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Notes and Discussion

Barriers to collaboration: an analysis of systemic barriers to collaboration between teachers and speech and language therapists

Elspeth McCartney
University of Strathclyde, Glasgow, UK

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Abstract

A systems approach is used to examine the barriers to collaboration found in the working practices of speech and language therapists and teachers. Functional, structural and systems–environment barriers are found, but few process barriers, which may explain why good collaborative practice can be found in the field. The differences that serve as barriers are listed and discussed, with a view to fostering mutual understanding between teachers and speech and language therapists.

Keywords: collaboration, systems analysis, speech language therapy teachers.

Introduction

McCartney *et al.* (1998) outlined a systems analysis approach to educational evaluation that has proved useful in evaluating a small specialist centre for children with cerebral palsy. McCartney and van der Gaag (1996) used the same systems framework to suggest ways of evaluating the work of speech and language therapists (SLT) in educational settings generally. This systems approach, adapted slightly from Banathy (1992 1996), allows a useful conceptualization of a service, such as a school or SLT service, as a three-dimensional system embedded within a fuller systems network.

Such perspectives can be applied in real-life contexts to develop an appreciation among staff within a service of the impact of the service's functioning upon their

Address correspondence to: Elspeth McCartney, Department of Speech and Language Therapy, University of Strathclyde, Southbrae Drive, Glasgow G13 1PP, UK. e-mail: e.mccartney@strath.ac.uk

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own practices. One relevant context is where SLT and teachers are working together in close collaboration within mainstream and special schools to meet the needs of children with language difficulties. Professional and indeed government opinion converges on the sensible proposition that the needs of such children can best be served by close inter-professional cooperation, and in the joint planning of services and service delivery (RCSLT 1996: 54, HMI 1996: 33, DfEE 1997: 72); and there is evidence that school and SLT services are working together effectively in a variety of contexts (Kersner 1996, Reid *et al.* 1996, McCartney 1999). However, good collaborative practice is not wholesale (HMI 1996: 41, Wright and Graham 1997) and some difficulties remain. Indeed, the education system, where teachers are based, and the national health service, where SLT are based, differ so radically that it is perhaps surprising that good collaboration occurs as often as it does.

This paper uses the previously outlined systems analysis approach to consider some relevant differences between the two systems. Miller (1996) discusses SLT/teacher collaboration as benefiting from an educational process, and Daines (1992) and Newman (1996) have given accounts of some of the differences in perception between teachers and SLT. Such perspectives are grounded in differences between education and health systems, and there is a need to spell these out in detail, on the assumption that listing the inherent tensions and foregrounding them may foster mutual understanding of the opportunities and constraints which result.

Barriers to collaboration

Banathy's (1992) model was adapted to give the four dimensions of *functions, structures, process* and *systems–environment* (McCartney *et al.* 1998). These headings will be used in turn to outline the barriers that can hinder teacher/SLT collaboration. Schools and SLT services will be described in general, and the educational and health services in which they are embedded, although not all individual services will have identical characteristics. Since both health and education are UK-wide public services subject to national legislation, there is probably sufficient commonalty to justify this approach. Banathy explored his model in relation to schools, but also gave examples from healthcare systems.

Functional barriers

In Banathy's (1992) model, *functions* include the goals and purposes that are set and achieved by the system in focus, here the school or SLT service. Two major areas of functional difference can be identified for comment: notions of who the service is provided for (*all children* for education versus *targeted children* for health, leading to pathology or deficit models of intervention); and models of *inter-professional interaction*, including social interaction.

'Inclusion' versus 'caseness'

A fundamental functional difference between the services is discussed in McCartney and van der Gaag (1996). They note that school is an *allocating* service—children currently receive a fixed number of years in school irrespective of their individual circumstances, and indeed irrespective of how they personally perceive the benefits of schooling. SLT services are *commissioning* services, and intervention is only offered

to targeted children where a specific need arises: 'unnecessary' intervention in the wider health context is seen as an assault. SLT services are also increasingly *prioritizing* services (RCSLT 1996: 271ff.), where the needs of an individual are balanced against the competing needs of another individual for a similar service. To that extent SLT services are *rationing* services, where decisions about resource allocation are based upon both evidence of potential effectiveness and the overall resources needed to attain predicted results.

Policies encourage selection of appropriate 'clients' and assume that they can be differentiated from the normal population—the notion of 'caseness'. 'Cases' are prioritized according to the urgency with which they are to receive a particular service. SLT as providers of services are encouraged to outline their service allocation context and principles (DoH 1989, 1992) and have become increasingly involved in prioritizing, monitoring and evaluating service delivery (Meikle 1996). The amount of provision and service offered has been keenly debated.

These concepts are less fundamental within schools, where there is a notion of some equal amount of school provision and resource, and access to an agreed curriculum to be provided for each schoolchild. Children are encouraged to stay in education after the legal school leaving age, and the notion of a lifetime of learning and continuing professional development is current where adults continue to use educational services, although not usually school services, throughout their lives. There is no notion of an excess of education: learning, as a product of education, is rather seen as a universal good, associated with notions of citizenship, quality of life and personal opportunity; along with general gains to society arising from the aggregate influence of the educational process. Such assumptions are spelled out in government policy such as the UK Department for Education and Employment Lifelong Learning Project (Fryer 1997). In this context, the allocation of education to children is seen as a *right*, and is one that for the past two decades at least has been offered to all children, including those with special educational needs.

Some parallels between the services can be found in decisions about allocating additional support to children with special educational needs, but debates around who will receive basic services have not been necessary in education. The background assumption of school staff about children's rights to service may mean that they find an SLT prioritizing process unacceptable. A service that, in educational terms, cannot deliver intervention to pupils may be seen as ineffective.

A further, related, barrier to collaborative work can occur when children are selected for help by one service but not the other. A well-documented example (Shaw *et al.* 1996, AFASIC 1997, Luscombe personal communication) arose where educational services had prioritized certain children by opening Statements of Special Educational Needs. The cognate SLT services devised a carefully planned needs assessment, analysed the appropriate mode and frequency of SLT provision, and adopted collaborative working practices. However, restrictions on SLT resources meant that, with the agreement of the LEA and Health Authority Purchasers, SLT input was offered only every other half term, so that every child would receive their identified level of input in school on a half-termly rotation (Shaw, Luscombe and Ostime 1996).

Furthermore, the number of referrals meant that in the absence of new resources SLT service levels could not be maintained in the following year. Prioritization measures (set up jointly with physiotherapy and occupational therapy colleagues) allocated children to categories of higher or lower priority according to clinical

needs for SLT services, regardless of Statements of Special Educational Need. SLT services were withdrawn over time from low priority groups, and targeted at those who needed them most and had the greatest potential to benefit. Rising referral rates enforced further prioritization and reduction of provision across the service, so that each child received 50% of what they required.

Such carefully planned provision is exemplary practice in health service terms, but in some cases caused distress to parents and the SLT involved (Luscombe and Shaw 1996). It also meant some children with a Statement of Special Educational Needs specifying SLT input were not receiving that input. The parents of such a child took the issue ultimately to the high court.

The judgement (that the local education authority had to make special educational provision in accordance with the Statement) has been influential in clarifying legal aspects of provision, but the difficulties for SLT in attempting to prioritize within a basically allocating service such as education are clearly illustrated. They reflect a fundamental difference that will continue to have a effect on collaborative practice for the foreseeable future.

Educational provision versus 'deficit' models of practice

A related area of tension concerns basic conceptualizations of how children are helped to learn. Schools are concerned with adapting and structuring children's learning experiences, and children with special needs require actions to help them access the curriculum. In the UK, such actions are specified in Statements (in England, Wales and Northern Ireland) or Records (in Scotland) of Special Educational Needs and in Individual Education Plans (IEPs). The philosophical basis for considering learning in this way can be traced back at least 20 years to the work of the Warnock Committee (DES 1978), which construed special educational needs as: 'not caused solely by deficiencies *within* the child. They result from interaction between the strengths and weaknesses of the child and the resources and deficiencies in the environment' (Wedell 1993: 2). This has resulted in schools quite properly looking to the actions they can take to enable children to benefit from the curriculum. The whole school is involved in setting appropriate policies and encouraging a helpful learning environment (Morris and Parker 1997). Such approaches do not ignore children's disabilities, but the emphasis is less on the child's difficulties than on the appropriate actions to be taken by a school to help a child learn.

SLT on the other hand often use a model where they assess a child, decide whether there is a problem and outline areas of strengths and difficulties. Intervention is planned on an individual basis, followed by re-assessment to measure progress. Such an 'episode of care' once again reflects common health service practices, deriving ultimately from medical models of deficit and disability. In so far as difficulties are located within the child rather than within the child's learning environment they differ from current educational planning procedures.

Since both impairment and the educational environment are important factors in learning, these two broad approaches can be married up. In an important contribution to the debate Norwich (1996) presents an 'ideologically impure' approach which recognizes both individual-personal and social-organizational perspectives. Such approaches could help to overcome functional barriers if the issues were teased out and debated at practitioner level to align expectations.

Models of professional collaboration

The second major area of functional difference is that schools and SLT services may have different models of professional collaboration. A 'strong' definition of collaboration (Conoley and Conoley 1982) involves joint goal planning and an equal relationship among colleagues. Other models of professional interaction exist where either or both of these factors are omitted. For example, in a transplant model (Cunningham and Davis 1985) the 'expert' owns the knowledge, skill and resources and the 'aide' has 'transplanted' only the information needed to carry out particular tasks. Teachers and SLT are used to working as 'experts' in this way with their respective assistants. Good relationships often emerge, but neither of the factors needed for a collaborative partnership operate.

A common health service model is the multi-disciplinary team (McGrath and Davis 1992) where professionals independently address aspects of a problem and create a forum to meet and discuss their aims and objectives for (and often with) the client. Partnerships are fairly egalitarian, but joint goals are not established. This may be a familiar model to SLT, but less familiar to teachers. Where the assumptions of the SLT and teacher about the underlying nature of their working relationship differ, or are simply unexplored, functional barriers to collaboration may occur.

Social barriers

When SLT are working in schools, their teacher colleagues have little or no knowledge of the rest of their working context. The social difficulties inherent in being a 'visitor' within a school are enhanced for members of a non-educational profession (Reid *et al.* 1996). Teachers unsurprisingly are not aware of SLT conditions of service, such as their fewer weeks of holidays and different working hours: SLT tend not to be aware of how difficult it can be for teachers to leave a classroom. These may seem trivial points, but the consequences identified by Reid *et al.* (1996) were serious: misunderstandings affected good working relationships, and perhaps inhibited the 'mutual trust and respect' identified by HMI as a hallmark of effective collaboration (HMI 1996: 33).

Structural barriers

Structural barriers relate to the formalized ways in which the parts of a service interact, dealing with relatively permanent and consistent aspects of the service. Banathy (1992: 92) argues against a 'celebration' of structure and incorporates structure within a functions/structures model. However, McCartney *et al.* (1998) argue that *a priori*, given features of a system are relevant for staff working within a service, and should be considered separately. Significant structural factors appear to be the *timing and location* of service delivery, *management* structures and *curriculum* structures.

Timing and location of service delivery

Schools and SLT services differ in how they make services accessible to clients. Schools have predetermined periods at which children will attend and a timetable programmed ahead. This is a matter of *equality:* since all children have to attend school, timing structures are organized in an equitable way within localities. The

amount of time a child spends in school is a legal requirement, representing a predetermined optimum. The inevitable rigidity is due to the fact that such decisions are made *en masse*. SLT services in health service settings are more flexible, offering services at a time suitable to individual children's families.

When SLT services move into schools such flexibility can be lost, as schools need services to be within school time. This can lead to some tension around SLT holidays and contracts (Reid *et al.* 1996) and is possibly a special case of the differences between offering a service to a *child* rather than to a *school*.

A more fundamental difficulty is that SLT's opportunities to meet and work with parents may be limited compared with clinical settings (Reid 1996: 77). Schools use a variety of meetings and written methods to keep in contact with parents, but SLT are not routinely included (Reid 1996: 102).

Children in health centres tend to receive SLT services individually or in small groups: within schools there is a move to work within classrooms (HMI 1996: 30, 31). This prevents peace and privacy, and can cause distraction for children with concentration and attention difficulties. Although there are compensating gains, SLT may find the option of working in the classroom difficult and distressing, and teachers may also find it difficult to accommodate another professional within the class (Lovey 1996). Time and continuity will be needed to build good working practices.

Management structures

Schools are part of a larger education system where most of the other elements are themselves schools, with national and local policies and a recognized management hierarchy. Most of the people within these systems share the profession of teacher, and can reasonably assume some shared attitudes and experiences. Teachers, however, may have had limited opportunity to interact with other professions, even in pre-service training.

SLT work in NHS trusts where the number of SLT employed will be small and where the therapy services director may be from another profession (Mays and Pope 1997). SLT conform to local and national health service policies but these are not specifically targeted to SLT. An individual SLT has usually acted as an independent professional, responsible for selecting clients and organizing access, thus operating rather like a whole school. Working collaboratively will be affected by these structures—teachers being asked to share classrooms with other professionals perhaps for the first time: SLT losing independence of action on some decisions. Such differences, badly handled, will provide barriers to collaboration.

Curriculum structures

After extensive debate, the countries of the UK have in place agreed national curriculums covering the school years to adolescence. Details of curricular approaches alter, refined by the distillation of good practice. But the idea that there will *be* a nationally agreed curriculum appears to be settled, and the right of every child to access the curriculum, including children with special needs, is accepted (Dyson 1997).

SLT have had no such central direction about what language and communication skills to teach, or how to approach teaching. They make individual decisions, relying

on published examples of good practice and on research studies, but there are no practices comparable to the UK national curriculums. The very fact of trying to work to a nationally agreed structure may be a problem for SLT, and using the curriculum to plan intervention can seem divorced from reality.

There are also potential conflicts arising from the state curriculums' particular conceptualizations of language. Daines (1992) points out that SLT take a developmental approach to language, matching language goals to the appropriate developmental stage. National curriculums have moved away from this viewpoint and are developmentally insensitive: the needs of children with profound leaning difficulties may difficult to accommodate (MacKay 1993) and conversely the curriculums contain target examples of language normally used by younger children in the home context.

Daines (1992) also notes that the national curriculums look at language largely in terms of the functions and use of language: SLT are often concerned with language forms, which are particularly difficult for children with language disabilities (Rice and Wexler 1996). If SLT and teachers are talking a different language *about* language, tensions will arise.

Process barriers

A process model focuses inquiry on the dynamics of system behaviour. Focusing on the child, and taking a simple event sequence, process models allow discussion of the ways in which a child can access services, how progress is reviewed and how transfer to other services is organized. In education these processes involve consideration of a Statement or Record of Special Educational Needs, with decisions to be taken on when to *open* a Statement or Record and *plan within* it.

Opening a statement or record of special educational needs

Decisions about when it is appropriate to set up a Statement or Record are clarified and amended by the outcome of ongoing policy debate. At present there seems to be unexplained local variation (at least in Scotland) in whether or not children with language difficulties have a Record (HMI 1996). There is a particular tension in Scotland in that SLT services for children with Records of Need are funded somewhat differently from other children and this his has lead to a 'rush to Record' (Reid *et al.* 1996: 78), possibly for resource rather than educational reasons. Educationalists worry lest the process of opening a Statement or Record will waste time and perhaps stigmatize children unnecessarily: SLT managers worry that as children are recorded but not discharged it will be impossible to maintain levels of SLT service to education (Reid *et al.* 1996: 74). However, SLT and education appear to have no fundamental difference in perception about the nature of a Record/Statement. Schools and SLT services collaborate in a thoroughgoing process involving review of a child's special educational needs, the formation of a plan to differentiate learning experiences to meet these needs, and undertaking further reviews.

Planning for special educational needs

Formal ways in which teachers and SLT professionals collaborate to help children communicate and learn include service level agreements between a school and SLT

service which plan what the school and the SLT service will provide, and to whom, and at what times in considerable detail (Reid *et al.* 1996: 108). This reduces tensions by clarifying expectations about work patterns.

At another planning level, children engaged in a differentiated curriculum often have an Individual Education Plan (IEP) detailing individual adaptations to the curriculum. There is no particular tension between SLT services and school services in such approaches—both are usually happy to spell out what their aims and objectives are for a particular child, and how they will set about achieving them. SLT are very familiar with measuring outcomes of intervention, often measured as language gains; and following the Code of Practice (in England and Wales; DfE 1994) teachers are engaged in a similar process. Dyson (1997) is not certain that this process is entirely beneficial, but it does serve to reduce tensions between the two services.

Process models, therefore, appear to show up fewer tensions between SLT and teachers than functions and structures models. This is a hopeful conclusion, and may underlie the fact that much good collaborative practice is flourishing 'on the ground'.

Systems–environment barriers

Systems–environment models consider school and SLT services in the context of the community and of the larger society: a 'bird's-eye view of the landscape' in which the system is sited. Such an outlook encourages questions about how adequately a service responds to the context in which it is set and, conversely, about how responsive that context is to the service. In the case of schools and SLT services the field could be very wide, and some influences of educational and health service supra-systems have already been considered. There is, however, the more immediate effect of *family context* to be considered. The systems–environment model could also take account of children's own perspectives, but for the purposes of this paper families are considered as surrogate service users.

Families and services

Carers and families are formally welcomed as partners in both educational and health service approaches to child services (SOED 1993, DfE 1994, RCSLT 1996: 56, 59), but in different ways.

Families often have extensive contact with SLT services before the child goes to school, and have discussed plans and activities for their child. Some will have carried out tasks in the home and attended workshops to develop optimal interaction strategies. Many will have experience of multi-disciplinary teams in specialist settings with the family as the focus for intervention approaches.

As discussed above, schools have to timetable contact with families in a different way, and where children are escorted to school by special transport face-to-face contact between parents and school staff is difficult. SLT working in schools worry that this can mean a lack of contact with parents, especially in mainstream settings (Reid *et al.* 1996: 77). Parents are included in formal review meetings, but HMI (1996: 31) noted that some parents were intimidated by such large conferences. Parents have limited input to goal setting in schools: less than half of the parents interviewed by Reid *et al.* (1996: 102) were involved in deciding upon therapy plans,

and less than one-fifth had been included in devising an IEP or in decisions about educational programmes.

If parents have internalized an SLT-based model of how services should operate, it may be difficult to convince them of the benefits of a different model of service delivery as practised in schools. Even when good collaboration is carried out between teachers and SLT, parents may feel excluded. If parents' models of service remain as one-to-one intervention, collaborative working may be seen as less focused and less intensive. Services wishing to adopt a collaborative approach will have to explain their context and rationale for service provision with care, and to be prepared that parents might resist such explanations.

Conclusions

The systems approach has proved useful in discussing differences and some difficulties that arise in collaborative practice. Application of the models suggested that there were fewer process barriers to collaboration, and that the systems in place at that level of planning can minimize potential problems if used effectively. This provides an essential point of contact for the services, and perhaps explains why so much good collaborative practice can in fact be found (McCartney 1999). However, there are structural, functional and systems–environment barriers, and these seem set to remain for the immediate future. The two systems will proceed in parallel, and those working in either will at times be confused by the assumptions and practices of the other. The value of spelling out the differences may therefore be to allow SLT and teachers reciprocal access to the other profession's overarching context, to foster mutual understanding, and to help improve what can be improved.

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