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Collaboration and integration of services in Greek special schools: two different models of delivering school services

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Multidisciplinary collaboration is considered to be very important for the education of pupils with special educational needs and particularly those pupils with the most severe disabilities. This research adopts a multiple case-study design in order to understand collaboration and the integration of services and the effectiveness of these among pupils with profound and multiple learning difficulties (PMLD) in Greece. The teams, choosing case studies in five special schools, considered 10 pupils and their parents. Reviews and analyses of the legislation; the use of diaries; participant observations and semi-structured interviews were used for the collection of data. Two different models of service integration which provide different opportunities to the inclusion of pupils with PMLD were revealed since schools have different methods of integrating health and social professionals. In the first model, the school works with outside services, whereas in the second, services are within the school. In addition, roles and responsibilities differ within the different models. Service integration and collaboration were found to be more effective in schools where teachers and health and social professionals work under the same management. The study suggests the expansion of the second model of multidisciplinary collaboration with the integration in schools of health therapists, educational psychologists and social workers.

Keywords: multidisciplinary collaboration; service integration; multiple case-study; profound and multiple learning difficulties

Introduction

This research study is concerned with the ways in which teachers, parents and health and social professionals collaborate for the education of pupils with profound and multiple learning difficulties (PMLD) in Greek special schools. In particular, we are interested in the process of collaboration between professionals from different disciplines and the effectiveness of their collaboration with respect to the way in which services are integrated in schools. The integration of services is mainly connected with their organisation in the school in terms of the different working relationships between professionals and the consequences of these relationships to collaboration. We consider that the different approaches to service integration in schools provide

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different opportunities for the inclusion of pupils with PMLD in the educational system.

In Greece, pupils with severe PMLD are, almost exclusively, educated in special schools. In addition, social and health professionals are employed only in special schools and up to date there are no other professionals than teachers working in mainstream education. The last major piece of legislation in special education (Law 3699/2008) implies that pupils with severe PMLD are better educated in segregated settings, since their access to mainstream education is subject to the presence of special settings in their area. However, it is extremely difficult to locate pupils with PMLD in mainstream schools. As Zoniou-Sideri (2004) says, new special schools have been founded since the formal beginning of special education in Greece (Law 1143/1981). It is worth mentioning that even last year several special schools were unexpectedly established by Law (3699/2008), which, among other things, gave emphasis on the equal opportunities for all students.

In some countries, the move into the school setting of health and social services began in the early 1970s, when children with severe and profound learning difficulties were transferred from care centres to special schools (e.g. in the UK after the 1970 Education [Handicapped Children] Act). This was the beginning of the development of educational support services for the most severely disabled group of children. The deployment of health and social professionals into schools brought changes in school life and created better opportunities not only for the social inclusion of pupils with PMLD (Allan 2004) but also for their access to the National Curriculum, which, according to Lacey (2001), has not been designed for their needs.

Once teachers and other professionals started working with the same children, the issue of multidisciplinary collaboration emerged not only as a crucial issue but also as a possible problem. One of the difficulties appears to lie in the origin of the roles and responsibilities of the support services in schools. Whereas it might be expected that people's knowledge, attitudes, professional background and personalities would determine what happens in schools, in fact the impetus seems to have come from legislation. In the USA, for example, legislation encourages collaboration between support services and education (US Department of Education 2004). The Education for All Handicapped Children Act of 1975 (PL 94–142) was the first to insist on multidisciplinary teams in schools, a piece of legislation which has influenced multidisciplinary collaboration in many other countries. Legislation in England has also reinforced the need for collaboration between local educational authorities and the Health and Social Services (DES 1978; The 1981 Education Act; The Children Act 1989). The Green Paper, *Every Child Matters* (DfES 2003) focused upon improving the level of professional support for children in need and this was taken up in the subsequent 2004 Children Act. Scottish legislation (Education Scotland Act 2004) also stated that the integration of services is essential and has recently reinforced this by establishing integrated community schools (ICS), where partnerships with health and social services have been extended. In Greece, legislation in the early 1980s (Law 1143/1981; Law 1566/1985) also integrated health and social professionals and pupils with PMLD in special schools. However, the role of health and social professionals in schools remained unclear for several years, since the government has only recently provided clear guidelines regarding their work in schools (ΦΕΚ 449/τ.Β/3.4.2007). Even though this recent policy document encourages collaboration between professionals, no clear guidelines regarding its implementation are provided.

In addition, not all services for pupils with special educational need (SEN) are integrated under the Ministry of Education. For example, regarding the assessment and first diagnosis of children with SEN, both the Ministry of Education and the Ministry of Health and Social Care were and still are responsible. According to Law (1143/1981), for the process of assessing and identifying children with special needs, both Ministries had to collaborate. A few years later (Law 1566/1985), further information was provided regarding the role of the 'assessment units', which were mainly presented as the responsibility of the Ministry of Health and Social Care. However, this was incompatible with the general position of this law, which transferred almost every responsibility for students with SENs to the Ministry of Education. For the next 20 years, statements of SENs were provided from centres which belonged either to the Ministry of Health and Social Care or to the Ministry of Education. The former were named 'medical-educational units' and the latter 'psycho-educational units', an inconsistency which caused a number of problems in the collaboration between services. However, this irregularity changed in 2000 (at the policy level) with a major new piece of legislation in special education (Law 2817/2000), whereby all the responsibilities for identifying, assessing and educating children with SENs were transferred to the Ministry of Education, specifically to the new educationally oriented centres for the first identification and assessment of SENs. This law represents the first attempt in Greece's determination to use an educational rather than a medical model for the education of pupils with complex disabilities.

The biggest change for the integration of therapy into Greek special schools was made at the same time when the above law increased the number of health and social professionals in schools, where more specialists, such as music therapists, were introduced. The most significant change, however, was that this law changed the category of all the health and social professionals working in schools from 'special staff' to 'special educational staff'. This was an important step for the inclusion of health and social professionals into the educational system and the conceptualisation of therapy and education as similar and not different realities.

Legislation has put teachers and other professionals together in some schools, but does this necessarily mean that people will collaborate? The Greek legislation simply encourages collaboration between professionals from different disciplines without providing any specific directions for implementing this policy. The phrase 'multidisciplinary team' has only recently been used in legislation and at the moment there are no recognised multidisciplinary teams in schools.

The need for collaboration

As Whitty and Campbell (2004) argue, educational intervention alone cannot lead to social inclusion and justice, but inter-agency working may provide the answer. According to Limbrick (2004), children's needs should be assessed 'in the round', for this, as he argues, is the essence of a multi-professional approach. Orelove and Sobsey (1996) also report that children's needs ought to be addressed holistically since the more the professionals work in isolation, the greater the likelihood that they will generate false information. Yet to respond to a child with severe or profound learning difficulties as a whole has, in practice, been found far from easy. Most writers have advocated a shared framework of goals, knowledge and expertise (Miller 1999; Allan 2004; Forbes 2006). There seems to be a consensus among researchers that if professionals from different disciplines work towards the same goals, the child's needs may

be met more effectively. In a broad sense, working together means joint assessment, joint planning and joint implementation of goals.

Barriers to collaboration

According to Lacey (2001), the fact that different services work under separate funding and management arrangements causes inconsistencies to their integration in schools. It is these inconsistencies which also hinder understanding between professionals. Miller (1999) also reports that it is not likely that teachers and therapists who work under different agencies and schemes will collaborate. She argues that this results from the different operational models which are associated with different ways of thinking between teachers and therapists (Miller 1999).

Also, the fact that teachers and other professionals are trained within different models (medical and educational) brings about fundamental differences in their approach to work and consequently create a different vision to collaboration (Orelove and Sobsey 1996; Sloper 2004; Forbes 2006). In addition, role stereotypes and the status which professionals expect to have within the team has caused unwillingness to share knowledge and a sense of being threatened in doing so (Miller 1996). Hart (1991) has argued that sharing expertise with other professionals in a form of role release implies that each feels secure in their role and has confidence in their own abilities. However, in order for professionals to feel secure, their roles should be clearly defined (Clough and Lindsay 1991). This does not necessarily mean that each person's role has to be completely separate (Lacey and Ouvry 1998), but rather that team members should contribute general assistance as well as discipline-specific knowledge (Rainforth and York-Barr 1997) and other team members should implement some of their discipline-specific practices in the absence of a team member.

Another area of difficulty is that of the difference in language used by professionals from different disciplines and the different attitudes towards confidentiality, which brings restrictions to the communication between services. The use of jargon has historically segregated professionals, sustained the boundaries of specific disciplines, frustrated parents and blocked their involvement in teamwork (Rainforth and York-Barr 1997; Sloper 2004). Communicative problems easily arise when issues of confidentiality are raised. Although official papers talk about 'extended confidentiality' (DES 1978), there are still restrictions on sharing information with different services, which, of course, make a barrier when people try to work together.

Apart from jargon and confidentiality, a major practical problem faced by professionals trying to work together is time. Collaboration needs time for meetings, sharing of information, joint assessments, planning and programme implementation. As Lacey and Ouvry (1998) state, it is impossible to be a team without time to talk. The amount of time required in order to make joint working practice effective was indicated as one of the major drawbacks by most of the respondents in research surveys by Wright (1994) and Kersner and Wright (1995). To date, the Greek government has not allocated time for joint assessment, planning and implementation, although it has been officially stated that this collaboration should be scheduled (ΦΕΚ 449/τ.Β/3.4.2007).

The purpose of the present study

Most research studies in the area of multidisciplinary collaboration, no matter what their methodological strategy, are descriptive in terms of the people involved in a

given team, their roles and the obstacles to collaboration (Porter and Lacey 2005). Empirical data on team process and the factors which can hinder or promote the work of the multidisciplinary team are, however, very scarce (e.g. Wright 1994; Kersner and Wright 1995; Miller 1996). Real-life collaborative or non-collaborative practices, their process and effectiveness have rarely been investigated (Friend 2000; Sloper 2004). Limited also is the research on multidisciplinary collaboration in Greece; we hardly found any discussion on this issue. Consequently, there are still many unanswered questions concerning collaboration in multidisciplinary teams, which point to the need for the present study.

The aim of the study is to understand service integration and collaboration in Greek schools by exploring and evaluating the process and effectiveness of collaboration. It is understandable that this small qualitative study does not attempt to evaluate the ways in which multidisciplinary practice takes place in Greece as a whole. Rather, the aim is to provide an exploration of multidisciplinary collaboration and to contribute to its understanding within the international context.

Method

The case study

The case studied in this project is a team which consists of pupils with PMLD, their parent(s), teachers and all the other professionals working with them. Thus, it is the different professionals who work with pupils, their parent(s) and their relationship, which constitute a case rather than the pupils themselves (see Figure 1 below).

To identify the teams/cases, we planned to locate pupils with PMLD who received services from at least three professionals from different disciplines working together. Having selected pupils, we considered all the different professionals working with them as a team and consequently as a case. Moreover, we included the parents of these pupils as members of the team.

Two children were selected from each school. Since this study deals with the work of the team rather than the child itself, the children's gender, age and ethnicity were not taken into account in selecting them.

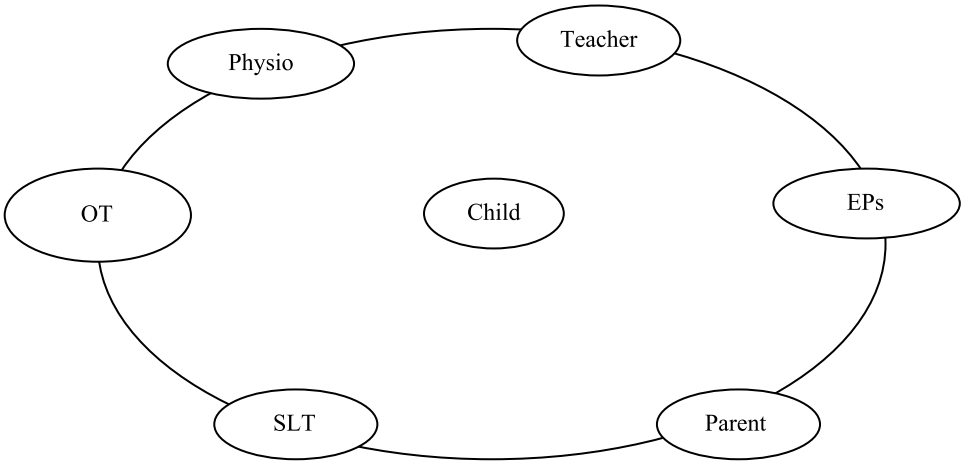

Figure 1. Case study.

The selection of schools

According to Stake (2000), we should examine the cases from which we feel we can learn the most. Multiple case studies cannot easily follow a sampling logic, although Mason (1998) suggests that sampling and selection – if appropriately conceived and executed – are vitally important strategic elements of qualitative research. Consequently, the cases chosen are expected to be representative of a certain population of cases, but, according to Stake (2000), selection by the sampling of attributes should not be the highest priority, since balance and variety are more important. For this reason, we decided that our sample should include schools which are located within institutional and recovery centres. This is mainly because in Greece students with PMLD are usually educated in these schools or they live in these institutions. According to the Greek literature (e.g. Soulis 1997; Polichronopoulou 1999; Angelides 2008), the majority of pupils with PMLD are kept at home, since there is no help in schools for this population. Although all the special schools in Greece belong to the Ministry of Education, all institutions and recovery centres belong to the Ministry of Health and Social Care. It is clear, then, that this was a purposive rather than a representative sample, since the intention was to seek groups of people where some of the features or processes in which we were interested were more likely to occur (Silverman 2000).

Consequently, in order to choose cases, we found five schools for students with severe PMLD. All schools were selected from the capital of Greece, Athens. As shown in Figure 2, three of the five schools were either attached to therapeutic units (Site 2) or within institutions (Sites 3 and 5). In Sites 1 and 4, the schools functioned independently of any sort of institution or therapeutic unit. In Site 2, the school was attached to a therapeutic unit for pupils with physical disabilities. In Site 3, the school was within an institution where all the pupils were living, whereas in Site 5, the school was located within an institution but the pupils of the school were living with their parents. The institution mainly accommodated adults with learning disabilities.

Process and analysis

Two members of the research team visited each school for 1–2 days in order to observe the children and to collect all the necessary documents. In our participant observations, we sat by the children in the class, helped them with their work and observed them in their therapies. In addition, we tried to develop intimate and informal relationships with all the professionals working with the child. We took notes (in narrative form) about the schools' environment, our contact with the teachers and other professionals and the days we spent in schools with each selected child. We also kept notes of any informal conversations we had with people in the families which we visited. We used a research diary for the first analysis of these data, reflecting thoughts and feelings as we came out of the field. At the same time, we collected documents relating to these children, such as individual educational plans (IEPs) and physiotherapy or/and speech and language therapy reports. The analysis of these documents complemented the information gained from interviews and observations. We did not set out to produce any systematic analysis on the documents, but rather used them within the understanding of each case study. We wanted to see the documents in relation to the team and to learn how the members of the team produced the documents.

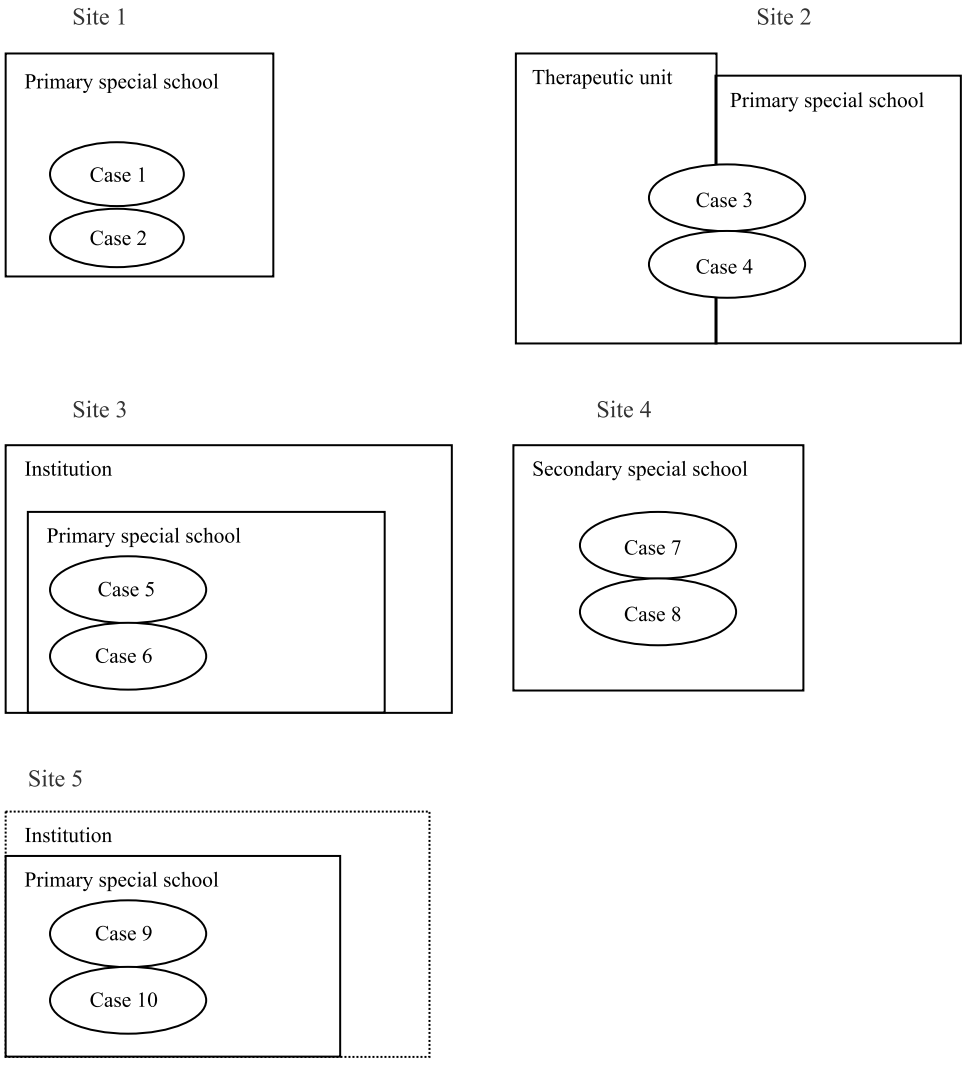

Figure 2. Multiple case study design.

The next step was to interview all the people directly working with the children and their parents. All interviews were conducted by one researcher. The interview schedule (Appendix 1) was similar for all participants but adjusted to the focus of their profession. Since interviews were conducted after observations, the phenomena which we had already observed determined most of the questions. People were asked to describe their practices and, if possible, give reasons for them. In other words, we were interested in describing respondents' external reality (e.g. facts, events) as well as their internal experiences (e.g. feelings, meanings; Silverman 2001). The interviews involved questions about the pupils who had been selected as case studies in terms of the work which the team was doing for them during the *assessment* of needs and abilities, *planning* for goals to meet those needs and abilities and the *implementation* of these goals.

Table 1. Professionals in each case.

Site 1 (primary special school)	Case 1 and Case 2	Two teachers, two parents, one social worker, one OT, one physiotherapist and one SLT
Site 2 (primary special school attached to therapeutic unit)	Case 3 and Case 4	Two teachers, two parents, two OTs, two physiotherapists, one social worker and two SLTs
Site 3 (primary special school within an institution)	Case 5 and Case 6	Two teachers, two parents, two OTs, two physiotherapists, one social worker, two SLTs, one psychologist and one school nurse
Site 4 (secondary special school)	Case 7 and Case 8	Two teachers, two parents, one OT, one physiotherapist, one social worker, one SLT and one psychologist
Site 5 (primary special school within an institution)	Case 9 and Case 10	Two teachers, two parents, one OT, one physiotherapist, one social worker, one SLT and one psychologist

All the semi-structured interviews lasted from 30 minutes to an hour and were recorded on audio-tape. In total, 49 people were interviewed – 10 teachers, 10 parents, seven speech and language therapists (SLTs), seven physiotherapists, seven occupational therapists (OTs), four social workers, three psychologists and one school nurse. Table 1 shows all the professionals participated in each case.

In the analytical process Nvivo software was used. First, the interviews and the diary notes were analysed in groups of 4–5, according to the specific case studies. The purpose here was to identify patterns which held in some settings but not in others, or, as Huberman and Miles (1998) recommend, to bring out distinct 'clusters or 'families' of cases. Moreover, cases were analysed and compared within each one's data as well as between one and the next in order to establish themes, categories and meanings.

The second step was to read all the interviews and to identify the most important 'themes'. Some of the themes emerged immediately from the way in which the interviews had been designed. For example, we knew that the 'process of multidisciplinary collaboration' would be a topic under investigation. Others were derived from interviewees' accounts, such as 'roles and responsibilities', which was not a topic which we had planned to discuss as a separate theme when the project started. For some themes, several 'sub-themes' emerged. The most important themes and sub-themes are presented in Table 2.

Table 2. Themes and sub-themes.

Themes	Sub-themes
Teamwork	Working together (including parents) Models of service integration
Process	Assessment–planning–implementation Most collaboration Pairs–clusters
Roles–responsibilities	Understanding Conflict
Effectiveness/overall evaluation	Team members' evaluation Parents' evaluation

The next step was to separate interviewees' accounts according to the selected themes. We used this pattern as the major method of observing the data in all cases. Once the interviewees' comments were segregated into different themes, we were able to divide the data further into categories/codes. For example, for the theme 'teamwork' six categories were designed: (1) personality, (2) same goals, (3) sharing of information, (4) meetings, (5) when there is a problem, and (6) written reports. From this point onwards, we started saving and printing reports according to categories and created models in order to visualise the multidimensional aspects of our data.

Using the Nvivo software, we were able to look at our data from different angles, for example, to split the themes up according to the cases (e.g. what the teachers said relating to teamwork); or to split the cases up according to themes (e.g. what the psychologists, SLTs and physiotherapists said about the IEPs); or to count the use of a single category within each case or theme; or to identify the use of one category within a specific case study, together with several other possibilities. Generally, we linked cases, themes and categories in different ways to make different analyses. Since it is impossible to describe each single one, in Appendix 2, we provide an example of the identification of category 'solve the problem' in Case 1.

However, our main concern was to look at the meaning of each category in terms of similarities and interests between and within the cases. We paid significant attention to the interviewees' words, in particular when they occurred in the interviews very often. As Basit (2003) points out, the analysis thus facilitated the generation of theory grounded in the data.

It is worth mentioning that all the members of the research team work in education and consequently, we recognise the different views that a researcher from a social or health discipline could have added to the discussion.

Results

The different models[1] of service integration

Collaboration between teachers and professionals from other disciplines for the purpose of meeting the needs of pupils with SEN can be found in policy documents in many countries. However, reviewing the most recent legislation in Greece makes it obvious that multidisciplinary collaboration is evident in the policy documents in an abstract way. In addition, the gaps and inconsistencies in legislation create two different models of multidisciplinary practice which present different ways of integrating services. The two models which are described and evaluated below are distinctive in terms of the different ways in which social and health professionals are integrated in school settings and of the ways in which teachers and other professionals work with the children.

In the first model, therapists, school nurses, social workers and phychologists work for the Ministry of Health and Social Care. They provide their services to schools, but they belong to a different organisation (e.g. an institution or therapeutic unit) which is attached to the school. In other words, they work for a different organisation while serving the pupils of the school. In the second model, health and social professionals belong to the school and the work for the Ministry of Education.

In the first model, health and social therapists have different working hours and earnings from those of teachers. They spend most of their time in different buildings, which are either attached to a school or located within it. Children are moved to different buildings in order to receive their therapy. Education takes place within the

school and then children have to move to the therapeutic unit or the institution for physiotherapy, occupational therapy or speech and language therapy. Different therapies are implemented in different rooms.

In addition, in these schools, children from the same class often have different physiotherapists or OTs, which means that a teacher might have to make contact with several physiotherapists, OTs or SLTs. The teachers said that it was difficult to meet the therapists and some of them did not even know the names of the therapists allocated to the children in their class. Such a practice is in itself disruptive not only for the children but the professionals as well. The teachers were complained that the pupils taken out of the class could not follow the curriculum. It seems that the difficulties in the integration of services in the school led not only to the exclusion of the pupils of the class but also to their poor inclusion in the educational system.

A teacher very vividly summed up the situation:

> Yes, unfortunately it's not one therapist. It would be nice to have one OT for the class, if you have eight children in your class and you have eight OTs how on earth can you meet all these people, it's impossible.

The head in one school was extremely dissatisfied with this but he said that there was nothing he could do about it:

> I cannot ask them to change the way they work. I have complained several times but, you know, the therapists work for the therapeutic unit. I cannot force them. I have to wait until the Ministry of Education hires therapists for the school, it won't happen tomorrow but it will. But again if the Ministry of Education gives me one physiotherapist then again he cannot serve all the children of the school, so again we have to rely on the therapeutic unit. (Diary)

In these schools, all the participants mentioned that multidisciplinary collaboration is not the common practice.

The second model provides a different pattern of integrating education and therapy. Here, all the teachers and the other professionals work in the same school and are hired by the Ministry of Education. In addition, they have the same working hours and earnings as teachers. Health and social professionals usually provide services to a single school and work as full-time members of staff. Most importantly, the recent legislation in special education (Law 2817/2000), as mentioned above, changed the category of all the health and social professionals working in schools from 'special staff' to 'special educational staff'.

Do we feel as if we are working as a team?

Irrespective of the amount of collaboration between teachers, other professionals and parents, almost every participant in this study had a positive attitude to joint working practice.

However, to our question if they felt as if they were working as a team, we mostly received negative answers. As a teacher said:

> As a team? … No, because most of the time it's up to you to look for other people to talk and share ideas. But I strongly believe that this is happening because of the way things are organised. People are always willing to collaborate but it's the context. For example, there is no a particular time when professionals can talk about the children.

Even though information is sometimes shared, as participants said, it is done infrequently. In particular, in the schools functioning under the first model, it was almost impossible to maintain even minimum contact between all the people working with the same child. Only in schools where health and social professionals were working as 'special educational staff' was collaboration more evident and effective since participants from these mentioned good levels of information sharing.

However, in all the schools, the process of multidisciplinary collaboration, as most participants described it, is 'informal'.

> Yes, we try to, try to discuss what's going on. It's a bit thrown in between when students are picked up. (OT)

Almost everyone interviewed said that the sharing of information is informal, it can happen in different places (e.g. staff-room, classroom) at any time during the school day. Equally, most people raised concerns about the efficiency of this way of working as a team and recommended holding formal meetings.

In addition, with this informal sharing of information, most participants only 'think' that they are working towards the 'same goals' for the same child. It was very interesting in this research study that very few interviewees were found to be aware of the specific goals that the other people were working on for the same child. Most of them knew only in part how the other people were working with the child and were hoping that their goals were the same or overlapped.

> I *think* [italics added] probably we are all working towards the same goals … I haven't seen their goals but I'm sure that there is a certain amount of overlap between goals. (Physiotherapist)

This is very important if we consider that the interviewees were talking about the same child. Some of them also said that asking other professionals for help made them feel as if they were taking time away from them:

> When she (SLT) is here I don't want to take up her time to discuss things with me. (Teacher)

In addition, parents were not happy; they evaluated the work of the team as insufficient, with negative implications for their child's progress. Parents believe that the number of teachers and therapists working in schools is not adequate to cover the children's needs. In addition, most of the parents described their collaboration with teachers as effective, but found their collaboration with other professionals frustrating and complex.

> There is a lack of contact sometimes, it's hard to get hold of all the people that you need to speak to. The physio in particular, she is not always in the school. So if I need to speak to her there is a lot of delay … of me phoning waiting for her to phone me back and actually get in touch. (Parent)

Parents were found to be happier in their collaboration with teachers and professionals working under the same management. As one parent said:

> Yes, I am in close contact with all the people working with Alexis (the child). Because I can pop into the school and talk to everybody very easily.

What are the barriers to service integration?

Almost every participant mentioned 'the lack of time' as the most important barrier to service integration.

> It is very difficult to see the therapists … I have tried but they are always busy. (Teacher)

> you know, I have to give time in my break to find somebody but again it's very difficult because when I am at break they might be working and vice versa. (Teacher)

Thus, in almost every school, 'time' was the most important obstacle to collaboration.

The data also revealed two major tendencies that were particularly important in the nature and process of collaboration. The first was the tendency of teachers and other professionals to work 'in pairs' and not 'in teams'. For example, an SLT and a physiotherapist could work towards the same goals for the same child or an SLT and a teacher could work collaboratively, but without necessarily sharing their practices with the other people working for the child. Consequently, the data revealed the existence of 'multidisciplinary pairs' but not 'multidisciplinary teams'.

Another important finding was the tendency of people working around a child to collaborate only 'when there is a problem'. By 'problem', these respondents meant a risky situation such as severe feeding difficulties or when parents raise concerns and conflict begins.

> here it seems to be like we only get together as a team if there is a problem and that's how we work. (Teacher)

An OT also referred to this 'problem situation', even though she did not particularly feel as if she was working as a team with the other professionals:

> no, I wouldn't say, we are a team, but … I do not think we work together as a team. They know they can contact me, any time they want to, but my idea of working as a team, would be somebody can … beyond. Here, it seems to be like we only, get together as a team if there is a problem and that's how we work.

In one case, the teacher mentioned that they work as a team only with the SLT but not the school nurse or the physiotherapist, who were also working with the child. However, when the child first came to the school he had severe feeding difficulties. At this time, where, according to his teacher, 'there was a problem' everybody was working in collaboration with the others.

> Everybody was there (at lunch time), even his mother at the beginning and the physio. We were all looking at his sitting, communication … but I think that this was the only time we actually worked as a team, I can't remember anything else.

Which are the roles and responsibilities of teachers and other professionals?

Research has shown that a clear understanding and appreciation of other members' roles contribute to an effective team-working (Field and West 1995). Professionals who understand other professionals' roles can better communicate, collaborate and expand their own. Galentine and Seery (1999) have defined role expansion as:

> exchanging information, each member of a discipline 'educating' the other(s) regarding his or her area of expertise. (18)

In the present study, the term 'role expansion' is mainly used to suggest the sharing of ideas and practices between professionals.

As described above, schools can follow two different organisational frameworks in terms of service integration. It is understandable that this has different implications for their roles and responsibilities in schools. Under the first model, as the participants said, the working hours of health and social professionals in schools are not adequate, their timetables are different and consequently there is not enough time for collaboration. For the same reason, multidisciplinary meetings are hard to arrange and often lack the presence of most of the professionals. In these schools, there is no evidence of shared assessment, planning or the implementation of goals because goals and programmes are implemented on an individual basis, usually outside the class. Hence, health and social professionals prefer to work in their own rooms.

In the second model, the everyday presence of health and social professionals in schools provides different opportunities for collaboration and creates different working relationships between people from different disciplines. The evidence in the present study, however, shows that health and social professionals in schools still work in a similar way to their colleagues in institutions or therapeutic units. Although health and social professionals, when working in schools, collaborate more with teachers than do professionals in institutions and therapeutic units, the nature of their work is still similar to the work of their colleagues outside schools. In the schools, however, the participants described some attempts at collaboration, with therapists visiting the class to work with teachers:

> The OT is coming to the class for two half hourly sessions every week. She plans the sessions but we both deliver it. I am very pleased with this. It's not enough but I think that it is a good start. (Teacher)

In all the schools that we visited, the teachers understand their main role to be the delivery of the curriculum. The curriculum in all Greek schools (including special schools) is cognitively oriented (Vlachou 2006) and it seems that it leaves very few opportunities for multidisciplinary collaboration, as teachers admitted.

> I teach Greek and math and she (the SLT) takes him in her room for speech therapy. I don't think that she could help me in the class. I think that we should be doing different things … and I don't want to interfere in her work. (Teacher)

Similarly, health and social therapists understand their role in schools as different from that of teachers. This cultural understanding that the work of other people is 'different from ours' is very obvious in the work of teachers and other professionals, which can be characterised as highly discipline-referenced. Due to the way that therapy is integrated in schools, therapists do not consider their role as consultative and advisory. Rather, the main part of their role is to provide individual sessions for pupils out of the class.

> I really cannot work with a group of students. I don't think it is effective. Each of them has different needs, putting them together … it's just confusing. (SLT, therapeutic unit)

It is less likely that they will visit classes or that they will design programmes and activities for others to implement in their absence.

> No, I don't believe that therapists should be working in the class. Therapists can take students any time they want to work individually, no, not in class. (Teacher)

In all the five schools, it is evident from the participants' accounts that they understood each other's role to a limited extent only. Most therapists said that teachers do not understand the role of therapists and that they feel insecure in the presence of therapists in schools. Equally, teachers felt that therapists undervalued them. In our participants' observation and interviewees' accounts, there is plenty of evidence in support of the above views. Notably, an SLT talking about teachers' knowledge, said:

> unfortunately teachers don't know, the two-year course they have on special needs is inadequate, and because they don't know they close the doors.

However, both teachers and therapists mentioned that this was more evident in 1980 and that things are steadily getting better. Generally, however, in all the schools, professionals were unaware of each other's assessment, planning and intervention. Consequently, there was little expansion of their role in terms of sharing with and learning from each other.

Discussion

Several models relating to multidisciplinary collaboration have been described in the literature (Dale 1996; Miller, Freeman, and Ross 2001; King and Meyer 2006), which provide different patterns of the way in which health and social services are integrated into schools. The first exploration, through studying the legislation and visiting the schools, revealed the existence of two different models of service integration in Greek special schools. The immediate conclusion was that the special schools integrate the health and social services in different ways, providing different implications for the process and effectiveness of collaboration. In addition, it seems that Greek legislation provides only very general and abstract information on collaboration and the integration of services, which seems to have a negative effect on school practice.

In the case of the first model, it is discouraging to find that the majority of people (e.g. SLTs, social workers) responsible for several aspects of the education of pupils with PMLD belong to different networks, which are either socially or therapeutically oriented. In the schools where they work, education and therapy are seen as two separate realities. Service integration seems extremely weak with negative implications to the inclusion of the pupils with PMLD. It was obvious that several practical barriers to collaboration and the integration of services, such as differences in holidays, contact times and places of work can be attributed to this inconsistency. Similarly, in a national survey of Scottish educational psychologists' (EPs) working practices and perceptions conducted by Thomson (1998), it was found that EPs feel that a strictly school-based system of service delivery would be more effective. In addition, Leadbetter (2000), in a survey of service delivery by EPs in England and Wales, reported very low levels of multi-professional teamwork in this model of current service delivery.

In the case of the second model, legislation has put all the professionals under the same roof on an ongoing basis. This was an important factor in the integration of therapy into schools and for the conceptualisation of therapy and education as similar and not disparate areas of work. In these schools, the increased time spent together by teachers and other professionals gave more opportunities for collaboration and created better opportunities for service integration. Even in these settings, however, schools had neither a well-defined system for collaboration, nor the time to develop one. Such developments would indicate a holistic approach to children's needs, bringing all the services under one management system (Evans 1997). But, even when legislation has brought teachers and other professionals together, it does not necessarily mean that people will collaborate on a systematic basis. For example, it is not adequate to place teachers and other professionals under the same roof without providing ways for them to work together and giving them time to do so. Similarly, in the ICS in Scotland, Forbes (2006) has noted that, even in these integrated service contexts, professionals 'are not, as yet, actively and energetically engaging with the ICS vision and ethos of service integration' (577).

Equally, research has shown that collaboration is not achieved by simply importing specialists onto the school site (Spratt et al. 2006) or by the co-location of services (White and Featherstone 2005).

In the present study, it seems that the lack of a specific framework for collaboration in the legislation and daily practice was the most important barrier to integrating the services, as many other writers have argued (McCartney 2000; McConkey 2002). Connecting the policies to the daily practice in the schools which we visited, it is evident that schools are left to decide individually on the model of collaboration between people from different disciplines.

Within this context, collaboration seems unclear and sporadic. In all schools, the sharing of information is informal and most participants think that they are working towards the same goals for the same child. However, the informal sharing of information does not guarantee good organisation and planning and may offer only poor collaborative practice. In addition, almost every participant mentioned the lack of time as the most important barrier to collaboration. Similar results have been reported by other research studies in England (Wright 1994; Kersner and Wright 1995; Lacey 2001).

The data also revealed two important things: the tendency of teachers and other professionals to work in pairs and not in teams and the tendency of people working around a child to collaborate only when there is a problem. Both provide poor integrative strategies for services and create very few opportunities for the effective inclusion of students with PMLD in the educational system. Knowing goals and practices of the rest of the team has been identified as an important prerequisite to collaboration (Rainforth and York-Barr 1997). In this study, concerned as it is with pupils with PMLD, it seemed highly desirable to share information, knowledge, goals and practices between professionals from different disciplines. Their education demands that professionals should collaborate as fully as possible across disciplines, since none of the disciplines alone seems to have the knowledge to provide quality education for these pupils (Lacey 2001). Common sense acknowledges that multidisciplinary teamwork will provide better quality education for pupils with PMLD. Any other pattern of multidisciplinary collaboration may be useful but is possibly not adequate to cover their educational and therapeutic needs as well as possible. Thus, we argue that multidisciplinary pairs cannot be considered effective for the education of pupils with

PMLD, since the needs of these pupils affect every aspect of development. In addition, there are ethical considerations regarding collaboration when there is a problem, since it is very difficult to decide what counts as a problem when we are dealing with pupils with severe and multiple disabilities. In this study, we consider the discontinuity of collaboration as resulting from the absence of an organised system for service integration. Such a practice encourages multidisciplinary collaboration only as a reaction to crisis. In contrast, multidisciplinary collaboration should have as its priority the prevention of crisis, which is ignored at the moment.

In addition, there is no evidence at present of role expansion in all schools and, most importantly, professionals do not meet other professionals as part of their role. It is worth mentioning that learning support assistants (LSAs) are scarce in Greek special schools, and consequently therapists and EPs do not have the chance to leave programmes to be implemented by the LSAs in their absence. The role of LSAs has been recognised by many research studies, even though their role in these teams still remains undefined and unacknowledged (Giangreco 1996).

Furthermore, the understanding of each other's role as 'different' influenced collaboration and made them consequently less likely to acknowledge collaboration as an urgent need. People who see their job in this way do not support multidisciplinary collaboration. In a survey on the role of the psychologist in Greek schools by Papadopoulos et al. (2000), psychologists mention as the most significant barrier to collaboration the fact that their role is not understood by teachers, who they do not accept any psychological intervention. Also, Kourkoutas (2000) argues that while people from different disciplines have different roles, covering each other's role is a prerequisite for the effectiveness of the team. In addition, according to Hart (1991), security and confidence are prerequisites for sharing experience and role expansion, but most therapists described teachers as insecure in the presence of a therapist in school. It is true that the way in which therapy is integrated within Greek schools leaves few opportunities for role expansion and collaboration. This, unfortunately, is a consequence of the way in which teachers and professionals conceptualise each other's role in school.

Moreover, it was evident that parents' participation is based on their personal willingness to participate, rather than on a well-organised system to enhance their collaboration (Stroggilos and Xanthacou 2006). Also, the fact that parents are happier with teachers than with other professionals could be ascribed to the fact that in most schools there is no clear link between parents and services.

Conclusion

Since the integration of services was found to be more effective in schools functioning under the second model, its expansion to all schools is necessary. Such a development moves all the responsibility for these children's education, therapy and care to education, which coincides with the changes which are promoted, for example, by the Green Paper *Every Child Matters* (DfES 2003) in England and the concept of the Team Around the Child in Ireland and Australia (Limbrick 2004). Unfortunately, the expansion of this model in Greek schools is still limited due to economic restrictions.

In no setting, however, did schools have either a well-defined system for collaboration or sufficient time to develop one. Thus, the effectiveness of services is impaired by the lack of an organised system of collaboration. Equally, a well-organised system

of multidisciplinary collaboration cannot work effectively unless people have enough time to satisfy the demands of the system. Thus, increasing the time for teachers and other professionals to work within the same settings (as in the second model) does not necessarily bring about collaboration unless there is a well-organised system within which this collaboration can work. Even though in theory, the integration of multidisciplinary services under the same management provides more opportunities for collaboration, this research showed that these opportunities were not always taken. It seems that the integration of social and health services is highly connected with the necessary educational changes into the schools.

Consequently, further legislation could provide time for meetings and shared planning. Policy-makers need to allocate time for collaboration in the timetables of teachers and other professionals. The opportunities for shared training and learning could also contribute to role understanding and expansion. In respect to the school curriculum, which, even in special schools, is very much cognitively oriented, changes are needed. More emphasis on social skills/aspects would increase the participation of pupils with PMLD and would also create opportunities for teachers and other professionals to work together. In addition, the role of parents within the multidisciplinary team needs to be reconsidered, as their participation is not included even in the recent policy documents (ΦΕΚ. 449/τ.Β/3.4.2007). The integration of multidisciplinary services in mainstream schools, which at the moment is non-existent, is also a challenge, since this would increase the inclusion of pupils with complex disabilities in mainstream education.

It is true that the recent changes in the legislation of children's services in other countries have already created many of the improvements which Greece is seeking. The Green Paper *Every Child Matters* (DfES 2003) in England and the concept of the Team Around the Child, in Ireland and Australia, which propose clear aims and shared roles, responsibilities and timetables under the same management provide an up-to-date context where the findings of the present research would have much to offer. Since this research has shown that simple co-location of services does not lead to more or better collaboration, the changes described above seem to follow the international developments in service integration. However, research will need to examine whether practice follows this new policy.

Note

1. The notion of model refers mainly to different patterns of integrating education and therapy in the school setting. The term 'model' does not refer to any conceptual or abstract scheme but rather to practical, working models.

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Appendix 1. The interview schedule

Personal

Qualifications.

Working experience in special needs.

Multidisciplinary training.

Months working with the child.

General questions

What would you define/describe as collaboration with people from different disciplines?

Who are the people you work with (e.g. talk to, meet) in N's case?

Do you feel that with the above people you are working as a team?

How would you describe your role and responsibilities in the school?

Assessment

Did you assess the child on your own or it was a joint assessment? Did you talk to other professionals after the assessment/exchange ideas or did you wait for their report?

Planning

Was planning implemented in collaboration with other professionals? (e.g. designing an action plan, draw up IEP goals)

Implementation

Do you implement goals/action plans in collaboration with other professionals?

Do you measure/evaluate progress in collaboration with other professionals?

Parents

Are parents involved in the work of the team and if so, how?

Do you advise them before selecting goals?

General evaluation

Who among all the professionals do you experience most difficulties in working with, and why?

In which of the above three phases – assessment, planning, implementation – do you experience least collaboration with people from different disciplines, and why?

Are you happy with the work that this team provides for the child?

What would you like to change in the way that services are integrated in the school in order to improve the effectiveness of the team?

Appendix 2

An example of the identification of the category 'Solve the problem' in Case 1

'I mean if we've ever got a problem, I will only speak to her (SLT) about Maria (the child), probably if I cannot find a way to communicate with the child' (teacher)

'Yes, yes I am in every day, so when there is a problem I can ask the teacher' (physiotherapist)

'If there is a specific issue I will try and contact the individual' (O/T)

'No not necessarily because often if there is a problem I know who to conduct first. We do not sit down and decide, would it be good to set' (SLT)

'I get some information from the school. I usually phone them up if I have a problem' (parent)