Multi-professional Prereferral and School-Based Health-Care Teams: A Research Review

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Abstract


The aim of this report is to review research on multi-professional prereferral intervention teams (PITs) as well as multi-professional school-based health care teams. In some instances, teams similar to these two types of teams are also included. A multi-professional or multidisciplinary team is an organized group of personnel, each trained in different professional disciplines and possessing unique skills and perspectives, who share a common purpose of cooperative problem solving. PITs include many professions such as counsellor, social worker, special education teacher, school principal, psychologist, and general education teacher. PITs employ multidisciplinary problem solving and collaborative consultation with teachers, to develop interventions that address the needs of pupils in regular education through remedial and preventive strategies, and are thus an alternative to referral to special education as a means for teachers to get assistance with “difficult to teach” pupils. Research indicates that implementation of multi-professional teams in schools in order to cope with at risk pupils or pupils with academic or behavioural difficulties and assist teachers in these matters has positive effects by decreasing this kind of pupil difficulties and reducing pupil exclusions from general education (i.e., referrals to special education). However, there is only a relative small body of research on team effectiveness and some inconsistencies among findings. Nevertheless, some studies indicate that the quality of team process is related to team effectiveness. University-based, trained and implemented team processes have significantly better outcomes than field-based team processes, i.e., existing team processes not influenced by researchers. According to observations and field studies, PITs typically spend little time on defining the problem. Systematic classroom observation and diagnostic testing is rarely used to help define the problem. There is also a focus on within-child explanations. Moreover, many teams tend to jump prematurely to a discussion of interventions without first gathering and discussing classroom observation and diagnostic data. There is also a tendency for recommendations to focus too much on factors outside of the classroom. According to research findings, there exists inequality of influence in relation to decision-makings. There is a major variation between the contributions of the other professionals present in which a few have a major role whereas others almost say nothing during the meetings. The suggested strength of “multiple perspective” of multi-professional teams is not always obtained, but often undermined by the social processes and forces. Lack of treatment or intervention integrity is another problem detected in research. Team effectiveness is counteracted if teachers cope with team-recommended interventions insufficiently.
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Background

Pfeiffer (1980) defines inter-professional team as “an organized group of personnel, each trained in different professional disciplines and possessing unique skills and perspectives, who share a common purpose of cooperative problem solving” (pp. 389). In U.S. for example, multidisciplinary teams, rather than individuals, are by law expected to make decisions concerning eligibility and programming for special education pupils (Huebner & Gould, 1991).

So-called prereferral teams or prereferral intervention teams provide “an approach that school can use to help nonidentified children and prevent unnecessary referrals to special education /.../ These teams can be used to help maintain at-risk students in the regular classroom” (Meyers, Valentino, Meyers, Boretti, & Brent, 1996, p. 120). These teams represent a trend toward an integration of general and special education by providing assistance to pupils with mild disabilities in the general education classroom (Nelson, Smith, Taylor, Dodd, & Reavis, 1991), and thus providing immediate assistance to teachers and pupils rather than the typical “wait-and-fail” model in relation to special education (Lane, Pierson, Robertson, & Little, 2004). Burns and Symington (2002) includes in their definition of a prereferral team any multidisciplinary problem solving team that develops interventions to meet the needs of pupils in general education that are difficult to teach. “These teams recommend modifications of instruction and/or classroom management that help teachers deal more effectively with difficult-to-teach students” (Myers & Kline, 2001/2002, p. 34).

According to Eidle, Boyd, Truscott, and Meyers (1998), prereferral intervention teams employ multidisciplinary problem solving and collaborative consultation with teachers, to develop interventions that address the needs of pupils in regular education through remedial and preventive strategies, and are thus an alternative to referral to special education as a means for teachers to get assistance with “difficult to teach” pupils.

One of the rationale behind multidisciplinary prereferral teams is that “a group of professionals using multiple criteria would make less-biased referral decisions than an individual acting alone” (Knotek, 2003a, p. 2). Thus, these “teams provide a context for combining diverse perspectives and expertise to solve problems, improve decision-making, build collaborative relationships, and respond to changing circumstances” (Korinek & McLaughlin, 1996, p. 41). Buck, Polloway, Smith-Thomas and Cook (2003) compile a list of defining features regarding the prereferral model:
1. A process that is preventive (i.e., interventions are developed and implemented before a formal, special education evaluation).

2. A problem-solving approach that is team-based (i.e., team members review data on a referred student, hypothesize causes to explain the student’s difficulties, and develop strategies to remediate those difficulties).

3. An approach that is action-research oriented (i.e., a team develops specific interventions that the referring teacher[s] is expected to implement in his/her classroom [either with or without outside assistance] and then evaluate in terms of its effectiveness).

4. An intervention process that is centered upon the enhanced success of students and teachers within the general education setting and in the general education curriculum (Buck et al., 2003, p. 350).

Based on literature, Hammond and Ingalls (1999) describe prereferral process in several steps. Usually, the teacher who has concerns about a pupil’s academic or behavioural performance refers the concerns to the prereferral team. S/he meets with the team to discuss the concerns, interventions that have been tried and the outcomes or effects or these attempts. Then, the teacher and team members engage in problem-solving activities to assist the teacher to implement, recommend the teacher continue to use the interventions for an additional time period, or a mix of both. The team may follow-up this by meeting the teacher again to discuss results of the prereferral interventions, which may result in recommended changes or continuation. If the prereferral intervention works, the pupil will not be referred for a special education assessment.

With reference to Burns and Symington (2002), prereferral interventions teams generally follow five steps: (a) request for consultation, (b) consultation, (c) observation, (d) conference, and if needed, (e) formal referral for special education eligibility. Fuchs and his colleagues (see Fuchs, 1991; Fuchs, Fuchs & Bahr, 1990; Fuchs, Fuchs, Bahr, Fernstrom & Stecker, 1990) have developed a four-stage problem-solving approach to prereferral teams: (a) problem identification, (b) problem analysis, (c) plan implementation, and (d) problem evaluation.

Prereferral intervention teams have many labels (cf., Buck et al., 2003, p. 353; Yetter & Doll, 2007, pp. 340-341), such as teacher assistance teams (Burns & Symington, 2002; Lane et al., 2003; Nelson et al., 1991; Truscott, Cohen, Sams, Sanborn, & Frank, 2005), school-based intervention teams (Truscott et al., 2005), prereferral consultation teams (Doll, Haack, Kosse, Osterloh, Siemers, & Pray, 2005), teacher support teams (Burns & Symington, 2002), student assistance teams (Burns & Symington, 2002; Yetter & Doll, 2007), child study teams (Burns & Symington, 2002; Eidle et al., 1998; Klingner & Harry, 2006; Lane et al., 2003; Lane et al., 2004), student study teams (Klingner & Harry, 2006; Lande et al., 2003), intervention assistance teams (Eidle et al., 1998; Meyer & Kline, 2001/2002; Slonski-Fowler & Truscott, 2004), instructional consultation teams (Eidle et
al., 1998; Slonski-Fowler & Truscott, 2004), school consultation committees, (Nelson et al., 1991), consultation teams (Yetter & Doll, 2007), general education intervention teams (Lane et al., 2004), and mainstream assistance teams (Eidle et al., 1998; Nelson et al., 1991). Nevertheless, there exist different normative models about how to conduct and process pupil cases in such teams, and now and then some of the labels above are associated with such specific models (see for example, Nelson et al., 1991; Safran & Safran, 1996).

The concept of school-based health care refers to a practice aimed at meeting the physical and mental health needs of pupils (Brown & Bolen, 2003), and these clinics or services are located in the school building (Shaw, Kelly, Joost, & Parker-Fisher, 1995). School-based health care provides services beyond traditional education, and may include: (a) health services, e.g., screenings, school physicals, and immunisations, (b) mental health services, e.g., group or individual counselling and psychoeducational interventions, (c) social services aimed to link pupils and their families with needed resources such as food stamps, housing, and parenting assistance or support, and (d) health promotion and primary prevention services in relation to issues as bullying, drug use, smoking, nutrition, and sexual risk-taking (Meyers & Swerdlik, 2003). This review includes research on multi-professional prereferral intervention teams (PITs) as well as multi-professional school-based health care teams. In some instances, teams similar to these two types of teams are also included, such as planning teams (which make decisions about special education placement) and special education teams. Furthermore, in this report, prereferral teams, prereferral intervention teams, and PITs, which most of the research presented in this review is conducted on, will be used exchangeable.
The Research Review

While there is some research on multi-professional teams in health care or medical services, e.g., palliative, cancer, geriatric, psychiatric, or primary care practices (e.g., Bokhour, 2006; Drinka, 1994; Hermsen & Ten Have, 2005; Sheehan, Robertson, & Ormond, 2007; for a review, see Blomqvist, 2004), there is a relative small body of research in relation to multi-professional school-based health-care teams and prereferral interventions teams (cf., Burns & Symington, 2002; Meyers & Swerdlik, 2003). According to Kury and Kury (2006), virtually no information from research is available on the interrelationships that take shape between members of school-based multi-professional teams on pupils’ mental health services. Etscheidt and Knesting (2007) conclude that there is limited knowledge about the process prereferral teams use in a problem-solving approach.

Implementation of teams and its effects

Implementation of school-based health care services has shown to (a) have positive effects on students’ academic achievement (see Brown & Bolen, 2008; Shaw et al., 1995), (b) reduce school absence (Gall, Pagano, Desmond, Perrin, & Murphy, 2000), and (c) decrease aggressive as well as substance use behaviours among students (see Brown & Bolen, 2008). According to a study by Jennings, Pearson and Harris (2000), pupils who receive contacts with school-based health care services show 95 pre cent reduction of disciplinary referrals, 31 pre cent reduction of course pass failings, and 32 pre cent reduction of school absence.

A Norwegian study (Anthun & Manger, 2006) shows that schools with special education teams (SETs), which are multidisciplinary teams whose purpose is “to find and implement adequate treatment or training programs after assessment and diagnosis” (p. 262) and partly function like prereferral teams, compared to schools without SETs have: (a) a reduced number of referrals to school psychology services, (b) fewer referrals with behavioural cases, and (c) more collaboration between home and school and other services, including school psychology services. In addition, the professionals of school psychology services evaluated the service quality of the cases in the schools with SETs highest.

Older research reviews indicate that prereferral teams are successful in a majority of pupil cases in helping the teacher to improve the performance of his or her pupil as well as having the effect of reducing referrals to special education (Chalfant & Van Dusen Pysh, 1989; Sindelar, Griffin, Smith & Watanabe, 1992; for an example of an older study, see Gutkin, Henning-Stout
& Piersel, 1988). Nevertheless, in their meta-analysis of the effects of prereferral intervention teams, Burns and Symington (2002) conclude that there is only a relatively small body of research regarding the effectiveness of such teams, which, in addition, suffers from serious methodological concerns (e.g., low sample size and a lack of control groups) according to the quantitative research model of effectiveness studies (also see Nelson, Smith, Taylor, Dodd, & Reavis, 1991). Seven of the nine studies reviewed indicate that the PIT approach has a strong effect on desired outcomes, suggesting that PITs are effective in decreasing pupils with behavioural and academic difficulties and reducing referrals to special education. However, because of the little amount of studies in this meta-analysis, its findings should be interpreted with cautious. While some studies show a significant decrease in referrals to special education that significant differed from schools without PIT (e.g., Fuchs, Fuchs, & Bahr, 1990), a few studies did not (e.g., Short & Talley, 1996). Hence, there is little and contradictory research findings in this matter (Burns & Symington, 2002).

However, McNamara and Hollinger (1997) compared prereferral intervention teams that use a systematic, data-based procedures to describe performance problems and to implement and evaluate the success of interventions in which eligibility for special education is evaluated through analysis of data associated with intervention outcomes (i.e., whether the intervention improved the targeted behaviour and this intervention required specialised resources or services) with less systematic working prereferral intervention teams. They find that the former type of teams referred fewer pupils to special education and thus improved more of the pupils’ outcomes in the regular classrooms of general education than the latter type of teams. A study by Fuchs, Fuchs, Bahr, Fernstrom, and Stecker (1990) shows that the more PITs following the Behavioural Consultation (BC) model on problem behaviour of pupils in mainstream classrooms, the stronger effects they have in reducing problem behaviour, compared to teams with less systematic working procedures. Kovaleski, Gickling, Morrow and Swank (1999) found in their study that students supported by prereferral teams had higher levels of academic performance only when their schools implemented the PIT process to a high degree according to a set of quality features. Low PIT implementation resulted in no differences in academic performance compared to schools that had not implemented PIT. Hence, these studies indicate the importance of considering the quality of the procedures of prereferral teams than just the existence of them. With reference to Flugum and Reschly (1994), the quality of prereferral process is related to the outcomes of prereferral interventions.

According to Burns and Symington (2002), the most significant findings in their meta-analysis is the difference between PITs that were university-based, trained, and implemented for purposes of empirical investigation, and PITs that were field-based, i.e., existing PITs that were not established or trained by university personnel. This is in line with Safran and Safran (1996), who argue that positive results for PITs are found much more frequently for university-based teams, compared to research findings from field-based teams, which outcomes are more inconsistent (see also Safran & Safran, 1997,
p. 95). PITs not conducted through university research projects often fail to satisfy several of the quality indicators constructed by researchers, such as following a systematic problem-solving process, collecting data systematically or collecting baseline data, formulating hypotheses for the problems, or systematically following up on interventions to measure its outcomes (Aksamit & Rankin, 1993; Bahr, Whitten, Dieker, Kocarek, & Manson, 1999; Eidle, Boyd, Truscott, Meyers, 1998; Meyers, Valentino, Meyers, Boretti, & Brent, 1996; Telzrow, McNamara, & Hollinger, 2000).

Team Members Reports of their Teams and Team Working Processes

Of the 200 schools (four per state), which participate in an American survey study (Truscott, Cohen, Sams, Sanborn, & Frank, 2005), 170 have prereferral intervention teams (PIT). Information about elementary school’s PIT was obtained from a national telephone interview survey with mostly open-ended questions but also some multiple-choice questions. Respondents were primarily school counsellors (60%) or school psychologists (32%). Team members who commonly are reported by them include referring teachers, general education administrators, school counsellors, other classroom teachers, special educators, and school psychologists. Seventy-five pre cent of the teams have at least four of these six categories. Lesser reported members are speech teachers/therapist, school nurse, and school social worker.

According to the responses of the question, “What is the purpose or goal of the PIT (in your school)?” there is few common goals among the 170 teams. The only goal shared by more than a quarter of the teams is to increase the student’s academic performance (28%). Other goals also identified by the respondents are: decrease inappropriate testing or special education referrals (21%), obtain needed support for students (16%), help the classroom teacher (15%), provide intervention in the general education classroom (12%), provide some intervention (12%), and provide collaborative problem solving (9%). All these goals are, according to the researchers, generally consistent with the literature. Nevertheless, participants in the study infrequently identified several other goals that are recommended in the literature too. These are, for example, increasing the appropriateness of referrals to special education (4%), evaluating student progress to make data-based decisions (4%), matching instruction to the student’s skill level (2%), and improving instruction (< 1%). Five pre cent of the teams actually reports that the team’s goal is to place students in special education, which is clearly contrary to the literature.

Interventions and recommendations that are reported by the participants are most often directed at the student, usually implemented by the classroom teacher, and academically related (74% of the teams). Another common type of student-focused, teacher-implemented intervention is to modify the classroom structure (39% of the teams), but very low frequencies of evidence-
based interventions, such as behavioural contracts (6%) and token economies (2%), are mentioned. About half (52%) of the teams reported recommending treatment-oriented, out-of-classroom programs for difficult-to-teach students, such as individual/group counselling and remedial instruction, which is, according to the researchers, inconsistent with prereferral interventions described in the literature. Twenty-two per cent of the respondents reported that their team recommended further assessment in response to referrals, usually by psychological testing (9%). However, many of the types of assessments recommended in the literature are seldom recommended in the 170 teams, Truscott et al. (2005) argue. For example, fewer than 1% of the respondents report that their team uses curriculum-based assessment or reading evaluation.

Furthermore, the survey responses indicate that the teams seldom approach referral problems and recommendations from an ecological perspective but are usually treatment-oriented, and suggest simple interventions, which, according to the researchers, are unlikely to be effective. Few teams report, for example, goals related to effective intervention in the general education classroom. The full context of the presenting referral problems appears rarely to be considered in the teams. However, a problem in this study is that only one member represents each team in the survey. Thus, there is a risk that their responses could be suffered from their professional as well as personal biased views. Furthermore, the voice of school counsellors actually dominated the survey responses. Is it possible that the findings could be different if, for example, special educators primarily had been the respondents? Finally, the research depends on people’s reports and not on direct observations.

In an old study by Yoshida, Fenton, Maxwell, and Kaufman (1978), 1344 subjects from 230 so-called Planning Teams (PTs), i.e., teams that make decisions about special education placement and programming questions, rated in a self-assessment questionnaire how much they participated during a PT meeting and how satisfied they were about their presence on the PT and with the PT process itself. A strong positive relationship between staff roles and participation was found. School psychologists, school counsellors, social workers, central administration personnel (i.e., directors, co-ordinators, supervisors of pupil personnel and/or special education who are responsible for district-wide special education programs), and principals often rated higher values than medical personnel, special educators, and regular teachers. Furthermore, school psychologists rated, more than the other staff categories, that they contribute information to team decisions, interpret information for the team, propose alternatives, evaluate alternatives, and participate in making decision. They also usually rated more than others, that their presence is necessary at the team meetings. The regular teachers seem to have the most passive role at the meetings, according to how they rated themselves. Moreover, they rated lesser than others, that their presence is necessary at the team meetings. Thus, the findings indicate that professional membership can influence how active team members are and how they value themselves in school-based multi-professional teams.
A survey study by Huebner and Gould (1991) about school psychologists’ attitudes to multidisciplinary teams, in which they are members of, indicated an overall “average” level of satisfaction with the typical team functioning. They reported “minor” or “moderate” lack of clarity regarding roles, team goals, systematic decision-making methods, interdisciplinary trust, and appropriate follow-up. According to a survey study conducted by Bahr, Whitten, Dieker, Kocarek, and Manson (1999), team members as well as problem identifiers (usually teachers of the pupils) most often selected special education teachers as most knowledgeable about interventions for academic problems. Furthermore, team members view the team as an effective service delivery model and view collaboration as essential in the consultation/intervention process. However, most members reported the use of teacher judgements to determine intervention effectiveness. The researchers problematised this quality index and argue that “too often, however, such judgment is based on subjective opinion, rather than data reflecting academic performance or displayed behavior, and thereby raising important questions about the objective and reliable nature of judgments” (p. 80). What is more, members indicated that they were most unfamiliar, and consequently did not use, data-based intervention evaluation methods such as systematic classroom observation, comparing baseline with postintervention data, and graphing results of interventions.

Doll, Haack, Kosse, Osterloh, Siemers, and Pray (2005) conducted focus groups with members of prereferral teams from 13 schools and found that data collection is described by team members as difficult, time-consuming, and requiring a specially trained person to implement. At the same time, team members rate training in data collection as the most important need of school-based PITs. Furthermore, according to PIT members’ reports, extra work is required but is largely uncompensated and in addition to the PIT members’ already full schedules. The extensive time demand of systematic PIT procedures is the most frequently described barrier to effective PIT procedures in the focus groups. A survey study conducted by Yetter and Doll (2007) indicates that effectiveness of PIT procedures, sufficient time to carry them out, and adequate human resources (training and staff) in the team, predicted prereferral team acceptability.

According to a survey study in which members of 10 prereferral teams participated (Hammond & Ingalls, 1999), team members report that their primary function of operation is to provide school personnel with direction and support in meeting the individual needs of students. One of the reasons why they believe the teams are successfully maintained in the school is that the teams are multidisciplinary in membership and transdisciplinary in operation. Hence, teams are not viewed as static, and the various strength of the members is valued in the teams. Regarding perceived challenges, team members believe they lack sufficient time to effectively meet to discuss students of concern. Some of the advice these team members offer for other prereferral teams are: (a) if new members are added, they should receive adequate training and support regarding team’s norms, operational style, and individual roles and responsibilities, (b) all team members should have clearly defined and deline-
ated roles and responsibilities so that the majority of work does not fall on one or two members, and (c) a training and clear procedures for conflict resolution should be identified, because conflict is a common characteristic of teams.

Group and Problem-Solving Processes in Teams According to Case- and Field-Research

Meyers, Valentino, Meyers, Boretti, and Brent (1996) have conducted a qualitative study of eight school-based prereferral teams by questionnaires (62 team members and 72 teachers who are not team members), interviews (57 team members and 34 teachers who are not team members), and observations of team meetings. The teams in the study include a counsellor, social worker, special education teacher, drug counsellor, school principal, psychologist, and general education teacher. Multidisciplinary is valued as something positive by many participants in the study, illustrated by comments such as “Each member has seen the children in a different context” and “Hearing other perspectives is very helpful”. According to the researchers, their team observations indicate that most of the teams contain group processes that create cohesive teams. At the same time, data from interviews and surveys show that some teams were perceived as not holding meetings with sufficient frequency or consistency. As an effect of infrequent meetings, many respondents feel that too many cases are discussed per meeting, which result in superficial case discussions. Insufficient teacher involvement or participation in team process as well as lack of respect for teachers by some teams or team members is also reported. “The team seems to sit there and wonder if you are telling them the truth. You have to defend your position”, as one respondent puts it. In addition, in some of the cases when the referring teacher is present, the team seems uncertain about the teacher’s role, e.g., should the teacher formally present the case or not?

The processes during the team meetings were observed and analysed too. According to the researchers, most teams spend little time on defining the problem. Systematic classroom observation and diagnostic testing is rarely used to help define the problem. Moreover, many teams tend to jump prematurely to a discussion of interventions without first gathering and discussing classroom observation and diagnostic data. There is also a tendency for recommendations to focus too much on factors outside of the classroom and the researchers interpret this tendency as a possible result of the minimal focus on problem definition and data gathering. Here is a tendency to view the referral problems as residing within the child rather then the school environment. Furthermore, there is tendency in some of the teams that one or two members dominated the meetings (unfortunately, it does not emerge in the research report if this is related to professional roles or not). In some teams, there is insufficient closure at the conclusion of the case so that individual members do not have a clear understanding of their responsibilities, or that responsibil-
Knotek (2003a) conducted a micro-ethnographic study in two predominantly African American elementary school within a poor, rural community to examine how members of multidisciplinary student study teams (SSTs) conceptualised and discussed students’ problem before deciding upon a special education referral decision. The professions represented in the meetings included teaching, counselling, psychology, and administration. One of the main theme in the findings is teacher’s focus of concern and the locus of the problem. The pupil’s teacher is the staff member who is most identified or professionally linked to the pupil. Hence, the teacher risks losing more than anyone else if the pupil misbehaves or performs poor academically. Moreover, the teacher has to discuss his or her problems with pupils in front of an administrator, the school psychologist, the counsellor, and fellow teachers. According to the study, teachers’ initial descriptions of the pupils were the most negative and evaluative of all the team members’. “Within the SST process, the teachers’ descriptions of the students were especially important because they framed the initial discussion. Being the initiator, the teacher set the tone and, as the referral form said, the ‘focus of the meeting’. Given the choice of focusing on instructional failings or student failings, the teachers consistently chose the latter” (Knotek, 2003a, p. 7). In the conversation process after teachers’ initial descriptions, team members tends to support the teachers’ representation of the problem by continuing putting the locus of the problem primarily upon the pupil or his or her family, and thus, collectively constructing representations that are in line with the teachers’ initial concerns.

Another main theme in the findings is members’ social status and conceptualisations of the problem. High-status team members, defined as “permanent team members with graduate academic degrees and specialized roles” (pp. 8-9), had a higher influence on how pupils’ problems were conceptualised by the team as a whole. Principals, counsellors, and psychologists introduced language and conceptualisations into the discussions that were then adopted by other members, which reflects social power and influence. Thus, a few individual perspectives actually became collective terms of the teams. As a result of the counsellors dominated role as leading the teams and chairing the meetings, and by framing the pupils’ school functioning in terms of family background, the problem were shifted from the child to the background environment, and thus, “the team found itself in a situation where there was little that could be done to support a child in the general education setting” (Knotek, 2003a, p. 9). These social processes that appear to be problematic in the problem-identification stage seem to most affect the interventions suggested for pupils who had been described either as behaviour problems or as being from low-SES families. When one or both of these factors were present, the teams’ problem-solving process was less reflective compared to when pupils were referred primarily for academic problems or were from higher SES backgrounds.
When pupils were described as having behaviour problems, the social process of problem-description stage focusing primarily on conforming the teacher’s experience rather than generating multiple hypotheses. Hence, the other team members support the teacher by colluding in the selective use of data. This focus was then carried over into the generation of interventions and limited the range of interventions, all focusing on controlling the pupils’ behavioural symptoms in the classroom. Academic concerns were rarely discussed as an antecedent to the behaviours. Teachers’ statements of having tried all kinds of interventions such as contracts, time-outs, detentions, and praises, where taken-for-granted. “Of the students who were initially described as possessing behavior problems, all of them in the country school were eventually referred for special education assessment, and most of the students at the town school were referred. All of the referred students were African American and all but one were boys” (Knotek, 2003a, p. 10).

A more limited range of alternative hypotheses and potential interventions was also typical in the problem-solving process for pupils from low-SES families than for other pupils, and thus, they were referred more often for assessment for special education. “Their problems were often conceptualized by the team as having an etiology and a locus of control that were beyond the bounds of the school, and the interventions reflected this characterization” (p. 10). Proposed interventions for these pupils, such as the “buddy” system or some type of formalised after-school tutoring, often had the effect of just “containing” the child in the classroom, and usually did not result in much academic gain for these pupils. Thus, the findings indicate that the suggested strength of “multiple perspective” of multi-professional teams were not always obtained, but often undermined by the social processes and forces which at times function to inhibit members from voicing competing representations of pupils. The decisions to place pupils, who are described as behaviourally out of control in the teacher’s classroom, in special education do not really occur within the team process, but rather occur with the act of referral. This confirmation bias has also been seen in older research on prereferral teams (Ysseldyke & Algozzine, 1983) as well as in research on school psychologists’ decision bias in relation to initial pupil information (O’Reilly, Northcraft, & Sabers, 1989).

The teams in a qualitative case study in four schools (Eidle, Boyd, Truscott, Meyers, 1998) frequently have to deal with cases of academic difficulties as well as behavioural problems and social-emotional issues. Team discussions rarely extend beyond the initial reason for referral, do not follow a systematic problem-solving process, and focus on within-child explanations. As a result of not taking an environmental or ecological approach to problem identification and intervention generation, there is a tendency to “search for pathology”. Most of the recommended interventions in the teams are treatment, indicating that they focused on “treating” a specific disorder, beyond the point of prevention or early intervention, including both in and outside school treatments such as referring to special education, in-school counselling, and outside counselling. Early interventions, i.e., interventions aimed at keeping a developing problem from becoming worse, is infrequently recommended,
however, with the exception of parent contact, which is quite common. Thus, most of the interventions recommended by the teams in the study take shape outside classroom and/or school. They seldom require the general education teachers to make any modifications in the classroom.

In a qualitative study of multi-professional child protection case conferences (including social workers, social services managers, teachers from children’s school and/or education welfare officers, police officers, and school nurses and/or health visitors), conferences were observed and team-members interviewed (Harris, 1999).

According to the findings, there exists inequality of influence in relation to decision-makings. The role of the chair is a very powerful role, not only by introducing, summarising, and timekeeping but also by giving guidance on decisions and making proposals. There is also a major variation between the contributions of the other professionals present in which a few have a major role whereas others almost say nothing during the meetings. The findings also indicate that the case conference appears only be a part of the decision-making process. There are references to decisions in between meetings. Furthermore, a lack of science is found in the meetings, i.e., there are no references to social, medical or psychological theories or research during the meetings. In their multidisciplinary decision-makings, team-members usually strive for consensus above all else. Few overt conflicts between professionals occur at case conferences. According to interviewees, it is difficult to disagree openly. Harris (1999) makes the conclusion that “the evidence indicates that the prime (if well-hidden) function of such a meeting may be to contain professional anxiety and provide support for the role and responsibility of the lead agency through the promotion of a no-conflict norm” (p. 251), and relates this to normative influence in contrast to informational influence.

An ethnographic study of decision-making processes in child study teams (CST) that result in the overrepresentation of ethnically and linguistically diverse students in special education was performed in nine schools. The CST processes of these specific student cases were investigated. According to the authors (Klingner & Harry, 2006), students’ difficulties were often attributed to intrinsic deficits of some kind (low IQ or learning disabilities) rather than a lack of full English proficiency. In some cases, there appeared to be an over-reliance on the teacher’s or parent’s opinions about a student’s English proficiency. Moreover, there was a biased overreliance on test scores, and the psychologist was the person with the most authority and decision-making power. “This overconfidence in test scores meant that little consideration was given to other factors that might provide alternative explanations for students’ behaviors, such as teacher or environmental factors. None of the CST conferences we observed seemed to take into account the ecology of the classroom from which a child was being referred. The assumption seemed to be that the problem was within the child, not in the environment” (p. 2267). Furthermore, prereferral interventions within the regular education were rarely suggested in the CST process. Parent involvement was also weak in the process.
Klingner and Harry (2006) noted several problems in relation to this issue: (a) negative comments and derogatory remarks about the families, e.g., labelling them as “crazy”, “retarded” or “unreliable”, (b) inadequate or sporadic translation services, (c) ignoring and unprofessionalism such as not acknowledging parents’ questions or comments or performing conversations in front of parents as if they were not there, (d) insensitivity in the interactions with parents, e.g., rudiness, and (e) failing to understand the hardships described by parents.

Hjörne and Säljö (2004) investigated the discursive practices in 14 meetings performed by a pupil welfare team (elevhälsoteam) in a Swedish primary school. The team members are a principal, an assisted principal, a school psychologist, a school nurse, a speech therapist, and a special education teacher. When a pupil case is introduced in a meeting, the presentation is focused on the child’s alleged difficulties and on suggesting an action to be taken. Information about the strengths of the pupil is generally not a part of the presentation. The conversation that takes place after the presentation of a pupil case moves forward through an enumeration of further accounts that support the picture initially given. The accounts produced individualise the problems of pupils by pointing to lack of ability or other necessary qualifications on the part of the individual pupil for managing school life. Lack of adequate intellectual capacity and/or knowledge is present in many of the accounts given in the meetings. One frequently used metaphorical construction is that of “weak”. Another frequent type of account relates to issues of the alleged immaturity of a child as a reason why the pupil is not performing as expected. There are also a large number of accounts referring to a psychological and/or folk-psychological social language pointing to problems such as lack of motivation or empathy, anxiety, aggression etc. Many of the accounts seem to be ambiguous and quite vague.

The problems and pupils’ inappropriate behaviours that are discussed are rarely contextualised as responses to what has happened in the classroom, nor as a consequence of the pedagogical arrangements in the class. Thus, “there is a clear tendency to decontextualize the child and his/her problems from the concrete practices of the classroom” (Hjörne & Säljö, 2004, p. 334). Furthermore, there is a lack of attention to the discussion of goals and to the evaluation of previous attempts to cope with the problems. “The analytical work mostly seems to operate in an ad hoc fashion in response to emergencies and renewed complaints, and it does not rely on the articulation of explicit strategies to deal with the kinds of problems discussed. There are very few occasions where the outcomes of previous attempts to handle problems are asked for. The minutes written are generally quite abstract and uninformative as to detail and substance. Thus, there is very little evidence of cumulative work where systematic attempts to deal with problems are formulated, tested and documented for further consideration” (p. 334).
Moreover, instead of using the full potential of the multi-professional composition of the team in terms of using different professional languages that potentially would contribute to new perspectives, the reliance on categories that focus on the individual, accounting for the pupil’s problems in terms of alleged biological and constitutional deficiencies appears to be shared by all. Hjörne and Säljö (2004) conclude that the problems discussed in the meetings are very seldom seen as consequential to pedagogical practices or teacher actions. “Current pedagogical practices are taken for granted and not addressed as being relevant to an understanding of the problems discussed /…/ The meta-message seems to be that children are problematic but pedagogical practices are in order” (p. 335). Furthermore, according to the findings, the pupils have no say in articulating their accounts of the issues discussed.

Kury and Kury’s (2006) study shows that when participants in multi-professional school-based health teams reach a high level of congruence of views regarding diagnosis and problems of the particular student, then the time between the point at which the case is brought to the attention of the mental health provider and the point at which the appropriate interventions from the student’s treatment plan is put into place (time to implementation) is significantly shorter, and teacher as well as parent satisfaction are significantly higher. Hence, this study indicates how urgent it is that members of multi-professional teams can reach a congruence of views instead of being occupied by territory-thinking and professional ego-centrism. Even if different professions have different professional languages, studies show that members of pupil health teams and prereferral teams can learn from each other and in long term develop a common language (Geijer, 2003; Knotek, 2003b).

Recently, Etscheidt and Knesting (2007) conducted a qualitative case study with the aim of investigating the interpersonal dynamics of a prereferral team at an elementary school nominated as a school with an effective, exemplary problem-solving process. Team members were interviewed and seventeen prereferral meetings were observed. According to their findings, a lot of themes characterised the well-functioning team and its effectively working process. Multidisciplinary interactions, i.e., the members emphasised the value of multidisciplinary perspective for group problem solving, and the fact that it contributes to a more complete understanding of each child. According to observations, all team members were active participants in the discussion of student needs. The experience and expertise of the team members were perceived by team members as contributing to the effectiveness of the problem-solving process. Observations revealed that members consistently referenced research about specific topics, theories, or programs. Furthermore, the team members reported about the advantages of team continuity and consistency in facilitating group discussion and decision-making. The commitment of the team members was also emphasised as a significant contributor to the effectiveness of the problem-solving process. Parent participation in problem-solving meetings was reported and observed as an important factor. Parents were viewed and treated as valuable resources and contributors. Administrator support and involvement, i.e., the principal’s decision to commit financial resources to facilitate PIT meetings as well as his active participation in the process.
Data and documentation guiding the dialogue: Teachers bring data about a student’s needs and previous interventions to the PIT meeting, which provide a foundation for discussion and decisions. According to the observations, “all meetings began with a brief, detailed and data-based description of the student’s current level of functioning, the teacher’s primary concern, and current interventions. Referring teachers came to meetings prepared with work samples and graphs” (p. 277). The problem-solving process then focused on a single concern for the student to define the problem. To concentrate on one thing was an effective way to structure the dialogue. Team exploration of multiple options for resolving problems: The exploration and discussion of a variety of solutions to academic or behaviour problems were most often about interventions in the general classroom classrooms. There was a focus on student needs and strengths, previously attempted interventions and their outcomes, and the type of support needed by general education teachers.

Professionalism in dissent: Team members talked about the importance of maintaining professional relationships throughout the problem-solving process, particularly during conflict or disagreement, and thus maintaining a safe and comfortable climate of the PIT meetings. An environment conducive to safe and open discussions was also confirmed by the meeting observations. Teacher acceptance and “buy-in”: According to the team members, the dialogue and decisions from the team were enhanced by the teachers’ active participations in the process. “Teachers focused on what they could do to make the student more successful, not what somebody else could do” (p. 280). Constant and continuing efforts to improve the process: Team members were focused on how to continuously improve the interpersonal interactions of the PIT meetings and the problem-solving process. Nevertheless, cautions about generalisation of findings from studying one “exemplary” team should be concerned. As Etscheidt and Knesting (2007) concluded, “although the study contributes to an understanding of factors influencing the interpersonal dynamics of the prereferral process, the results are context-specific” (p. 281). Furthermore, the findings cannot tell us if these themes cause nor correlate to the effectiveness of the team, only that they characterise the specific team and the problem-solving process in the school.

Teachers Role in Team Processes and Its Outcomes

With reference to Slonski-Fowler and Truscott (2004), the classroom teacher’s role in the PIT process, i.e., implementing team interventions or recommendations and controlling the instructional environment, is critical but virtually ignored in the literature. “Consequently, there is neither a clear understanding of the teachers’ role in the PIT process nor a general model that describes the teachers’ engagement in prereferral intervention” (p. 3). Of a total of 73 real-life difficult-to-teach student problems described by teachers during interviews, 80% of these problems were thought to have emanated from the children, their parents, or a combination of these sources, while only 20% of the problems were attributed by the teachers to their own behaviour or classroom practice (Wilson, Gutkin, Hagen & Oats, 1998), which confirm teachers’
focus of concern and the locus of the problem when they present their pupil cases in PIT, according to Knotek's (2003a) field study.

Moreover, the teachers were unable to describe their interventions and methods with difficult-to-teach pupils in anything other than vague terms, unable to describe these in sufficient detail, which, according to the interpretation of Wilson et al. (1998), indicates that “the interventions implemented for difficult-to-teach children in general education classes by general education teachers may be of relatively low quality (p. 56). “This findings are especially noteworthy in light of the repeated encouragement given throughout the interview for the teachers to provide more detailed descriptions of their work” (p. 56). Teachers also frequently told that they lack knowledge of data collection and analysis methods. Almost all of the data collection practices described by them showed that they used haphazard methods (e.g., mental notes, infrequent observation, occasional journal entries, intuition) rather than systematic methods (e.g., frequency counts, graphs). Furthermore, most teachers describe their approaches to analysing the gathered data in order to making decisions only in vague terms. Teachers also mentioned uncertainty regarding if and when they should contact specialists from the PIT, whether these specialists would be accessible, or whether they had relevant knowledge to offer (Wilson et al., 1998).

According to teacher reports in a survey study (Lane, Pierson, Robertson, & Little, 2004), teachers largely refer pupils to the PIT for academic concerns with particular emphasis on reading and writing skills problems, compared to behavioural concerns. Among behavioural concerns, attention concerns is the predominate concerns. “Externalizing behavior patterns which include behavior such as disruption, noncompliance, and hyperactivity are clearly more apt to capture teacher attention as compared to internalizing behavior patterns that include anxiety, depression, and social withdrawal” (Lane et al., 2004, p. 435).

_Treatment integrity_ refers to “the degree to which an intervention is implemented as originally designed” (Lane, Mahdavi, and Borthwick-Duffy, 2003, p. 149). Low degree of treatment integrity in how teachers cope with team-recommended interventions has been found in research (Witt, Gresham & Noell, 1996). However, according to Lane et al. (2004), very few of the teachers in their survey study reports that they have received in-class demonstration for any intervention generated by the PIT as well as follow-up after the PIT meetings in the form of classroom observations and verbal feedback. Another survey study by Lane et al. (2003) shows that many teachers want support in implementing interventions generated by prereferral teams.

Slonski-Fowler and Truscott’s (2004) study indicates that teachers disengaged from the PIT process in response to team behaviours at three critical points. They disengaged when the team (a) devalued or ignored teachers’ input, (b) suggested limited, vague, or irrelevant interventions, or (c) exhibited little ac-
countability or follow-up after PIT meetings. Analyses of teacher interviews, PIT observations, and classroom observations revealed a model of the continuum of the teachers’ perceptions of the PIT process and the potential outcomes from the PIT process regarding teacher PIT participation (see figure 1).

Figure 1. Continuum of teacher PIT participation
(Slonski-Fowler & Truscott, 2004, p. 16)

Whereas the horizontal arrows in the figure represents ideal teacher participation stages, the vertical arrows represent various points during the prereferral process where teachers disengaged from the process, either by leaving it or by functionally disengaging such as not implementing some or all of the intervention strategies, being unwilling to engage in active problem solving with the PIT, being silent, or failing to challenge the team when meetings resulted in unacceptable outcomes. According to the study, 8 of 12 teachers think that the PIT devalued their role as informants. Teachers underlying assumption seems to be that the team likely would disregard their professional observations and their presentations of students. Nine of the 12 teachers think that the intervention strategies generated by PIT are redundant, generic, or too vague to implement, and thus “did not meet the individual needs of the referred students nor did it assist teachers in providing effective classroom interventions” (Slonski-Fowler & Truscott, 2004, p. 22). The PIT makes few novel classroom recommendations that the teachers had not already implemented before the PIT referral, according to the interviews with the teachers.
They also believe that the developing of the so-called instructional student support plan primarily is an exercise in documentation, and rather worthless. Furthermore, teachers perceive that the teams demonstrated little or no accountability for implementation or outcomes, which also is a source of frustration for most teachers. “This perception appeared to be rooted, in part, in the teachers’ frustration with the PITs’ lack of classroom observations, either as part of an initial assessment or after recommendations had been made. In fact, at the conclusion of this research, no PIT members from either team had checked back with teachers or observed teacher implementation of recommended interventions” (Slonski-Fowler & Truscott, 2004, p. 25). Nevertheless, even if many of the teachers in the study express all these negative attitudes, not all teachers voice these perceptions, but express more positive views about the PIT process. They, who do, think that their direct contact and interpersonal relationships with a member or members of the PIT give them a different and a more positive view of the process. Moreover, they who have positive feelings about PIT’s follow-up and accountability processes perceive accountability as a joint responsibility of the team and the teacher.

A study by Kutsick, Gutkin and Witt (1991) indicates the significance of collaboration and teacher participation in intervention generations in relation to teacher acceptance. Interventions reported to have been developed via collaborative interactions between school psychologists and teachers were found by teachers as more acceptable than identical interventions reported to be developed by either psychologists or teachers working alone. The findings from Slonski-Fowler and Truscott’s (2004) and Kutsick et al. (1991) points to the concept of treatment acceptability, meaning that “participants should ‘like’ a planned intervention, believe it will be effective, and find it practical to implement” (Truscott, Cosgrave, Meyers, & Eidle-Barkman, 2000, p. 173).

Spratt, Shucksmith, Philip, and Watson (2006) conducted six case studies in a Scottish context, with the aim of exploring the interactions between different professional groups in the school setting, in relation to the support of mental well-being of pupils. The interviews show that teachers generally feel a relief at having “specialists” working in the school, thinking that the welfare needs of the pupils in their school is addressed. Some of the teachers also describe a positive impact the teams have on their own well-being, but at the same time, the presence of other professionals appears to serve to absolve teachers of responsibility for mental well-being, rather then resulting in new thinking. Moreover, there seems to be significant impediments to communication between classroom teachers and other professionals. For example, school timetables and physical distance-making staff locations. More fundamentally is the problem of professional boundaries, i.e., the barriers and rivalries between professional groups. Teachers tend not to seek advice outside their own profession, regarding children with behavioural problems. Most teachers report that they would approach other teachers.
There was some evidence of teachers actively rejecting other professionals as a potential source of advice or information. Teachers questioned the validity of receiving training or advice from individuals without direct experience of classroom management, even when those professionals had specific expertise about the mental health of children” (Spratt et al., 2006, p. 397).

Furthermore, many non-teaching workers are aware of this suspicion and thus avoid engaging with teachers as a result of the potential hostility. This reinforces the professional boundaries between them. Thus, understanding about mental health is not transmitted to teachers. Moreover, as a result of the strict codes of confidentiality among health and social service providers, teachers experience loss of information that they think they need to cope more appropriate to students in need. Hence, teachers report a reduction in their feelings of competence and confidence. Finally, Spatt et al. (2006) conclude that while the non-teaching workers in schools are generally isolated from other members of their own profession and had instead developed effective interagency teams amongst themselves, teachers continue to be surrounded by members of their own profession and isolated from other networks. “Consequently, the non-teaching interprofessional team often supported young people in spite of the school, rather than in a spirit of co-operation” (p. 400). They also conclude that an “holistic” approach to well-being is not achieved by simply importing specialists into the schools, because it appears to be hard to change the well established practices of teachers in existing schools.

Consultation of Teams and Team Process Changes

An action research project in which prereferral intervention teams received consultation during an extended time (Truscott, Cosgrove, Meyers, & Eidle-Barkman, 2000) shows that the teams alter their goals and practices. In the beginning, the teams did not perceive their role as preventive, while the consultants did. Nevertheless, the consultation process changed team members view and they became to accept prevention as a PIT goal and asked for more time to plan how they could incorporate prevention in their practices. Another change was from the lack of teachers as team members to adapt teachers as team members in all teams in the study.

Thirdly, with reference to the data from observations of the teams and review of records, the consultants thought that existing PIT problem-solving strategies were ineffective. “These data suggested that the teams did not use a specific problem-solving model, focused almost entirely on within-child and within-family problems, and seldom considered the instructional environment in their deliberations. This limited their effectiveness because they neither collected the relevant data nor defined problems before working on interventions. The PITs also frequently discussed the same children repeatedly without planning interventions and seldom evaluated the outcomes of their efforts” (p. 192).
The consultants communicated data about the specifics of the teams’ problem solving processes and introduced a systematic problem-solving model (problem identification, problem analysis, problem redefinition, intervention plan, and evaluation). First, the PITs were opposed to implementing a systematic problem-solving process, including attention to classroom-based data collection and intervention. “For example, most team members did not believe that teachers would accept specific classroom recommendations for behavioural and academic referrals. In response to these concerns, the consultants included questions on the faculty survey that asked whether teachers believed the teams should make classroom-based recommendations. These survey results indicated that about 80% of teachers believed the teams should make classroom-based academic and behavioral recommendations” (p. 193). This survey result was reported to the teams. During the process, the teams began to endorse the concept of systematic problem solving. However, doing observations of classroom environment was never accepted among the team members. Many of them still believed that most teachers would not welcome such activities if the aim was to identify classroom practices that were need of improvement rather than the pupil’s problem behaviour. In conclusion, these findings indicate that there was a relationship between the acceptability of the ideas presented in the consultation process and the changes adopted by the teams. Thus, acceptability appears to be an important component in organisational consultation of prereferral intervention teams.
Summary and Conclusions

Research indicates that implementation of multi-professional teams in schools in order to cope with at risk pupils or pupils with academic or behavioural difficulties and assist teachers in these matters has positive effects by decreasing this kind of pupil difficulties and reducing pupil exclusions from general education (i.e., referrals to special education). However, there is only a relative small body of research on team effectiveness and some inconsistencies among findings.

Nevertheless, some studies indicate that the quality of team process is related to team effectiveness. University-based, trained and implemented team processes have significantly better outcomes than field-based team processes, i.e., existing team processes not influenced by researchers. Hence, to investigate latter type of teams and team processes is urgent to acquire a better understanding of the problems that counteract the official aims or goals of the team practice. Some aspects can be detected and discussed from the research in this review.

*Team goal diffusion*, i.e., when team members have problems with knowing the goals of the team, its work and its outcomes, is obviously a threat to the intention of reaching the official goals of the teamwork. *Lack of systematic problem-solving procedures* is a main problem indicated in some of the studies, such as insufficient problem identification, insufficient and unsystematic data collection, problem analysis and intervention generation without sufficient data, and deficiency in follow-up and evaluation practices, which lead to premature interventions. *Lack of science in the content of team conversions*, i.e., no references to social, medical or psychological theories or research during the meetings, can also be problematised in terms of quality, multidisciplinary, and intervention effectiveness.

Multiple disciplinary perspectives appear to be inhibited during team meetings by power asymmetry among team members as well as by striving of consensus. Thus, *inequality of social status and influence among team members* counteracts multiple perspectives and intervention suggestions. Instead, high-status team members and those who have the chair role, have a higher influence on how pupils’ problems are conceptualised and on the generation of interventions. Furthermore, *conformity bias*, both in terms of (a) taking the teachers’ initial descriptions of the pupil for granted and confirming this description during the team conversation process, and (b) avoiding conflicts within the team by striving of consensus and upholding a no-conflict norm, counteract the suggested strength of multiple perspective of multi-professional teams too.
Within-pupil and out-of-school explanation bias, i.e., a tendency to view the problem as residing within the child and his or her family rather than the school environment, can at least in part be interpreted as a result of taking teachers’ initial descriptions for granted, minimal focus on problem definition, lacking of collecting systematic classroom observation data, fearing of teacher rejection of classroom-based data collection and classroom recommendations, lacking of science in the content of team conversations, inequality of social status, and conformity bias. The tendency of putting the locus of the problem upon the pupil or his or her family, also limited the range of alternative hypotheses and potential interventions. This lack of taking a holistic and ecological approach to problem identification and intervention generation results in a tendency to search for and treat pathology, and a tendency to not consider prevention and early intervention.

Lack of treatment or intervention integrity is another problem detected in research. Team effectiveness is counteracted if teachers cope with team-recommended interventions insufficiently. This can be related to insufficient teacher skills in implementing the interventions as well as teacher disengagements from the team process as a result of being ignored or devalued by the team, receiving limited, vague, or irrelevant interventions from the team, or exhibiting little accountability or follow-up from the team after team meetings. Another problem indicated in some of the studies is lack of time. Team members need time to (a) hold meetings more frequently to avoid discussing too many cases per meeting, resulting in superficial case processes, and (b) to conduct a more systematic problem-solving procedure, such as conducting sufficient and systematic data collection as well as intervention evaluation. Different professional language can be a communication problem and slow the process, but research indicates that team members can learn from each other and in long term develop a common language.
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