalitarian relationships. Co-professional work often involves professionals who have nominally equal status in that neither is 'the boss of' the other in formal employment terms, and each has their own area of knowledge and expertise to share. Working together with equals should be a key feature in co-professional work, although in practice some may prove to be more equal than others.

Supportive relationships

Supportive and trusting relationships and mutual respect can arise or not irrespective of how egalitarian a relationship is – it is possible to trust, respect and receive support from an assistant or boss and to mistrust an equal. This dimension is concerned with inter-personal comfort and rapport.

Who sets targets

Where nominally equal professional relationships pertain, ways of setting targets have been used to distinguish models of working. McGrath and Davis (1992) distinguish 'multidisciplinary' models that involve professionals setting targets independent from 'interdisciplinary' models where targets are set and agreed jointly. In both cases learning activities are often delivered by professionals separately. Mackey and McQueen (1998) use the term 'transdisciplinary' to reflect joint goal-setting where the resulting learning activities are delivered by the professionals together, with considerable role-release as every member of the team contributes to holistic learning experiences as the need arises. RCSLT (Gascoigne, 2006, p.16) regard transdisciplinary models as central to work with children within integrated teams.

Named types

Considering these dimensions allows us to chart some of the types of co-professional working that have been described. Figure 1 summarises some of the types noted in the literature. In each instance some information is shared, and used to influence future decision-making: 'expert' models where one professional works quite independently are omitted. Figure 1 uses only three dimensions, but Marvin (1990) and DiMeo *et al*. (1998) would add the dimension of positive interactions through relationship building to interdisciplinary and transdisciplinary types to form 'collaborative' modes.

Targets agreed jointly:	**Activities delivered by:**	**Nominally egalitarian relationships:**	**Named variety:**
No	Each professional separately	Yes	Multi-disciplinary [1]
Yes	Each professional separately	Yes	Inter-disciplinary [1]

Targets agreed jointly:	Activities delivered by:	Nominally egalitarian relationships:	Named variety:
Yes	Professionals working together	Yes	Trans-disciplinary [2]
No	Professionals working together	Yes	Co-teaching[3]
No	Assistant	No	Expert – aide or Transfer[4]
No	Another professional	Yes	Consultancy [5]
Yes	Another professional	Yes	Co-operation [6]

Figure 1: 'Named Types' of professional co-working
1 McGrath & Davis (1992); 2 Mackey & McQueen (1998); 3 Creese (2002); 4 Cunningham & Davis (1985); 5 Law *et al*. (2002); 6 McCartney *et al*. (2006).

There is nothing intrinsically better or worse about any type of co-working, and each model may be used successfully in some contexts. (The somewhat anomalous situation where professionals in formally egalitarian relationships deliver activities together without planning targets jointly is found in a study by Creese, 2002, describing how teachers specialising in English as an additional language co-taught with secondary school subject teachers, concentrating on language issues. The pairs had not consistently planned together, and in this example were all teachers rather than coming from different professions. Creese's example is not an entirely happy one - the relationships became less than egalitarian in practice - but the named type of working is not dissimilar to that used successfully within many higher education post-graduate tutorials.) Some types, however, share more dimensions considered to be positive than others, particularly joint target-setting and working together, and much writing is from professionals celebrating the achievement of closer working relationships in terms of professional satisfaction (Miller, 2002) and (more rarely) child benefits (Wren, Roulstone, & Parkhouse, 2001). These two aspects should probably be kept separate - there is to my knowledge no strong evidence that closer working relationships that benefit staff also benefit children, despite a common (and commonsense) assumption that is does. Different types may also have different 'transaction' costs (Hudson & Ranade, 2003), the time spent meeting, agreeing, planning and working together as well as maintaining relationships, and so different staffing implications.

Closer interactions may flourish where there is continuity of staffing, joint responsibility, and time to plan and discuss together. For example, Wright (1996) reports that the more SLTs and teachers had opportunities to collaborate the more they valued it, and that working in close proximity helped information exchange. DiMeo *et al*. (1998) note that building a collaborative working relationship is like building a personal friendship, requiring time to develop and sustain, and so it is not reasonable to expect SLTs or teachers to achieve collaboration with all professionals with whom they interact. Williams and Salmon (2002) suggest that working together is facilitated where teams can anticipate long-term relationships amongst members, with stability in the appointment of key individuals, and with regular contact sustained.

Such facilitative factors should be considered when considering building new integrated services, if an aim is to develop closer partnerships. However, at present they do not commonly pertain, and the current situation reflects their absence.

What currently happens in the UK

Types of co-professional working encountered in practice reflect the opportunities afforded to professionals. McCartney, Ellis, and Boyle (2006) discuss how SLTs' and teachers' desire to develop language skills in the social and educationally rich classroom environment has coincided with SLTs' need to offer service to a large number of children with limited staff resources. This has led to widespread, although not exclusive, use of consultancy models of SLT service delivery (Law *et al*., 2000), where SLTs provide teachers with advice and guidance on language teaching procedures to be implemented by school staff.

Consultancy approaches are not particularly close models of collaboration, and their widespread adoption has received critical comment. Law *et al*. (2002) recognise the assumed learning benefits for children who undertake language work in their classroom, but also that severe service capacity limits have motivated the move towards consultancy services as 'a pragmatic solution to the problem of coverage' (p.154). Lindsay *et al*. (2002) make similar points, questioning whether consultation approaches have become the method of choice for professional or pragmatic reasons (p.200). Law *et al*. (2002, p.158) note that the consultancy model relies heavily on

the availability and commitment of educational staff with whom to consult, and that there are low numbers of staff with specialist language skills in schools, running the risk that activities recommended by an SLT may not be implemented systematically in the classroom. McCartney, Boyle, Ellis, Turnbull, and Bannatyne (2004a) found this fear was justified, in that language intervention activities shown to be effective in developing expressive language for children with language impairment when delivered by SLTs or SLT assistants (Boyle, McCartney, O'Hare, & Forbes, 2006) were less effective when delivered by classroom staff. This appeared to be related to the amount of time children spent on the activities, which was less than in the Boyle *et al*. (2006) study and which varied considerably across schools. SLTs can advise, but if classroom staff cannot deliver language activities consultation approaches may not result in particularly effective experiences for children.

RCSLT (Gascoigne, 2006) have also registered concerns about consultancy approaches, stressing the need to replace the term with a more accurate description of the service being delivered, and to uncouple consultancy used to enhance a child's levels of activity and participation from resource issues:

> Unfortunately, where models involving the delegation of tasks and programmes to others have been perceived as resource saving strategies, the positive reasons for such approaches have been lost. (p.18)

McCartney *et al.* (2006) suggest some ways of developing and improving the consultancy model, but this is hardly service-integration utopia. The SLT will still tend to be seen as an 'outside expert', advising teachers on what to do rather than developing partnerships that draw together the specialist knowledge of each profession. Teachers may feel pressurised or coerced into carrying out language activities, or into allocating tasks to their classroom assistant without feeling confident about their ability to supervise appropriately. The SLT's priorities may clash with the teacher's. Misunderstandings may arise, and synergy may not be achieved.

Why is this situation continuing?

Given that 'better' ways of working together exist, it is worth considering what has led to consultancy models being set up and sustained in mainstream schools. Hopes for language learning and generalisation and limits of staff to carry out direct work have been raised, but other factors are also relevant. As McCartney (1999) discusses,

health and education services are radically different organisations, giving rise to systemic factors which tend to hinder co-professional working. These will be considered using the systems headings presented by McCartney but in reverse order.

It is particularly encouraging that the systems environment in which services operate has become publicly friendly to interagency service development, although the opinions of staff and service users about integrated services will require to be continually monitored. Processes of planning for and delivering learning activities remain similar in health and education, involving the setting up and reviewing of co-ordinated support plans and statements of special educational need; devising and delivering individualised education programmes; and children monitoring their own learning. Limits to co-working remain chiefly around structures and functions. Structures that should facilitate co-professional working are now developing, such as new community schools, community health partnerships, children's services commissioners and aligned budgets. These are not as yet fully in place, and the continuing structural split between SLTs as health employees and education services has implications for models of co-professional working in terms of the different functions or goals of service that pertain.

Functional differences and limits to co-professional working

SLTs conform to highly determined health service philosophies and policies and their resulting procedures. Current key issues are reviewed here, and illustrative examples of 'culture clashes' raised by SLT students or collected during research with classroom teachers are presented.

SLT remains a commissioning service, offered only to targeted children where a specific need arises. SLTs also must prioritise such needs against the competing needs of other children for a similar service, taking into account both the potential benefits to be gained by the child and the costs of providing the service. This contrasts with education services who have to meet the needs of all children in their care, and who cannot take resources into account as a prime determinant of service provision.

Working only with selected children who have been accepted onto a case-load explains why an SLT cannot just 'take a look while they are in' at a child who is causing concern to a school: a clash that can be highly annoying to teachers.

As NHS employees SLTs may work only with children who are referred, accept service and join the 'case-load'. This has implications for ways of working in schools. As it is highly unlikely that all children in a class, particularly in a mainstream school, would be on an SLT case-load, types of co-working are limited. In particular, classroom-based group work carried out by an SLT or team teaching between an SLT and a teacher will be difficult to implement: the SLT has no 'right' to interact with children in the class who are not on the case list and cannot include them in groups along with a child who is (although the class teacher may do so if they consider it in the interests of all children). Lindsay, Dockrell, Mackie, and Letchford (2005b) found examples of joint SLT-teacher implementation of programmes and of SLTs offering direct support to children in curriculum subjects like science in specialist provision such as language units, but it would be most unusual to find this in mainstream provision, which is of course the default placement option for children in the UK.

This contrasts with education employees, for example learning support teachers, who form part of a school's repertoire of learning and teaching resources, and can work with all children. This difference explains why SLTs are surprised (and a bit shocked) when parents do not know that their child is working with a learning support teacher.

Selecting children also means that SLTs have to have clear standards of what will constitute 'case status', as they have a public health service responsibility to maintain equality of access to service (even and particularly where service is insufficient). SLT services therefore continue to spend time managing fair access to services, and attempting to construct equitable decision-making frameworks. This can compete with time taken to actually deliver services (and can cause problems - cf. Puttick, 2006) but is a corollary of selection, to prevent arbitrary or biased decision-making or services going to those who make greatest demands. Prioritisation parameters are not easy to construct and can be used to limit access to service (McCartney, 2000), and can upset schools, which offer services to all enrolled children. Determining who

should receive intervention can lead SLTs to spend a lot of time re-assessing and updating rather than 'getting on with' intervention - which can also annoy teachers who tend to assess children 'on line' while teaching.

Selecting children for service is ongoing in a context where there have been few attempts to plan a workforce sufficiently large to meet demand, unlike the planning undertaken to secure teacher numbers. Some workforce planning has begun in England in respect of AHPs (NHS Workforce Review Team, 2005) and has recorded low numbers of SLTs, who remain a shortage profession (Home Office, 2004) so that services struggle with high demand for services compared to staff resources. For example, Law *et al*. (2000) suggested that a case-load of around 40 children per SLT would be manageable in a school context, but Law *et al*. (2002) reported the average primary school case-load for children with speech and language needs as 123. There is therefore considerable overload on individual SLTs and pressure on services to be as fair and efficient as possible. Large case-loads also mean that SLTs run rigid timetables and cannot adapt to rapid short-term changes. This can frustrate teachers who want to liaise, and also SLTs if their work in schools is disrupted by other school activities. This is reportedly not a rare occurrence.

SLTs must ensure that confidentiality is assured, and information on children, families and services can only be transferred in pre-agreed circumstances, and with their consent. This explains why a teacher wanting to build up their personal skills and knowledge cannot visit to watch an SLT working with a child who is not the teacher's direct responsibility - or at least not without extensive discussion and agreement by all parties.

The health service is concerned with intervention and with 'what works' in a highly deterministic way. This affects the research designs used to measure 'outcome'. These are more complex than is sometimes realised, and are concerned not only with success but with the opportunities lost by offering or withholding service, and of the potential harm that can be caused by inappropriate interventions. Acceptable evidence of 'good outcomes' can reflect many aspects of health and wellbeing, and can relate to personal opinion, quality of life and evaluation of services received as well as measures of functioning. The aim is to perfect procedures and optimise interventions and to base procedures on the best evidence available. This has

differences with the research paradigms developing in education (Furlong & Oancea, 2005), particularly with respect to the idea of how far one can remove context from learning (McCartney, 2004).

Individual SLTs are therefore being judged against different research criteria from schools. NHS concentration on interventions and effects can mean that SLTs are puzzled by arguments for social inclusion framed only in terms of a child's rights and not as a matter of providing 'best' educational outcome. An understanding of research as an iterative investigative process involving trials and control of extraneous factors can mean that SLTs are unimpressed by policies that impose one educational approach (such as the use of synthetic phonics) upon children and their teachers without definitive randomised controlled trials (RCTs).

On the other hand, SLT services along with other health services are not compulsory. Unlike schooling which is unavoidable for children within prescribed age bands, each 'episode' of SLT intervention has to be agreed to by a child's parents, and by the child themselves from the point at which they have the capacity to understand the implications of the decision. For example, no research study concerning primary school age children would be funded that did not include procedures for obtaining the formal consent of each child, and extensive attempts must be made to ensure each child has understood and agreed to participate. A child can also leave such a study at any time, without giving reasons. A child's right to accept or reject SLT service can cause clashes with schools, particularly towards the end of primary school, when competence to make an informed decision about therapy can often be assumed, but where a statutory language curriculum still exists.

Given these factors, working together in the classroom and transdisciplinary approaches would be a very difficult to operate, and a consultancy model or at best a co-operative model is almost inevitable in mainstream schools, despite their limitations. This is less a decision about optimal co-working than the result of an absence of opportunity to make alternative decisions. It appears to be the best that can be done in the circumstances.

Reconfiguring services and preparing professionals

This seminar is taking place in a context where new services are being developed, and where the hope and expectation is that they will improve children's health, social and emotional development and their ability to learn. It is worth thinking forward to how services can be improved, and better meet these ends. One of the research questions posed concerns how schools should re-configure to include professionals from other agencies, but the discussion will continue to focus on both SLT and education services, and both pre-service and in-service issues, as a surrogate for health and education generally.

Considering the issues discussed above it seems to me there are some things that can be done to improve roles and relationships within existing structures, and to 'work' the prevalent consultancy model in a more productive way. There are also some things that new services could envisage changing, and some features that will probably not change and have to be recognised and lived with.

Reconfiguring within existing service structures

Suggestions for changes within existing services are based partly on recent research (Boyle *et al*., 2006; McCartney *et al*., 2004a, 2005a) which surveyed and talked to classroom teachers in mainstream schools and SLTs about their experiences of working together, as part of larger studies concerned with models of service delivery and cost-benefit analyses.

Co-working can be helped, we heard, by explaining the factors that lie behind unexpected cross-professional clashes as they arise, as is attempted in this paper. For example, teachers can be told that referrals are needed: they tend not to know this. However, they can also be told that SLT services will happily accept referrals from teachers with parental agreement (although headteachers tend to get a bit twitchy about this). Explaining professional assumptions before surprises occur is even better. Notions of consent, confidentiality, ethics, competition for service, efficiency and outcomes are perfectly comprehensible to both health and education staff, but they often require to be pointed out. Some SLT services have developed useful documents for schools explaining such factors.

Explaining, agreeing and committing to roles and responsibilities when using some version of a consultancy model, and recording what happens, is discussed at length in McCartney *et al*. (2006). Their model envisages that the considerable transaction time requirements needed for discussion, joint target-setting, and differentiated activities are built into such agreement. Existing monitoring and audit procedures that evaluate interagency work can be used to track how agreements are implemented.

Although this would be a step forward, this model probably places insufficient emphasis on the processes of learning to work together, and of learning how to do a new job, and on the feelings of uncertainty that can arise when coping with understandings one knows to be less than expert. Pre-service AHPs and pre-service teachers are now meeting with 'other' professionals to investigate co-working, and there are some in-service opportunities, but the issues remain new and challenging to many professionals. More training opportunities would help.

There are also issues about the inclusion of 'visiting' services that are only just emerging. Boyle *et al*. (2006) asked SLTs and SLT assistants who had been delivering services in schools to 119 children three times per week over 15 weeks how welcomed they felt by the schools. Schools for 69% of the children made SLT/As feel welcome or very welcome, for 27% of children schools made SLTs feel fairly welcome, and for 3% they were not very welcome (with 1% no response). Comments on 'very welcoming' schools included 'I was shown the staffroom, instructed to make coffee if I wanted to; the headteacher was often around and had informal talks'. Feelings of being 'not very welcomed' resulted when, for example, 'They never remembered I was coming'. Monitoring such factors and discussing the reasons behind such variation is probably needed before mutual trust and respect can be considered.

Configuring within new structures

New structures should consider their functions in order to set up structures. For example, if transdisciplinary working were considered desirable new services could move SLTs into the position now occupied by learning support staff who may work with children in addition to those on a defined case-load, although the views of parents and children about the value of this should be canvassed, and the need for

parental permission considered. This would open up new types of co-working such as classroom-based group work including SLTs. It would need careful management with issues of confidentiality as probably the major sticking point, and issues of best use of staff time would no doubt arise.

New services could, as Williams and Salmon (2002) suggest, aim to make and sustain long-term professional relationships and key appointments, rather than relying on short-term projects as has been common. This would make efforts to foster team-building worthwhile. Appointing individuals specifically responsible for managing and championing service integration and maintaining co-working (Ranade & Hudson, 2003) would be appreciated, preferably if these individuals were accessible and relatively local.

New structures to plan SLT and other AHP services to meet the expected demands would be very helpful. Workforce planning is already carried out for schools, and although not perfect provides a rough-and-ready match of staff numbers to children and classes. At present AHP planning is at a much more rudimentary stage, with limited agreement about the job to be done and who is going to do it. The background question is whether supported assistants could contribute to the provision of the same service just as effectively but more cheaply. And transferring skills to support workers is a main way in which SLT and other AHP services are being extended at present (McCartney *et al*., 2005b), with similar moves in schools. New structures that could reach principled decisions about such matters and determine appropriate staff numbers could remove the need to limit practice to meet resources.

Immutable differences?

This leaves out certain aspects of difference where I can foresee very little chance of convergence between health and educations, even within new services. A major instance is research, which I perceive to be a very sticky sticking point indeed. I see no way in which the evidence-based health service will accept the models of research being codified in education at present - they are too far away from the complex models currently in use. Whether education will bend towards health service models is also doubtful - an RCT of the literacy hour profiting from large numbers, assured

'compliance' and 'manualised intervention' seems unlikely, although without such studies policy decrees cannot be challenged. Perhaps the best solution is to explain the differences that pertain in the two services and ensure that professionals understand the paradigms that operate, and the limits to evidence that each produces.

But we can cope with diversity

New structures tend to want to set up teams by bringing a range of professionals 'in-house', and as stated there can be advantages. However, this cannot extend indefinitely - working with those not in the core team will often be needed, with 'outside' expertise required. Given this, even immutable differences between professions need not stop co-working. People need to work together specifically to gain access to the perspectives of others. A unifying culture is not essential - if teachers want to work with other teachers or other kinds of teachers they may do so. Where they want an SLT's perspective, they need a real SLT, including (most of!) their professional baggage. Explaining one to the other can be helpful, as suggested, but there is no need to construct some complex hybrid before co-working can take place. It is precisely the differences between professions that are relevant.

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