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Analysing and preventing school failure: Exploring the role of multi-professionality in pupil health team meetings☆

Eva Hjörne *, Roger Säljö

University of Gothenburg, Gothenburg, Sweden

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ABSTRACT

In many areas, expertise is becoming increasingly specialized and distributed between professionals. In response to this development, institutions have to organize inter-professional collaboration in order to be able to provide services required. In this study, we explore issues that concern multidisciplinary collaboration in pupil health teams in schools. The task of the team is to interpret and solve school problems. Team members have different professional backgrounds (teacher, psychologist, school-nurse, etc.), and this variety of expertise is expected to add to the quality of decision-making and problem-solving. The empirical question guiding the research is to what extent such multi-disciplinarity is visible in the work, and what the benefits may be. The analysis is based on micro-ethnographic work, including audio-recordings. The results show that the meetings are highly routinized, and that it is very difficult to find occasions where the various types of expertise represented by the participating professionals are made relevant. On the contrary, the discussion is co-ordinated on the assumption that the difficulties can be placed within the individual child. Important factors contributing to the persistence of this mode of reasoning is the collegial nature of the meeting, the dominance of a diagnostic culture, and strong institutional traditions of individualizing school failure. Multi-professional collaboration does not seem to promote alternative ideas or outcomes.

1. Introduction

In complex societies, knowledge and expertise become increasingly specialized. One sign of this is that professions are split up into a growing number of sub-areas or specialities, as is the case with engineers, teachers, economists, nurses and physicians, to mention but a few examples. The professional skills of a district nurse and a nurse in intensive or orthopaedic care no longer overlap, even though the persons have the same basic training. Such increasing division of labour is in a sense the price we pay for the expansion of the knowledge base and the introduction of new technologies and new work practices in many fields.

In such circumstances, the attempts to overcome the distributed nature of expertise in work practices imply organizing multidisciplinary or multiprofessional team work, where people with different backgrounds collaborate in the provision of services and goods (Edwards, 2011; Housley, 2003). In hospitals, for instance, health care teams with nurses, physicians, nutritionists, physiotherapists and others, engage in inter-professional work when assuming responsibility for the planning and provision of care for patients.

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* Corresponding author.
E-mail address: eva.hjorne@ped.gu.se (E. Hjörne).

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In schools, this increasing division of labour is also clearly visible. There are many different kinds of teachers with different backgrounds and institutional responsibilities (see below). In most schools there will also be representatives of other professions, who assume responsibility for various activities: educational psychologists, social workers, speech therapists, career guidance counsellors, school-nurses and so on.

One such responsibility of schools in which inter-professional team work has been introduced concerns the provision of support for children who experience difficulties in managing school work. In the Swedish context, so-called pupil health teams have been organized so as to prevent school failure by providing assistance to children at risk (Hjörne & Säljö, 2004). In the pupil health team different professions are represented. Typically, as members of such teams one will find an educational psychologist, a special needs teacher, a head teacher, one or more regular class teachers, a school-nurse and sometimes even a social worker or a speech therapist. The task of the team is to analyse difficulties that appear in school and to come up with suggestions for the support that should be provided. The idea behind using multidisciplinary teams in this particular context is to have access to a wide range of professional expertise in order to more effectively deal with problems that occur (Housley, 2003). The members of the team are expected to develop solutions of the problems at hand and make decisions about what interventions would be appropriate and what resources are available. Thus, the team has an analytical responsibility, but the members are also expected to be executive and suggest appropriate interventions.

In the present study, our ambition is to illustrate some features of how this team work is organized at a practical level, and what role multidisciplinarity and inter-professional collaboration plays. Thus, we have followed pupil health teams as they meet and do their work. In other words, we have studied the "doing" of pupil health, to use ethnomethodological parlance (Garfinkel, 1967). We will specifically focus on how professional knowledge is formulated and circulated in the groups, and to what extent the multidisciplinarity of the team contributes to alternative, and perhaps complementary, views of school problems.

2. Interpreting, preventing and solving school problems

The dilemma of pupils who do not fit into the mainstream is certainly not new to schools. Issues about how to categorize and classify the 'problem-child', i.e. the child who does not live up to the expectations, seem to have been on the agenda since schools were first instituted, and it seems likely that such problems will continue to be discussed in the foreseeable future. Even a cursory glance at classification practices through history shows that there have been many ways of categorizing pupils who fall behind or who do not fit in. School difficulties have been accounted for by classifying children as 'vagrant' or 'idiots' during the 19th century, and as 'weak', 'slow learners', 'imbecile', 'psychopaths', 'left-handed', 'immature' and so on during the early 20th century. At present, the discourse of neuroscience and neuropsychiatry is widely applied and children are diagnosed as 'having' ADHD, ADD, CD, dyslexia, Aspergers and so on (Hjörne & Säljö, 2008). In other words, classifying school problems by using different individualizing categories is a well-established feature of how the institution thinks and acts in response to problems (Douglas, 1986). Or, as Haug (1998, p. 237) puts it, the "grammar of special education persists", and a specific institutional language grounded in descriptions of children's shortcomings has become firmly sedimented as part of the tacit and explicit thought patterns of the institution. The introduction of multidisciplinary pupil health teams, in part, may be seen as an attempt to change this tradition.

An important line of empirical research on team work of this kind has been carried out by Mehan and his colleagues in the context of schools in the US (cf. e.g. Mehan, 1984; Mehan, 1986; Mehan, 1993; Mehan, Hertweck, & Meihls, 1986). In this work, details of the processes of sorting students into categories such as 'normal', 'special', or 'educationally handicapped' are documented. The studies show that a striking feature of the processes seems to be that the professionals make decisions without seeming to do so. Rather, decisions are presented instead of debated, as Mehan (1986) expresses it. In addition, Mehan and his colleagues found that the professional discourse of the psychologist, as a social language (Bakhtin, 1986), has a strong position in the US context. The reports presented by the psychologist (or, sometimes, the school-nurse) were accepted without challenge or further questioning. Thus, when "the school psychologist speaks, it is from an institutionally designated position of authority" (Mehan, 1986, p. 160). In these categorizing practices of the psychologist, the problems of the child "are treated as if they are his private and personal possession" (p. 154). This confirms the observation that there is a strong tendency in school to explain children's difficulties in terms of individual traits or alleged disorders. And, as a consequence, the problems become located "[b]eneath the skin and between the ears" (Mehan, 1993, p. 241) of the child.

In our previous studies (Hjörne & Säljö, 2004; Hjörne & Säljö, 2006; Hjörne & Säljö, 2008) of pupil health team meetings in Sweden, the results show that the activities within these meetings can be described as an "enactment of routines" (Mehan, 1984, p. 66) in which the diagnostic culture is strong and essentially unchallenged. The categories used by the staff in most cases refer to individual traits, such as lack of adequate intellectual capacity and immaturity, as causes of the problems observed. Other frequent types of categories appearing in the discussions are neuropsychiatric diagnoses. Pedagogical issues concerning how teaching and learning are organized, and to what extent these practices could be causing difficulties for pupils, are almost never addressed during the meetings. Nor are the activities of the teachers discussed as part of the picture of why pupils may experience difficulties.

An obvious feature of the discussion is that there is a high level of consensus in the team. The team meeting is a collegial forum in which professionals discuss among equals, and there is little overt disagreement or conflict. An interesting question in this context is the role that the multidisciplinarity of the team plays for the understanding of school difficulties and for the provision of solutions and action plans. This is the focus of this article.