Establishing premises for inter-professional collaborative practice in school: inclusion, difference and influence

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Establishing premises for inter-professional collaborative practice in school: inclusion, difference and influence

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ABSTRACT

Purpose: To ascertain stakeholders’ agreement and disagreement about inter-professional collaboration (IPC) when supporting the child with a developmental language disorder (DLD) in school.

Materials and methods: Two rounds of an online Delphi survey were undertaken with a purposive sample of 26 participants (researchers, practitioners and parents). Topics were informed by the views of children engaged in an earlier phase of the research. Agreement was set at an inter-quartile range of 1, with level of agreement measured using a five-point semantic differential scale. Qualitative data were examined using content analysis.

Results: There was strong agreement across the stakeholder groups about the child-led goals of IPC. Stakeholders also agreed that DLD is best viewed as a learning difference rather than a disorder. We identified ambivalence across the groups about the right of the child with DLD to have influence in decision-making about supports in school.

Conclusions: We propose that IPC should be viewed as a means of ensuring the inclusion of the child in school. A shift in focus from remediating perceived deficits of the child, to affecting change in classroom practice, is also indicated. The need to reinforce the unconditional right of the child to have influence in decisions about supports is highlighted. Implications for IPC when meeting the needs of children with a developmental disability in school are outlined.

IMPLICATIONS FOR REHABILITATION

- The goal of inter-professional collaboration should be to ensure the inclusion of the child with a developmental disability in school.
- Interventions delivered in school should focus on changing practice in the classroom, rather than on the child’s perceived deficits.
- The child with a developmental disability should be given influence in collaborative decision-making to ensure supports are relevant and responsive to their needs.

Introduction

For decades, in policy and professional guidelines, inter-professional collaboration (IPC) has been recommended as the means by which the needs of children with developmental disabilities can be met in schools [1–3]. Yet effective IPC remains rare in practice, leaving many children at risk of poor social, emotional and educational outcomes [4].

According to D’Amour et al. [5–7] effective IPC requires an ability to agree shared goals and vision, and internalization: an understanding of any professional differences which might exist between those involved. They also propose that having a client-centred orientation (keeping the needs of the service user central when planning supports) can facilitate effective collaboration between professionals. However, several researchers have proposed that a lack of shared understanding exists between professionals about how the needs of children with developmental disabilities can be met in schools [8,9]. Further, little is known of the priorities and preferences of children with developmental disabilities about supports in school, making it difficult for professionals to act in a client-oriented way [10].

One particular group of school-aged children, those with a developmental language disorder (DLD), is of interest in this context. For children with DLD, who form approximately seven percent of the school-aged population [11,12], IPC between a speech and language therapist (SLT) and the teacher is particularly important because language is essential not just for communicat- ing, but for literacy development and for accessing learning in the classroom [13,14]. Effective IPC between these professionals may prevent the long-term negative implications for educational outcomes [14,15] and emotional health [16], experienced by children with DLD.

Effective IPC can be particularly challenging, in part because the practitioners involved (SLTs and teachers) come from different professional backgrounds, making it difficult to agree shared goals [8,17]. Grunwell [18] discusses the importance of establishing premises when differences in assumptions are evident in clinical practice, as a foundation upon which to derive suitable
interventions. In this paper, we report on the final phase of our larger study to generate a set of agreed premises to underpin IPC between SLTs and teachers when working with children in school who have DLD. We also consider the implications of our findings for IPC when supporting the child with a developmental disability in school.

In an earlier phase of the research, we conducted an integrative review of empirical and theoretical literature across the fields of speech and language therapy and education to examine the evidence for a shared understanding about DLD that might inform the development of these premises [17]. Rather than finding a shared understanding about DLD, we identified clear and significant differences in perspective across speech and language therapy and education about DLD, about the goals for providing supports and about how such goals can be achieved in school [17].

Given the lack of shared goals identified in the literature, we next engaged key stakeholders involved in the planning and delivery of supports for children with DLD [19]. These included SLTs, teachers, parents, and children with DLD, who were each asked to describe their “optimal” or “ideal” speech and language therapy supports in school [19]. Again, clear differences in goals and vision between the children with DLD and the professionals were identified.

Based on our findings from these two earlier studies, we wanted to examine whether the views of the children with DLD could be used to generate shared goals for SLTs and teachers when collaborating about supports in school. Currently, children with developmental disabilities are not routinely included in decision-making regarding additional supports in schools [20–22] so it was also necessary to explore stakeholder views about the role of children in making decisions collaboratively about supports.

Study aims

The aim of the study was to establish the extent to which a sample of stakeholders (SLTs, teachers, researchers in the field of speech and language therapy, researchers in education, and parents of children with DLD) agreed and/or disagreed on the following topics:

- The role of the child in collaborative decision-making about supports in school.
- The nature of DLD.
- Child-led goals of IPC between SLTs and teachers.

Materials and methods

Ethics

Ethical approval was granted a priori for this study by the Faculty of Education and Health Sciences’ Human Research Ethics Committee at the University of Limerick (2016_12_15_EHS).

Design

A Delphi methodology was chosen as it is an effective method of seeking consensus about a complex practice issue, allowing the researcher to explore underlying assumptions that have led to any differing judgements [23]. This method also ensures equal status can be given to all participants, which was important as our sample included parents as well as practitioners and researchers [24]. A Delphi method also allows anonymity for participants, ensuring that they can give their views freely without feeling obliged to agree with the views of others. This was pertinent to this study, as some topics might be prone to social response bias.

Participants and recruitment

Guided by the recommendation that a sample of no more than 30 participants should be recruited for a Delphi procedure [25], we recruited a purposive sample of 24 participants. Initially, a “knowledge resource nomination worksheet” [26] was developed by the authors—a list of inclusion criteria for each participant group so that potential participants could be assessed against these before selection. See Appendix 1.

The 24 participants included eight researchers, eight practitioners and eight parents. Researchers and practitioners were recruited from two disciplines—speech and language therapy and education. Practitioners and parents of children with DLD needed to have experience of either providing or accessing a range of speech and language therapy services, including from primary care, mainstream school and language classes. Recruitment of parents and practitioners was extended to parts of the UK as well as the Republic of Ireland in order to source sufficient participants who had provided, or accessed, school-based speech and language therapy services, as these services are not currently well established in Ireland.

To source research-active professionals, electronic searches of peer-reviewed papers were scrutinised and contact details of suitable authors identified. Practitioners (SLTs and teachers) were recruited through pertinent professional networks/associations. Parents were recruited by circulating posters to established parent groups/organisations and through social media.

Data collection and analysis

Two rounds of an online survey were conducted using Questionpro—an online survey tool. Author 1 conducted the study and managed the process. Agreement was considered to have been reached when responses to a statement, across all participants, fell within an inter-quartile range (IQR) of 1. A level of dispersion measure was used as, according to van der Gracht [27], this is an objective and rigorous way to measure consensus.

In round 1 of the survey participants were presented with a series of statements and asked the extent to which they agreed with each one, choosing from a five point semantic differential scale (1 = strongly disagree to 5 = strongly agree). Because many of the statements were abstract in nature, explanatory notes and practice scenarios were provided to enhance clarity. Participants were requested to write reasons for their decisions.

At the end of round 1, descriptive statistics (% of responses, IQR, median) were calculated for each statement, and key categories from the qualitative data provided by the participants were summarised. Statements where there was good agreement were then removed.

In round 2, participants were given the overall results of the first round (percentage of participants who agreed/disagreed/ were undecided, together with the median score and IQR), their own score, and a summary report of the comments received from round 1 for the remaining statements. They were asked to reconsider their views and were required to provide an explanation when they changed their view.

Prior to each round, the survey was tested with a researcher, a practitioner and a parent of a child with DLD not involved in the study, to ensure clarity of the questions. To enhance rigor, a second researcher, not involved with the previous studies,
summarised the feedback between rounds, independently of Author 1. The second researcher was a PhD student undertaking another health-related qualitative research study.

**Statements for the survey**

Figure 1 illustrates the topics of interest and related concepts used to develop the statements for the survey. These topics were informed by our previous studies (described earlier) and in particular by the findings from interviews with children who have DLD.

Topic one was about the role of the child in decision-making about supports. Concepts included “voice” (being facilitated to express one’s views), “audience” (being listened to by those who are able to affect change) and “influence” (the child’s views being acted upon, as appropriate), as described by Lundy [28]. Lundy [28] advocates for a model of “pupil voice” comprising “the right to express a view” encompassed by space and voice as well as “the right to have views given due weight” encompassed by audience and influence.

Topic two related to the nature of DLD—whether it is best considered a difference or a disorder. Tomblin [29] has a full discussion of these assumptions in relation to DLD. Topic three related to priority goals for collaboration. These goals were informed by the views of the children and aligned with concepts discussed by researchers who studied inclusive education [30].

**Results**

**Participants**

Twenty-six participants were recruited to the study, 25 females and 1 male, with equal numbers of practitioners and researchers across speech and language therapy and education.

Two additional parents were recruited (n = 10) in order to include the perspective of those with experience of accessing services in secondary as well as primary school. Two parents lived in the UK and the remaining eight in Ireland.

Of the eight practitioners recruited, five were from Ireland, two were UK-based and one was from Finland (recommended by a potential participant whom we contacted but was unable to complete the survey). Researchers were from the Republic of Ireland, UK, Canada and Australia.

Twenty-six participants completed round 1—ten parents, eight practitioners and eight researchers—and 25 completed round 2. One teacher did not complete round 2 due to their “busy workload.” See Table 1 for participant details.
were decision-making about their supports in school. Four participants agreed (1) The child with a language disorder should have influence in decisions about

Table 2. Statements relating to the role of the child in decision-making: percentage responses and inter-quartile range.

<table>
<thead>
<tr>
<th>Survey statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>N</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) The child with a language disorder should have influence in decisions about</td>
<td>R1 0</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>their supports</td>
<td>R2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) The child with a language disorder should be given the opportunity to express</td>
<td>R1 0</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>11</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>their views to those who have the power to make changes happen</td>
<td>R2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) It is best if adults decide whether the child with a language disorder is given</td>
<td>R1 3</td>
<td>10</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>a say in decisions about their supports</td>
<td>R2 3</td>
<td>16</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>(4) Knowledge that the child brings about their language disorder should guide the</td>
<td>R1 1</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>11</td>
<td>1.75</td>
<td></td>
</tr>
<tr>
<td>practice of the SLT and teacher</td>
<td>R2 0</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>15</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Key: R1: round 1; R2: round 2; *: Consensus not reached. Note: only statements 3 and 4 were included in round 2 of the survey.

Survey results

The results are presented as three sections; (i) the role of the child in decision-making about supports in school, (ii) the nature of DLD, and (iii) goals of collaboration. Descriptive statistics are presented in each table. Illustrative quotes from participants are included within each section.

The role of the child in decision-making about supports in school Participants were asked the extent to which they agreed with four statements about the role of the child in decisions about their supports in school. Descriptive statistics are presented in Table 2.

For statement one, 18 of the 26 participants strongly agreed and/or agreed that the child with DLD should have influence in decision-making about their supports in school. Four participants were undecided and four disagreed. This statement reached agreement at round 1 (IQR = 1).

From the qualitative data, 16 participants referred to the right of a child to be heard in decisions that affect their lives and/or how understanding their priorities and preferences can help improve service delivery, as illustrated by the following quote from a researcher in education:

It is only through discussions that we will be able to fully understand the barriers and enablers which exist for the child, their priorities for goals of intervention and also the appropriate modes of delivery which will promote their self-efficacy and independence.

The remaining ten participants (some of whom agreed with the statement) qualified their view by stating that influence should be conditional upon a child’s age, and/or their capacity to understand as illustrated by this quote:

I am not sure because very young children, especially those with a language disorder, cannot verbalise where exactly their needs lie.

Regarding statement 2, nineteen participants either strongly agreed or agreed, three were undecided and three participants disagreed that children with DLD should have audience; that is, have the opportunity to share their views with those who have the power to make decisions happen regarding their supports in school. Agreement was also reached for this statement at round 1 (IQR = 1).

From the qualitative data, the most common view held by those who agreed/strongly agreed with the statement, was that it would be beneficial for children with DLD to have the opportunity to be able to express their views directly to those who can make decisions happen. Six of those who agreed stated that this was unlikely to be achieved in practice as those who have the power to make decisions in school would need to listen to the child—which, in their view, was unlikely to occur.

Some of those who agreed with the statement cautioned that having the opportunity to express views to those in power might benefit some, but not all, children with DLD. Again, older children were considered more able to express their views—as were those with less severe language needs:

It depends on age/level of disorder; but generally empowering the child as they are all so different long term would have very beneficial impact.

Participants who were undecided and/or disagreed stated that it was best if the child expressed their views to a familiar adult and then this person advocated on behalf of the child. One participant was undecided, not for any reasons to do with the child, but because they believed staff to be limited in their capacity to change how things are done in schools.

Regarding statement three; two participants strongly agreed, three agreed, seven were undecided, ten participants disagreed, and three strongly disagreed that it is best if adults decide whether the child is given a say in decisions about their supports. Agreement was not reached in round 1 (IQR = 2).

Those who strongly agreed, agreed or were undecided reasoned that children may not know what is best for them and/or that the child may be too emotionally vulnerable/may lack capacity to decide for themselves.

The most commonly-cited reason given by those who disagreed with statement 3 in round 1, related to the right of a child to express a view about decisions that will have an impact on their lives:

This goes against the human rights of the child. I believe children/young people should be encouraged and facilitated to be active decision-makers, and given the skills to fully participate.

Eight people changed their view about this statement in round 2, so consensus was reached (IQR=1). Two participants changed their view from agree to disagree and five participants changed their view from undecided to disagree. There was an acknowledgement from those who changed their view that, although they knew of exceptional cases where it may not be appropriate, they now agreed a child should, as a broad principle, decide on the supports to be provided to them. One parent however changed their view from undecided to agree. After considering the views of others, they formed the view that that an adult is best placed to decide on behalf of the child:

I wasn’t sure but now I agree with what people said that adults should decide if the child cannot verbally or mentally make decisions—because parents know the child best.

For statement 4, eleven participants strongly agreed, five agreed, seven were undecided, two disagreed, and one strongly disagreed. Agreement was not reached for this statement in round 1 (IQR = 2).
The needs of the child with a language disorder cannot be met in school unless the expressed uncertainty, stating that the child will always require individualised interventions outside of the classroom.

The extent to which a language learning difficulty is a problem depends on how barriers to their learning and participation are addressed.

Because of the nature of their needs, the child with a language disorder cannot be met in school unless the needs of the child with a language disorder cannot be met in school unless the expressed uncertainty, stating that the child always has, regardless of the environment in which they function, this can help to persuade others that their needs are real:

No I don’t agree, it is like people saying someone who can’t do something has a problem and others saying “no its only society that makes it a problem” and I disagree. DLD is awful for my child all of the time, wherever they go, and people believe me when I say he has a real medical condition.

For Statement 6 in round 1: four participants strongly agreed, three were undecided, nine were disagreed, and two strongly disagreed that the child with DLD will always require individualised intervention outside of the classroom. Agreement was not reached for this statement after round 1 (IQR = 2).

The seven participants who strongly agreed and/or agreed in round 1 with this statement referred to the need for tailored supports for the child with DLD due to the nature of their needs which they argued is best delivered by an SLT.

Six participants who agreed and three who were undecided qualified their position by saying 1:1 (client: SLT) outside the classroom is needed, due to inadequacies of current classroom practice and/or resource constraints, rather than solely due to the needs of the child with DLD:

Unfortunately it (the necessary supports) is not happening the way it should in class so 1:1 is necessary.

Those who were undecided drew a distinction between individualised supports and supports delivered individually. They agreed that supports for a child with DLD in school will always need to be individualised, but expressed uncertainty about whether such supports needed to be delivered outside the classroom.

Those who disagreed stated that individualised goals were required but these could be worked on in class:

I think that individualised goals can be met in the classroom environment with some new creative classroom practices.

At the end of round 2, nine participants had changed their view about statement 6.

Five of nine participants changed their view from undecided to disagree, stating that, in principle, inclusive class-based models are optimal. One participant (a researcher in SLT) changed their view from disagree to undecided, clarifying that their first response was based on certain classroom conditions being met:

What I originally meant is closer to undecided than disagree, because it depends on certain conditions being met—mainly the type of class and resources.

One participant changed their view from agree to strongly agree, stating that unless the child was in a “specialist” setting, they would always need 1:1 intervention outside the classroom because of the nature of their needs.

At the end of round 2, agreement was not reached for this statement (IQR = 2).

Twenty-two people strongly agreed, two participants agreed with statement 7, and one participant strongly disagreed that the barriers to the child’s learning must be addressed if their needs are to be fully met in school. Agreement was reached across participants at round 1 (IQR = 1).
The importance of language for thinking and learning in school was cited frequently by those who agreed or agreed strongly with this statement. Here an SLT practitioner explains why language is central, and acknowledges that SLT practice needs to change:

Language is like the air we breathe, in school everything that is done involves language, everything that is said and not said involves language, everything that is tested is tested though language; there are so many barriers and they are invisible and SLTs have to start addressing them.

The parent who disagreed expressed concern that this view could result in less funding for direct (face to face) speech and language therapy:

I’m worried about this statement if it’s saying this was the only type of intervention needed. When people hear about stuff like this then they can use it as an excuse to withdraw pure SLT support because they think “oh, the school can do that”.

For statement 8 in round 1, five participants strongly agreed, 12 agreed, eight were undecided, and one participant disagreed, so agreement was reached (IQR = 1).

Those who strongly agreed or agreed stated that in order to be led by the priorities and preferences of the child, new methods of working together would be needed. One participant who agreed referred to this as “co-construction” and described how it differs from present practice. Two participants who agreed added that this way of working could assist the professional development of those involved:

Yes I agree this is necessary and could be an exciting and dynamic experience that would nurture the professional development of both disciplines.

Those who were undecided thought that some, but not all, collaborative methods would be new, but that learning ways of listening to the child would be new. The participant who disagreed stated that, in their experience, collaborative working required a refining of known methods, rather than developing completely new ones.

Goals of collaboration
Participants were asked the extent to which they agreed with four statements relating to child-led goals of collaboration. Descriptive statistics for these statements are presented in Table 4.

For statement nine, 18 participants strongly agreed, and four agreed that the main goal of collaboration is to ensure the child/young person with a language disorder has equal opportunities to learn and be included in class/school. One participant was undecided, and three participants disagreed with the statement, so agreement was reached for statement 9 at round 1 (IQR = 1).

Of those who agreed or strongly agreed, seven participants discussed the importance of including equal opportunities as a principle, as this is not always enacted in practice:

As a basic principle I am glad this is here. We all say it but actually it doesn’t happen in practice. A lot of what we currently do is not guided by this. It takes the kids to remind us.

Two further participants who agreed with the statement discussed a lack of relevant evidence, which they stated acts as a barrier to achieving participation by the child:

Intervention should always have real world outcomes which impact on the ability of the child to fully participate. The problem here is that the research doesn’t help us with these kinds of outcomes, so practitioners are confused as to how to achieve them.

Those who disagreed stated that the main goal of collaboration between the SLT and the teacher should be to improve the language skills of the child:

The good practice in school should mean that the child/young person has equal opportunities anyway. The over-arching goal of collaboration should be to improve the language skills of the child.

For statement 10, 18 strongly agreed, three participants agreed, two were undecided, and three disagreed. No-one strongly disagreed so consensus was reached (IQR = 1).

The most commonly stated reason given by those who agreed with the statement was the need to deliver outcomes that have a positive impact on a child’s life chances.

A common view expressed by those who were undecided or disagreed was that supports should improve language-specific outcomes:

SLT support should help the child in the areas that they struggle in and children with DLD struggle with language. I want the SLT to help my child to make progress in their language skills and school can worry about the rest.

For statement 11, 18 participants strongly agreed, three agreed and five were undecided. No participant disagreed with this statement so agreement was reached for statement 9 at round 1 (IQR = 1).

Those who strongly agreed expressed the view that setting the child apart from their peers can have many negative results for that individual and should be avoided:

Absolutely… stigmatising leads to disengagement, reduction in self-efficacy and hence poorer long-term outcomes and so is crucial to avoid.

Three participants who agreed added that they would integrate the effective aspects of an intervention into the classroom setting.

Those who were undecided, mostly parents, stated that if there was an intervention, which was known to be effective for the child with DLD, they might try to persuade the child to engage

Table 4. Statements relating to the goals of collaboration: percentage responses, and inter-quartile range.

<table>
<thead>
<tr>
<th>Survey statement</th>
<th>R1 N</th>
<th>Disagree N</th>
<th>Undecided N</th>
<th>Agree N</th>
<th>Strongly Agree N</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9) The main goal of collaboration should be to ensure the child with DLD has</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>equal opportunities to learn in school</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>(10) The desired outcome of collaboration is to enable the child with DLD to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>participate and achieve in school</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>(11) If a particular language intervention is known to be effective, but risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stigmatising the child with a language disorder, it should not be delivered</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>(12) It is part of the collaborative work of the SLT and teacher to promote</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive views of difference across the school</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>15</td>
<td>1</td>
</tr>
</tbody>
</table>

Key: R1: round 1; R2: round 2; SLT: speech and language therapist. Note: No statements in this section were included in round 2 of the survey.
with the intervention—even if it was different from what other children were doing:

Previously my son has not wanted to be set apart from his peers, he is very head-strong but if I think he should do something I might talk him round even if it is going out of class to do things that are different from the rest and he is embarrassed.

For statement 12, 15 participants strongly agreed, seven agreed, two were undecided, and two disagreed that it is part of the work of the SLT and teacher to promote positive views of difference across the school. Agreement was reached for statement 12 at round 1 (IQR = 1).

Many of those who agreed were clear that the SLT had a role in this work due to their specific knowledge of DLD:

I agree it is for the SLT to be involved with this goal because there are many misconceptions amongst school staff about language disorders and the SLT can put them right.

One participant who was undecided expressed the view that this may not be necessary, depending on the school setting, but that it should be a goal of collaboration to determine whether this work is needed or not:

This depends on the school. In some schools this might not be necessary as it is in place, whereas for others it might be required. A commitment to inclusion may be a necessary baseline for collaborative practice and so if not present would be a priority.

The two participants who disagreed stated that it was the responsibility of the school (and not the SLT) to ensure that students understand the ways in which people differ:

It is important in life for people to understand that everyone is different…. but it is for the schools to educate and remind pupils of this, not the SLT.

Discussion

We report the findings of an online survey using a Delphi methodology, the final phase of our larger study to generate agreed premises for SLT/teacher IPC when working with children in school who have DLD. The survey topics were informed by previous phases of the research, in particular by the views of children with DLD.

Regarding the goals of collaboration, consensus was reached for all statements about this topic at round one. Participants strongly agreed that the collaborative practice of teachers and SLTs should ensure equal opportunities for the child with DLD in school. They also agreed that supports should be individualised, but not delivered in a way that sets the child apart from their peers, thus overcoming the “dilemma of difference” [31,32]. Based on these findings, the first premise to underpin IPC is that collaboration ensures the inclusion of the child with DLD in school.

Regarding the nature of DLD, much of the speech and language therapy literature reviewed in our earlier study [17] was focused on understanding the diagnostic boundaries of the condition and on establishing the efficacy of interventions to reduce the language deficit of the child. In this study, only a small number of participants (mainly parents) agreed that DLD is best viewed as a medical condition and they gave two key reasons—there were benefits of doing so when securing services/funding, and when persuading others of the seriousness of their child’s needs.

Most participants agreed that the extent to which a child’s language learning difficulties are considered a “problem” is dependent on the environment in which the child must function. They discussed the need for assessments designed to understand/explain the child’s language learning differences in context, rather than to diagnose them.

This consensus view was consistent with those of the children in the earlier phase of this research [19]. While acknowledging their difficulties in learning language, the children stated that the classroom environment was a barrier to their achievement in school, and provided suggestions of how that environment could be adapted to enable them to better learn and participate. Based on the findings, the second premise to underpin IPC is that DLD is a learning difference not a disorder.

If guided by this premise, the focus of collaborative practice of SLTs and teachers would be to implement adaptations in the classroom to enable each child to achieve and participate. This is in contrast to the “diagnostic-remediation” approach, which underpins many current speech and language service models in school [33–35]. Rather than delivering supports to reduce a child’s language deficits, interventions are designed to change teachers’ practices in the classroom. Sustained practice change is acknowledged to be difficult to achieve and requires ongoing coaching and/or professional support for the practitioners involved [36,37]. When planning therapy services to schools for children with developmental disabilities (such as DLD) sufficient time and resources need to be made available for practitioners to successfully enact necessary change.

The most contentious topic in this study related to the role of the child in making decisions about supports. Although many participants agreed that the child with DLD should be included in decision-making, they were ambivalent about giving the child genuine influence (aka agency) in the process. There was also a lack of clarity from some professional participants about the concept of rights. Many agreed with the right of the child to be heard, but then stated that this should be conditional on particular individual factors, such as the age of the child and/or their language competence. While it was acknowledged by most participants that the child could bring useful insights when making decisions about supports in school, some (mainly parents) expressed the view that it is the “expert” knowledge of the professionals, rather than the knowledge that the child brings, which should inform practice.

Such ambivalence (about the role of the child in decision-making about supports) can be accounted for by a commonly-held belief that a child is not yet a sentient being [38], resulting in scepticism about the validity of their contribution to decision-making. There may also be a reluctance to relinquish power/control over the child [28]. This may explain why school children with additional needs are rarely included when decisions are being made about their supports [20,39,40] and/or even when they are present, they have little influence in shaping the outcome of such decisions [20,41]. Based on these findings, our third premise to underpin IPC is that the child is a human being in their own right.

Implications of the findings for inter-professional collaboration

This study was concerned with establishing premises to underpin IPC between SLTs and teachers in relation to children with DLD. However, our findings have broader implications for planning of supports for any child with a developmental disability in school.

In earlier phases of this research, we examined the literature and engaged a diverse range of stakeholders (teachers, SLTs, parents and children with DLD) to propose a set of shared
premises to underpin IPC when supporting the child with DLD in school. We identified a lack of shared goals and vision across these stakeholder groups [REF].

Children whom we involved in this earlier phase were able to provide clear goals and a vision of an inclusive classroom and a school in which they could achieve and participate [19]. After using the Delphi methodology described earlier, we presented these children’s views to parents, practitioners and researchers and found strong agreement in support of them. However, there was ambivalence in terms of stakeholders giving the children “real” influence in decision-making. Integrating the findings from our two studies, we propose the need for a client-centred orientation, as discussed by D’amour et al. [6].

Rather than assume knowledge about the support that a child wants, teachers and health practitioners should first seek to understand each child’s goals and desires about supports in school, and such information should then guide collaborative planning. We recognise that this may represent a significant shift in roles for the practitioners and the child. Attention to policy, research and practice is needed to effect such change.

At a policy level, reinforcing the unconditional right of the child to have influence in decisions about their support in school is required. This may be done by creating opportunities for children with developmental disabilities to get involved as stakeholders in policy change. In terms of speech and language therapy research, developing an evidence-base to guide language use/discourse when teaching and learning in the classroom is required. This will involve the use of different research methodologies, which can take into account the complexities of the classroom context. At a practical level, practitioners need to be trained in participatory methods of listening to children, such as by using photovoice [42] and/or the mosaic approach as described by Clark [43]. Encouraging such usage by professionals would enable meaningful engagement with the child about their supports, not as a once-off event, but as part of an ongoing dialogue.

Strengths and limitations of this study

Through engagement with a diverse range of stakeholders, we established premises about (i) SLT/teacher collaborative practice in schools, (ii) the nature of DLD, and (iii) the role of the child in collaborative decision-making about their supports. The study is unique in preserving the views of children with DLD as central throughout.

A purposeful and transparent recruitment strategy, the careful tracing of diverse perspectives during analysis and reporting, actively seeking feedback from multiple sources and the independent analysis of qualitative data, all added rigor to this study.

We acknowledge that the topics presented to the participants (particularly child voice and inclusion) may be prone to social desirability bias [24]. However, the diversity in views identified during analysis reassured us that participants openly expressed their views and/or disagreements with the statements presented.

Finally, as with any purposive sample, these findings cannot represent the views of all practitioners, researchers or parents. However, these findings advance our understanding of IPC between teachers and SLTs when supporting the child with a developmental disability in school.

Conclusions

In this paper, we report the final phase of a study to generate a set of agreed premises to underpin IPC between SLTs and teachers when working with children in school who have DLD. Based on our findings, three premises are proposed: (i) collaboration to ensure the inclusion of the child with DLD in school, (ii) DLD is a learning difference not a disorder, and (iii) each child is a being in their own right.

We recommend that practitioners first seek to understand the goals and vision of the child with a developmental disability and that they use these data to then guide their collaborative practice in schools. We also suggest that services/supports should focus on practice change in the classroom rather than on remediating the perceived deficits of the child.

Working in this way not only ensures that supports are responsive to the needs of the child, but that the child with DLD and others with developmental needs and disabilities have the opportunity to develop self-advocacy skills that are needed to participate and achieve in school and in life.

Notes

1. Grunwell [18, p.161] defines premises as “primary, in that they state the fundamental theoretical framework underlying a therapeutic approach.”

2. A language class is a class with reduced numbers of children (typically 7), in a mainstream school in Ireland which is attended only by children who have severe DLD. Children can attend such a class for a maximum of two years during the primary school years.

Acknowledgements

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Disclosure statement

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Data availability

Ethical approval for the study required that data are accessible only to the researchers.

References


Appendix 1. Participant sampling grid

<table>
<thead>
<tr>
<th>Participant type</th>
<th>N</th>
<th>Criterion1 (essential)</th>
<th>Criterion2 (essential)</th>
<th>Criterion3 (essential)</th>
<th>Criterion4 (desirable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher/lecturers in education</td>
<td>4</td>
<td>Works in university setting</td>
<td>Actively engaged in research/ teaching</td>
<td>Has published in peer-reviewed journals about SEN/inclusion</td>
<td>Has contributed to policy/professional guidelines about SEN/inclusion/collaboration</td>
</tr>
<tr>
<td>Researcher/lecturers in speech and language therapy</td>
<td>4</td>
<td>Works in university setting</td>
<td>Actively engaged in research/ teaching</td>
<td>Published in peer-reviewed journals about DLD/SEN/inclusion</td>
<td>Has contributed to policy/professional guidelines about DLD/inclusion/collaboration</td>
</tr>
<tr>
<td>Speech and language therapists</td>
<td>4</td>
<td>Works in mainstream schools with children with DLD</td>
<td>Engages in collaborative planning and practice as part of current role</td>
<td>Active member of DLD national network</td>
<td>Has contributed to training/development about working in schools for their professional body</td>
</tr>
<tr>
<td>Teachers</td>
<td>4</td>
<td>Works in mainstream school with additional responsibility for SEN</td>
<td>Engages in collaborative planning and practice as part of current role</td>
<td>Active member of professional network</td>
<td>Has contributed to training/development about SEN/inclusion for their professional body</td>
</tr>
<tr>
<td>Service- users</td>
<td>8</td>
<td>Mothers/fathers of a child with DLD</td>
<td>Experience of collaborative meetings about supports for their child in school</td>
<td>Experience of different models of speech and language therapy supports for their child</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*aSpecial educational needs.

bDevelopmental Language Disorder.