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NARRATIVES of PROFESSIONAL HELPING

Special Issue on Interprofessional
Collaborative Practice and Education

Jayashree Nimmagadda and Judy Murphy, Guest Editors

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Introduction to the Special Issue on Interprofessional Collaborative Practice and Education

Jayashree Nimmagadda and Judy Murphy

Abstract: These narratives describe how interprofessional relationships, communication and collaboration improve client care and enhance community health and well-being. Much research in this area focuses on the health care field is and limited within the education field. Research shows that health professionals work collaboratively, quality and efficiency improve, there are better client outcomes, and professionals are more satisfied. Research on interprofessional education (IPE) indicates that IPE promotes positive interactions and improves attitudes towards other professions. When students learn together they develop an appreciation for one another's role in health care and develop trusting relationships.

Keywords: interprofessional education; collaborative practice; Interprofessional Education Collaborative; community health; well-being; knotworking theory; relationships

Welcome to the special section on interprofessional collaboration in practice, research and education! We have been working on this issue for about a year now and are excited to share the narratives that have been crafted by several professionals. About five years ago the two of us met on campus at Rhode Island College. Our deans brought us together because of our mutual interest in Interprofessional Education. The timing was perfect. Shortly after we met to discuss how social work students could be involved in simulation, we were invited to be part of a team charged with developing an interprofessional curriculum for healthcare students. This grant-funded alliance brought us together to think about how we educate our social work and nursing students to work collaboratively. We were part of a larger workgroup consisting of faculty from three universities (both public and private) and practitioners from the community. We were fortunate to have much support from leadership and other professional schools in the State of Rhode Island.

Our work began shortly after the Interprofessional Education Collaborative (IPEC) published core competencies delineating interprofessional competencies that are expected of the next generation of healthcare providers. We used these competencies to frame our Interprofessional Simulations and to measure self-efficacy of learners before and after working together in a simulation. We had to face several challenges, however. As we muddled through to figure out how to actually "teach" interprofessional concepts, we found that there were hardly any narratives/stories that we could read and get a good sense of the how this work is being done (particularly in the field of social work). Most of the work was in nursing in collaboration with medicine and pharmacy. Much of the literature for social work's involvement is from Europe or Canada, with only a few from the USA (Charles, Barring, & Lake, 2011; Nimmagadda & Murphy, 2014; Pecukonis et al., 2012; Sims, 2011; Smith & Anderson, 2008; Villadsen, Allain, Bell, & Hingley-Jones, 2012).

These narratives describe how interprofessional relationships, communication and collaboration improve client care and enhance community health and well-being. Much research in this area focuses in the health care field and is limited within the education field. Research shows that when health professionals work collaboratively, quality and efficiency improve, there are better client outcomes, and professionals are more satisfied (Kyrkjebo, Brattebo et al., 2006; Hicks, Bandiera et al., 2008). Research on interprofessional education (IPE) indicates that IPE promotes positive interactions and improves attitudes towards other professions (Thistlethwaite, 2012). When students learn together they develop an appreciation for one another's role in health care and develop trusting relationships.

We use two theories: activity and knotworking theory (Engeström, 2005), from social science to

frame our discussion of the articles. Knotworking theory's central tenet is that collaboration involves ever changing combinations of individuals over a period of time (Varpio et al., 2008). Utilizing this framework, the authors urge that just as in a knot there are different threads, in the knot of healthcare/K-12 education, each thread represents a particular profession, and people may come in and go out of the knot based on client needs at a given point in time. The interprofessional team is fluid, requiring that members communicate effectively with one another and the client, adapting to the circumstances to support client-centered care. When the collaboration is effective, the team forms a closely woven support structure, which Engeström (2005) describes as a 'strategic alliance.' The narratives in this section describe each author(s) experience with interprofessional groups.

Two themes emerge from these articles – those of relationship building and trust. Dr. Netting from Professor Emirata, Virginia Commonwealth University shares her experience in collaborating with professionals from social work, public health and veterinary medicine. Using the principle of the central importance of human relationships, the author explores how an early not-so-positive interview at a humane society job led her to connect with colleagues from public health and veterinary medicine, and how she embarked on a project to connect animals from shelters to older adults. To achieve this goal, the colleagues had to have deep respect for each other, have knowledge about each one's roles, listen to each other and problem solve. As a result of this collaboration, a tenure-track social work faculty was hired by the School of Veterinary medicine to help teach students the importance of human relationships in the practice of veterinary medicine.

Reflecting on her thirty plus year journey in interprofessional collaborative practice, Dr. Flanagan from University of North Dakota explores the changes in the field (from use of the term interdisciplinary to interprofessional, for instance). The article discusses four lessons that she thinks will be useful for us to create more effective interprofessional work – the need to appreciate one's own professional discipline, using professional hierarchies to provide structure rather than control, collaboration rather than competition and need for formalized curriculum for IPE (rather than a sporadic workshop). The essence of Dr. Flanagan's narrative concerns the trust she developed with her colleagues through dialogue and hands-on working experience.

The most common model of IPE education has involved medical students with another health care professional school. Dr. Bolin and Dr. Chapman, faculty in the social work program at Wichita State University received an invitation from the medical school to participate in IPE activities. Eight students participated, but the model was unique. Three medical students met with the standardized patient and had to go over to the social work student for a consultation. Emphasis on the physician to reach out to the social worker and present the case scenario is more reflective of practice in the real world. Working together to analyze patient needs and discuss a plan of care gives the physician and social work trainee an opportunity to learn from and trust one another.

What pushes academics towards collaborative practice is varied, as discussed in the article by Dr. Chakradhar and her colleagues (Murray State University). The initiative taken by one faculty member to connect with others to collaborate on research snowballed into a whole interprofessional collaborative practice with older adults experiencing chronic illness. Throughout this unique university-community partnership, faculty from social work, nursing, recreation, gerontology, psychology and anthropology aimed to use interprofessional practice to impact regional health status. Working together with a common goal of enhancing patient care provides the varied professionals an opportunity to learn from one another, to build rapport and to learn to trust one another.

Discussing their interprofessional experiences in the education world, Dr. Glantz and Dr. Gushwa (Rhode Island College) give us a peek into the school system and its handling of foster care children. The Education Collaboration Project was developed to bring professionals from the overlapping systems that care for these vulnerable children. The ECP model allowed for the validation of each profession, but also explored the need for a strong relationship with one another and its connection to foster kids' success in schools. Presenting their ideas at two

national conferences, the authors had an intense experience connecting with child welfare professionals who related to the "working in a silo/isolation" feeling, and felt energized by the hope of the ECP model to better serve the children. Working together with other health professionals assists with developing trust and collaboration, which builds relationships.

Forging a trusting relationship is central to establishing a collaborative practice says Diaz (New York City College of Technology/CUNY) in her narrative on her experience in working as an outside consultant with the school system. She shares her story where she was part of an effort to build a team consisting of different professionals in the educational system. This team then worked together and with kids who had social-emotional and/or academic challenges. The contexts and group dynamics that support or create barriers to this team effort is well illustrated through examples.

At the two higher education institutions in the Rochester, New York area (College of Brockport, SUNY and Nazareth College), what started as an interprofessional dialogue evolved into a full-fledged program on the university campus to help students with developmental disabilities transition into college. Faculty from the school of education, social work, communication sciences and disorders, education technology, inclusive education and the office of civic engagement came together to design a campus-based transition program for students. This group was expanded to include partners from school districts and agencies in the community and transformed into a university-community partnership. This dialogue among stakeholders led to trusting relationships, giving the team the opportunity to learn with and from one another. The common themes noted in these narratives indicate that learning together enhances relationships, trust and helps develop communication skills essential for healthcare today.

We hope that you enjoy these narratives and are inspired to initiate interprofessional collaborative practice in your institutions. Thanks to all the contributors who took time to write their story. Without their effort, this special issue would not exist. Thanks to Alicyn Murphy for her illustration of knotworking theory as we envision it: fluid, supportive and collaborative. We especially appreciate the assistance of Dr. Michael Dover and his team who patiently worked with us to effectively utilize the computerized system that manages the manuscripts.

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Interprofessional Collaboration: A Serendipitous Convergence of Skills, Opportunity and Learning, to Make a Difference

Kala Chakradhar, Kelly Rogers, Kathleen Farrell, and Steve Jones

Abstract: This story on interprofessional collaboration had a truly serendipitous beginning motivated by the bane of being in academia, "publish or perish." What unfolded seemed a deliberate coming together of a group of faculty sharing a passion for working with older populations and a desire to promote better health for the community. Representing the disciplines of social work, recreation, gerontology, nursing, anthropology, and psychology in a regional, rural, comprehensive university, our collaboration transcended multiple facets to discover pathways that would impact regional health status. Beginning with one faculty member's drive to connect with others inclined to take on research, and the chancing upon an article addressing chronic disease self-management by another faculty member, the group snowballed to initiate a university-community partnership. This partnership, at multiple levels, helped forge a series of group-oriented chronic disease self-management workshops in the community for people experiencing chronic illness. This article shares how this collaboration played out over three years and the valuable lessons learned as we looked for ways to sustain this resource.

Keywords: interprofessional collaboration; chronic disease self-management; rural

The Genesis

It started in the fall of 2010. After several years at his institution, he (KR) had become very aware of how little time he had for research between teaching and professional service. This time shrunk even more when he agreed to serve as an interim department chair. The question became, "How will I ever keep up a research agenda with so little time?" Solution: "Collaborate with other faculty in similar boats. Surely there are others!"

One such person was a social work faculty member (KC) in his college. He knew her through college meetings and involvement in community activities. They both had students who were volunteering and completing service learning projects or internships at local nonprofits and other agencies serving seniors in the community. KC was also teaching courses in social work focusing on health care and seniors. "What were the possibilities?" he thought. KR himself represented the discipline of recreation and leisure services. He was teaching the leisure and aging course every fall semester and had developed partnerships with many of these nonprofits and agencies over the last decade. Each fall, his students provided leisure programs through service learning projects. While these projects met real community needs and his students were learning a lot, he knew he needed to do more research. Yet, he lacked expertise and initiative, and had some trepidation about starting. He could have used some help!

He sent KC an email with the idea of a collaborative research group looking at issues in gerontology. She immediately responded with an interest and some ideas of her own. It was an opening she was waiting for, being new to the U.S. and the academic community here. She had found building a research portfolio on her own very challenging, but not impossible. However, the prospect of working collaboratively with better-connected and more experienced colleagues was exciting. She had been thinking similar thoughts as KR and forwarded an article by Dr. Jane Tilly entitled "The Administration on Aging's experiences with health, prevention and wellness" (Tilly, 2010) as a potential direction to pursue. She specifically reported on an evidence-based intervention, namely the Chronic Disease Self-management Program (CDSMP), initiated and tested by researchers at the Stanford University School of Medicine and implemented successfully in more than half of the states with older populations experiencing chronic illness. This promising prevention-focused, cost-saving, group-

oriented intervention stressed that groups be led by trained lay leaders who were coping with chronic illness themselves. The article reinforced the need for expanding this program especially encouraged by the Patient Protection and Affordable Care Act (PPACA) and the specific allocation of funds for the same through the National Aging Network, Administration on Aging and the Area Agencies on Aging (AAA).

This knowledge led to some inquiries with our local AAA and the discovery that such a funded initiative was active in our state of Kentucky, but had not yet been initiated in our region, namely Western Kentucky.

Subsequently, KR further explored the Stanford website and secured the book entitled "Outcome Measures for Health Education and other Healthcare Interventions" (Lorig et al., 1996). After all, if he was to conduct research on the subject, it would be good to know what others have examined and how they went about measuring outcomes. This search would also enlighten us further and help develop a workable plan. To further kick off this potential research-cum-practice opportunity, KR created individual binders for us to store and organize the literature and materials we were exploring and gathering. KC shared this idea with the Chair of her department (SJ), a cultural anthropologist by training who taught courses in gerontology and human diversity. According to him, social work and exercise science have an explicitly applied orientation compatible with his academic training and scholarly research. It was a natural step for him to become a member of the CDSM research team since it had a goal of using social science research to change behavior in the process of solving a particular set of problems: in this case, finding ways to mitigate the effects of having a chronic illness. He was managing his own chronic illness and was more than willing to come on board.

Hey, That's My Book!

Like many teachers, KR was excited when the outcome measures book arrived in the mail. However, there was little time to take a look at the pages within, so he packed it up and was off to the next "administration" meeting. Upon taking his seat, a nursing faculty member (KF) across the table said, "Hey, that's my book!" Well, that was a surprising comment. He knew her from around campus, but had no idea what she was talking about. "Her book," he thought. After all, it had just arrived in his mailbox. Surely she was mistaken.

By "my book," she was referring to the fact that her dissertation topic was on the very subject and she was very much married to the book to which he had become recently acquainted. Anyone in the All But Dissertation (ABD) club would completely understand. Her doctoral work had been on this very program. She had implemented the chronic disease self-management intervention with a group in rural Kentucky after having acquired training as a Master Trainer. Given this hands-on expertise, she was able to inform this group of three about the protocol involved in getting such an intervention group started in the community. This Stanford training followed an interactive train-the-trainer model with the Master Training offered by Stanford based T-Trainers. These Master Trainers in turn train leaders to facilitate the community-based chronic disease workshops in addition to leading similar community groups (Stanford Patient Education, 2013). So now, we had a fourth member on board.

Show Me the Money: Completing a Grant Application

With most projects, there is an associated cost. The CDSMP intervention as created by the Stanford group required the agency setting it up to acquire a license and the leaders of the groups to be trained to implement the six-week weekly group-oriented workshop. In order to receive training and serve as a lay leader, one must have a chronic condition and/or serve as a caregiver for someone who does. Once trained, the leaders were also to obtain training workbooks to use with and distribute to group members.

Therefore, an application for the university institutional grant, having a limit of $2500, began. As we met to crystallize our objectives and rationale, we realized how invaluable this exercise would be for the predominantly rural community. One of four risk factors that seriously compromised the quality of life and life expectancy of Kentuckians was chronic disease (Jia & Lubetkin, 2009). The state of Kentucky also fell below the national average when it came to prevalence of

chronic diseases like diabetes, asthma, heart disease, Alzheimer's, and unhealthy lifestyles (The Henry J. Kaiser Family Foundation, 2015). With rising health care costs and limited access to resources, especially in rural areas, switching from a palliative medical model to a participatory and prevention-based approach may provide these regions with a better quality of life and help reduce unnecessary medical costs.

KC, who taught research to social work students and whose forte was proposal writing, took the lead with the grant proposal writing and submission. KR's administrative skills helped with drawing up the budget, and KF's familiarity with CDSMP helped with the literature sources. At this stage we learned that the Institutional Review Board (IRB) did not need to be involved. The requested funds were granted!

Training Next and a Pleasant Surprise!

The serendipitous streak continued when the training needed to conduct the CDSMP just happened to present itself. The training certified participants as "lay leaders." Finding a training opportunity in the area seemed hard at first. The nursing faculty member began by reconnecting with program leaders she had worked with during her dissertation. She found a lay leader training was being offered by the State's Department of Aging and Independent Living who had Master Trainers available. The Department of Public Health had the funding and license to disseminate the CDSM program by facilitating training. Since the training was grant-funded, it was completely free of charge. This training venue specifically planned for folks like us was at the other end of the state. Much to our surprise, however, a training was to be offered that very summer at a state park only 30 minutes away. Lodging and meals for this 4 ½ day training were also free of charge and mileage was being reimbursed.

With free training and a statewide license at no cost to us, we saved all of the money from our grant. We had to be able to put the funds to use in other efficient, but justified, ways. Ultimately, we decided to use the grant money to provide healthy food options when we got the workshops started. This made sense because one of the topics being covered in the workshop dealt with making healthy food choices.

The Community Connection

This aspect of the collaboration was the most valuable in that it focused on stimulating community involvement. As envisioned by the creators of this program at Stanford, we set out with the mission and hope of making a lasting impact and sustaining this program. This community participation was to happen in different ways. At the outset, recognizing that the training in chronic disease self-management was intended for lay leaders dealing with chronic illness themselves and enlisting potential lay leaders to attend the state-funded training became our goal. Three of the four members of our initial faculty group registered for the training. In fact, two of these faculty had chronic health conditions themselves.

An important first task was to get word out to the community about this opportunity. Information was suitably drafted and disseminated through the local newspaper, word-of-mouth, announcements at meetings we attended, which we complemented with informational sessions and opportunities for signing-up both in-person and by phone. These informational sessions required us to use our already established connections (KC & KR) with the senior citizen's center, the skilled nursing facility, the retirement home, the assisted living facility, the health department, the local hospital, and the community free clinic. As can be surmised, these were the venues for the informational meetings led by KC and KR depending on their availability and kicked off by KF as well since she was already familiar with the process. The staff at these agencies helped consolidate the list of potential trainees. We had seven community members sign up in addition to the three faculty members (KC, KF, and SJ), including two from the senior citizen's center, one undergraduate student, and four from the general community. Although we worked with preparing the community recruits for the training schedule, including carpooling logistics, a lesson we learned was in being able to anticipate and address individual limitations. For one participant, the challenges of navigating the training venue and the accommodations provided led her to withdraw the very first night. Two other participants did not particularly buy into the training format and withdrew the second day. A majority of the other

participants at the training outside of our recruits were staff representatives of senior citizen centers. They were from the surrounding counties addressing chronic illness themselves or were caregivers as well.

The recreation faculty member (KR) and his wife, who has Fibromyalgia, attended a later training. They went on to facilitate a workshop at the local hospital's wellness center.

The Lay Leader Training

Conceptually based on Albert Bandura's Social Learning theory, the overarching emphasis of this training is on building self-efficacy and empowerment for not only the individual but also the community. Education and skill-building to empower people to self-manage the challenges posed by their chronic illness are key principles (Stanford Patient Research, 2013). The training itself was both informative and, by nature of its format, interactive. This workshop and training is identical to the one offered to people with chronic disease. We assumed the role of people with chronic illness; participating and experiencing the workshop like community members would when they attend the chronic disease self- management workshops (Stanford Patient Research, 2013). It also enabled reviewing the curriculum and practicing teaching. The fact that we were at a beautiful state park with great scenery and food didn't hurt either. By the end of our training, we felt more than prepared to conduct a workshop. The training itself, unique in its delivery, sensitized us to skills we had and did not have in initiating behavior change in those who suffer from chronic illness. It also helped us look into our own health status. We brought back training manuals and companion books and tapes (also free) to be distributed to group members who participated in the upcoming workshops.

So, What's Next?

So, until this time what we had accomplished extended over a six-month period, it was the end of June of 2011. Our next logical step was opening up the self-management workshop opportunity to the community and enlisting members for the trained lay-leader-led groups. Seeds for this phase had already been sown in the earlier informational sessions, when attendees had been prepared for these groups in the very near future. To acclimate the non-faculty trained leaders (they were candid about their apprehension to lead), they were invited to participate in the very first CDSMP workshop led by the 3 faculty members who took the lay leader training. All four trainees chose to participate because the understanding was that they would allow them to be better equipped to lead future groups. Understandably, for the faculty their academic background provided an easy launching pad.

A crucial phase was the launching itself. The venue for the group, suitable starting and ending dates spanning 6 consecutive (preferably) weeks, and a workable two and a half hour time slot each week had to be finalized. With the senior citizen center already expressing willingness, KC drew up the schedule to take into consideration the faculty leaders' work schedules. Then followed announcement flyers, courtesy of KR, and one more round of informational sessions and dissemination of flyers to various community agencies. We named our workshop "The Living Well Workshop" following the lead of what other leaders had done. We were set to begin the second week of September of 2011 on Wednesday afternoons. In adherence to the prescribed training format, charts and other teaching aids to display weekly workshop content had to be manually prepared. PowerPoint slides and printed materials were discouraged as part of program fidelity. We were preparing and working with lay leaders from all walks of life. The trainers had to get familiar with the workshop content as well, although the format strictly prescribed keeping to a prepared script provided in the manual (Program fidelity, 2012). Ten members signed up for the very first workshop.

The Research Component of the Project

Enthused with the progress until this point, we started thinking about ways in which this intervention exercise could investigate outcomes and track changes in members' attitudes and behaviors. Being in the health profession, the passion for service dominated the need to capitalize on a research and publication opportunity. KR was aware of another faculty member from the discipline of psychology, with gerontology as his teaching focus. The latter had expressed an interest in

conducting research with older adults in the community. He had the expertise in the field of gerontology and research, but was having a hard time connecting with the nonprofits and government agencies in the area serving seniors. In fact, he was hitting a wall and becoming frustrated. His research background and experience with developing tools would help us in creating and adapting some metrics for assessing outcomes. So KD's joining our working group resulted in bringing together a mixed-methods approach to examining not only the first group's experiences but also future groups.

The evaluative exercise began with a focus group of the first group's participants who volunteered and then to a deductive pre-post quasi-experimental design with future groups. The faculty group needed adequate time to develop and review the required tools and to also obtain IRB approval before implementation. With KD taking on a key role in this tool development, two of his graduate students were also enlisted. They assisted with documentation and transcription of the focus group interactions facilitated by KC and with subsequent pre-post data collection with the second group. Since the workshop was a pioneering effort by the researchers in a rural community focused on chronic disease management, it was important to receive input from this first group of participants about the content, delivery and potential problems encountered. This IRB-approved qualitative investigation enabled the creation of a deductive quantitative design to review outcomes in future workshops. The solicitation of feedback in turn assisted in making necessary changes in the implementation of future workshops.

Thus, with the inclusion of the research component, we as a group had come full circle from where we began, growing membership and skill sets incrementally.

It wasn't long before the group began writing the IRB application. Meetings were held to determine research goals, the population to be sampled, the methodology, and the instruments to be used. Considering that the nursing faculty member's dissertation topic was the same as the project we were undertaking, it wasn't hard to get started. She contributed greatly to the needed background information. This, along with the careful selection of measures, led to a nearly complete application. Because both the recreation and psychology faculty members had recently completed a research project with older adults as the sample, they knew what was needed to get IRB approval. If all went well, we would soon have a publication manuscript or a conference presentation in the making!

The "Living Well Workshops" Journey

The first CDSMP group in September of 2011 led by three of us (two at any given session) with 10 members was a remarkable experience both for the group and us leaders. It was an especially insightful exploration of the group process and growth for SJ and KC who also had the opportunity to witness individual member transformations over the six weeks. Although the training we underwent committed each of us to facilitating 2 groups in 2 years, we set a goal of at least 2 a year. The next group, in February of 2012, was led by 2 of the newly trained leaders who had also participated in the first group. They were assisted by 2 of the faculty members as needed. As leaders, we could identify and encourage suitable members for lay leader training as well when the opportunity for training arose. We soon came to realize, as invested faculty, the juggling we had to do with our university schedules. Along with our classes and other university commitments, we had to get to the weekly workshop and also plan, shop and have the healthy snacks ready. It was indeed an exercise in skillful coordination and time-keeping. KC remembers an instance where she had just enough time to drive to a workshop meeting after teaching a class and consequently had no time to shop for the snacks. She quickly called KR and he promised to get the snacks in time for the break, himself snatching time between meetings.

Reaching out to Minority Groups

By this time SJ African American himself was strongly motivated to set up a workshop in his own community, 25 miles away, where he had been a long-standing resident. With all Caucasian members in the 2 workshops so far, he felt the need to reach out to the predominantly African American population there. According to the Centers for Disease Control and Prevention (CDC), the top 4 leading causes of death among African Americans in the US are chronic disease related such as heart disease, cancer, stroke, and diabetes (Black or

African American populations, 2014). This places an emphasis on the need for educational programs like CDSMP, especially with minority populations. The venue this time was the Agricultural Extension Office, who subscribed to the mission of health education and were glad to partner with us. They not only offered space, but also provided the healthy snacks for the meetings. An independent exercise of getting the word out in this community through a newspaper write-up, informational meetings, and word-of-mouth by KC and SJ led to a good 10-member group, with half of them being African American. This was in July and August of 2012.

Two more workshops followed in September 2012 and July 2013. The latter was led by KR and his wife, both of whom took the training offered again by the State. Three other members from the already completed workshops chose to take the training as well in order to be lay leaders. One of them in turn connected with another lay leader at a medical practice and went on to facilitate two workshops in 2013. The medical practice is worth a mention since it follows the medical home model. KF introduced the practitioners there to the CDSMP, who in turn committed to refer eligible patients to register for the CDSMP to be conducted at the medical facility.

The Research Agenda

The group began dissemination of this collaborative exercise in the fall of 2012 at presentations in regional, state, national and international conferences held by their respective disciplines, specifically nursing and social work. The focus of these presentations was the interprofessional collaboration and how it unfolded to accomplish a community health initiative. We were also able to tie in our experiences to a conceptual framework of interprofessional collaborative practice and draw a parallel of the competencies and principles to what we were doing. The framework identifies four domains of core competencies, namely values and ethics, roles and responsibilities, communication, and team roles needed by health professionals to provide integrated quality care. The CDSM initiative reflected the principles of being process-oriented, relationship focused through the partnerships, community-oriented (lay leaders and venues chosen), and patient and family-centered interactive sessions and action plans (Interprofessional Education Collaborative, 2011). The workshop content and implementation was sensitive to context, developmentally appropriate, applicable across professions, and outcome driven. Important to us as teaching professionals, this provided the opportunity for interprofessional education to teach students how to work effectively as part of a team (Interprofessional Education Collaborative, 2011).

The pre-post data collection began at our second workshop, including the six subsequent workshop groups, with the purpose of tracking outcomes longitudinally. The plan included a pre-test before the first session of the six-week workshop, post-tests within a week of completing the workshop, and another follow-up 3 months after the workshop the professional presentations included preliminary data and inferences from these assessments.

When getting ready to set up the minority population-focused workshop, SJ and KC, fueled by their qualitative research leaning, proposed to take on an ethnographic study of the group experience. Following IRB approvals, they worked at observing and documenting the workshop experiences in addition to facilitating the workshop. Seeing potential for expanding these workshops in that community, they explored the idea of bringing in a student to assist and learn in this qualitative endeavor.

What We Learned

The lessons learned were multiple given the multifaceted nature of this project we undertook. One aspect, as evident from our narrative, is the way that we ventured out, reached further and further, opening up possibilities we could choose to either take on or limit. We began with the intention of carving out a research agenda that would need investment in hands-on research activity to culminate in publishing.

Beginning with a potential idea of chronic disease management for older populations, we discovered multiple agencies involved from the local to the national level. It was an illustration of not only the practice-research interface and evidence-based intervention but also of funding-driven realization of benefits to the community. It was a great example of political will and policy-enabling program

implementation. Through university-agency partnerships and the expanding workshop opportunities, the prevention-oriented program was able to foster community collaborations, both at the level of the group and individual.

Another lesson was related to the logistics involved in implementing the workshops, designed to meet six consecutive weeks for 2.5 hours each meeting. This is a commitment for those that participate. Finding the best location to offer workshops involved trial and error. During the informational sessions, we learned fairly quickly that assisted living residents as well as individuals in nursing facilities or retirement homes were not able to commit to the workshop timetable. Two and a half hours is quite a long time, especially for some seniors dealing with health-related issues. Facility staff were hesitant to commit to the schedule as well. We found that the best locations for workshops were daytime facilities used by seniors such as health departments, hospitals, wellness and senior citizen centers. The agricultural extension office was a valuable discovery and asset. We worked with facility staff to identify and recruit workshop participants and with media outlets to inform the community. We also learned that these workshops could have value for younger populations who are also affected by chronic disease. Self-management for the younger populations, if begun early, can be even more beneficial than with older populations.

We took away valuable lessons from the workshops themselves. Fidelity in the implementation following the scripted manuals (Program fidelity, 2012) to the T (of course, we could paraphrase!), and the structure in each meeting as we covered the content was somewhat in contrast to the flexibility and autonomy we had gotten used to in our academic lives. A unique experience was leading by example when we initiated member sharing when making an action plan for the upcoming week based on the behaviors focused upon in the meeting. Led again by leaders, meetings began with the sharing of how action plans had worked over the week. It was an invaluable insight-building exercise into our own health behaviors with a focus on change. We were accountable not only to ourselves but also to the group. The content of the CDSM workshop presented themes that reflected the disciplines of our team. These included the value and practice of physical exercise, effective techniques for engaging, communicating with and understanding social and medical service providers, and practice in role playing related to social settings associated with ones played by those with a chronic illness.

We were also touched by the many members' lives and experiences as the workshops progressed over the six weeks. Some were caregivers of aging and sick relatives in addition to being managers of their own health. There were struggles with emotions, relationships, physical limitations, sexual orientation, compulsive habits, and initiating change as well as remarkable stories of accomplishments, life journeys and resilience. There were losses through members' passing and crises in other members' lives. The group's power in instilling hope and courage, motivating change, sustaining focus, recognizing universality and creating bonds was an experience beyond what words can capture. For example, one member was dealing with her mother’s terminal illness and final days with hospice care. The workshop group's strength in supporting her was evident when she attended the sixth and last session after her mother's funeral the same day.

Lastly, and most importantly, was the interprofessional collaboration experience. Bronstein's (2003) model for interdisciplinary collaboration provides just the right platform to discern the core elements that came into play as our group of interdisciplinary faculty connected to “contribute to a common product” (Berg-Weger & Schneider as cited by Bronstein, 2003, p, 299). Using Bronstein’s model (2003, p.299), the interprofessional processes that we experienced included “interdependence, newly created professional activities, flexibility, collective ownership of goals and reflection on process.”

Interdependence: We were clearly dependent on each other to accomplish tasks while also respecting each other’s ideas and professional expertise. As cited by Bronstein (2003), we were able to capitalize on the combined knowledge and experience of our team, each knowing when to step in and when to step back and allowing the others to take over. This was apparent when it came to contacting agencies and initiating dialogue

(KC/KR/SJ), drawing up the requirements and logistics for the CDSMP (KF), creating promotional materials and filing needed research tools (KR), research and presentation (KF/KC), and keeping things glued and consolidated (KC/KR).

The CDSMP initiative in the three county regions was a *newly created professional activity.* It was the result of a collaborative navigation of interpersonal and structural processes not achievable if one worked alone.

Flexibility is described as "the deliberate occurrence of role blurring" (Bronstein, 2003, p. 300). Although all of us were tenured faculty, we differed in years of experience, academic and administrative ranking, age and gender. We struck such a harmonious balance where neither hierarchy nor gender, experience nor age threatened disruption. We were juggling responsibilities and roles, deferring to each other, accommodating and discreetly making compromises where needed in order to move forward with the task at hand. Whether it was one member not being able to meet, making sure we followed up on the workshop list, arranging snacks, having the workshop materials ready, preparing for the conference presentation, being there for the data collection or making follow up calls, we were willing to step in or take the liberty to call and revise plans. Formal roles had blurred and informal respectful interaction amidst mutual trust helped us operate with relative ease.

Collective ownership of goals was evident in the ease of decision-making due to a shared vision. We were committed to communication via e-mail, phone or face-to-face meetings to keep each other updated. Tasks were taken on, volunteered for or declined (often due to inevitable circumstances). For instance, when it came to planning a potential workshop or a conference presentation, any of us who saw potential would take the lead and get working on it, soliciting input and assistance as needed.

Finally, *reflection on process* was really the binding force for this group. We were constantly thinking and talking through our experiences as we moved along and talked about it: what amazed us, what things didn't seem to be going well, what could be better, what options there were to explore.

Preparing for and presenting at professional conferences were productive ways to reflect and process. It helped to not only share in the learning but to also discover what we had not otherwise observed or thought about.

There were also some not-so-favorable learning and events that occurred raising questions about the continuity of this collaborative activity.

Will the Journey Continue?

This whole endeavor was not devoid of its challenges. As mentioned earlier, the serendipitous creation of this community program needed a substantial investment of our time. It was more than collecting data and writing a manuscript. Keeping the workshops going required planning suitable time, two and a half hour slots for 6 consecutive weeks, leaders' availability, recruitment participants and implementation. We initially hoped the new lay leaders would sustain the workshops, so we faculty members would then be able to take on the task of simply coordinating, and concentrate instead on the research component. It became a daunting exercise for the faculty to invest the time for the workshops. Recruiting participants also posed challenges. We knew our efforts had to be renewed by looking for better ways to promote and expand our community referral network.

The research component involving longitudinal outcome assessment (pre-post workshop) posed problems as well. Since participation was voluntary, members did not necessarily want to complete survey instruments. Time had to be set aside for the pre-post-tests in addition to the 6-week schedule. The lengthy nature of the assessment tools and ease of administration became another hurdle amidst the health or schedule limitations participants already had. Interestingly, none in the minority group opted to complete the assessments. Our research agenda therefore was moving at a very slow and discouraging pace at certain points in time.

As for our group, unprecedented events led to an unintended reduction in members. The psychology faculty member who assisted with the research tools moved to another job. The cultural anthropologist member (SJ) chose to retire after 35+ years in academia. KF earned full professor status and took

on a book-writing project. That left two active members who have since been exploring ways to pursue data gathering with the help of the State Department of Aging and Independent Living. Our academic department oversees CDSMP leaders it has trained in the multiple agencies and tracks the workshops being implemented. So we are left with the questions of where, and how, we go from here. What follows, are our individual perspectives and what each took away from this collaboration.

Perspectives: KC's perspective

I came to this country to teach at the university level, six years after getting my doctoral degree and a hiatus from formal academic work. I had not had any academic training in this country and therefore had no academic advisors, mentors or research partners who could orient or guide me through the writing and publishing that were needed for tenure. A trusted friend helped me with my first publication and then on I had to make my own connections and tread the arduous road to publishing. This opportunity to collaborate for the purposes of research and writing was just what I was looking for. The prospect of implementing an evidence-based intervention, with a focus on prevention and better well-being for individuals challenged with chronic illness, was equally exciting.

I constantly look to bring real-world experiences to share with students in my social work classes. This research and practice exercise was just the kind I could share with students in my research and health care classes. It became a valuable teaching tool for my gerontology course and an opportunity to familiarize students with the process of group intervention as well. Every aspect of this interprofessional collaboration including grant writing, program planning and implementation, dissemination, and creating community liaisons became aspects I could exploit and incorporate into my teaching to demonstrate how they worked.

Given my social work training with group work, the group-based interventions took me back to my practice days. My group work skills were particularly valuable in facilitating sharing and interaction, and understanding group dynamics and group process. I was especially enriched by the workshops in being able to understand group members' struggles with multiple forms of chronic disease and internalize the behaviors that govern self-management.

Although it is disappointing that the workshops and research have arrived at a plateau, what we gained through this collaboration and the healthy working relationship is invaluable.

KR's Personal Perspective

After sixteen years at my current institution, I am at a crossroads in my career. Along the way, I successfully completed my dissertation and managed to satisfy my institution’s tenure committees. I am glad I ran this marathon, but I never wish to run it again. After I was granted tenure, I was eventually promoted to the rank of Associate Professor. Like many of my colleagues, I have spent the better part of the last several years consumed with teaching, professional service and administrative responsibilities, all of which are valued at my institution.

However, even at our regional comprehensive university, there is an expectation that one must publish in order to receive promotion. With an economy in the slumps and very little money for raises, it became apparent that the only way to increase my salary was through promotion. While promotion served as a primary motivation in the beginning, I have always enjoyed bringing people together for collaborative, multi-discipline projects. At the outset of this particular project, I had little concept of where things would go and who would be involved. All I knew was that in my current position, the only way I was going to get any research done was through collaboration.

I have truly enjoyed working with my colleagues on this project. The fact that the program helps people improve their quality of lives makes me feel proud to have contributed as a member of the group.

KF's Personal Perspective

After 25 years of experience in critical care and emergency nursing practice, I changed direction in my career path and joined the ranks of academia after going back to school to earn my doctorate. Frustration about the recidivism rate of patients with chronic disease led me to focus both my clinical practice and research on chronic disease management. The Stanford CDSMP guided by

Albert Bandura's self-efficacy theory guided my research study on the rural working poor. After the study, my community lay leader relocated out of state. The sustainability of the CDSMP program was difficult and although disappointed, I could no longer continue with the program.

My excitement and motivation kicked into high gear as soon as KR arrived at the university meeting with the outcome measurement book and we began to talk about the plans to do collaborative community service and research. An interprofessional collaboration was needed to sustain this program in our rural region and I envisioned success! The formulation of our interprofessional team was the impetus to reach out to our community needs while fostering interprofessional education and research. A win-win for all involved.

SJ's perspective

A central thread in my reactions to the workshop experience was my ability to see the words and actions of workshop participants from their perspective. This perspective is a fundamental principle in the subfield of Cultural Anthropology. This ability to see the world as those being studied is called the *emic or insider's perspective.* The analyst or observer is able to "walk a mile in another's moccasins" to see the world as participants being observed see it. Anthropologists do not argue that they can see the world exactly as their respondents do, but the view of the analyst or observer is a close approximation of that of the investigated population. An insider's view is absolutely essential in the development of effective techniques to control the effects of chronic illnesses.

My views as an anthropologist were enhanced by the fact the respondents in the CDSM Workshops and I shared an important characteristic: I too have suffered and continue to suffer from a chronic disease, namely Type II Diabetes. I have many of the same common experiences dealing with doctors, many of the same fears (especially the universal fear of losing one's independence), the dread of losing a limb (another limb in my case) to mention some of many examples.

As a trained cultural anthropologist, I assume that people who suffer from chronic diseases have a somewhat common experience, a common culture they share with one another. While there are cultural similarities that those with a chronic disease share with non-sufferers, there are enough similarities within the chronic disease community to classify it as a single, somewhat discrete social system. Social science investigation of the CDSM culture will make it possible to develop better techniques to teach those who suffer from a chronic illness more effective and verified methods of disease control.

In summary, the main lesson I learned was that those who suffer from chronic diseases have to be taught how to record, preserve and communicate relevant information through their network of medical providers. Doctors and related medical specialists have to do a better job of seeking relevant information related to other diagnoses provided to the patient. As a professional with an earned doctorate degree, in my role as a diabetic patient, I was still challenged to comprehend, record and pass on information from one member of my "team" of doctors and other medical specialists to another member of the group. I often thought to myself: how does this process work with a patient who is poor and has a low level of formal education?

As a result of working with the CDSM team, I have developed a more informed, holistic approach to the subject matter in question.

Conclusion

Interprofessional collaboration is a ubiquitous process in healthcare settings, mental health and school settings but our experience in a university setting extending to the community was a unique one. The lessons learned by initiating a series of group-oriented chronic disease self-management programs through this healthy collaboration were valuable. The experience gained has implications for teaching, research and preventive health care.

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Reflections on Foster Youth and Education: Finding Common Ground

Tonya Glantz and Melinda Gushwa

Abstract: It was during the winter of 2010 that Tonya Glantz, Child Welfare Institute, and Melinda Gushwa, Rhode Island College School of Social Work, discovered their shared passion for supporting school success for students in foster care. Tonya Glantz shares The Education Collaboration Project (ECP), a model she developed for engaging participants from overlapping systems in a critical discussion and problem solving process. Melinda Gushwa shares reflections from more than two decades as a child welfare worker, forensic pediatric medical social worker, educator, and child welfare researcher. Their joint interest led the duo to present a workshop, Bridging the Education-Child Welfare Communication Gap: A Model for Cross-System Collaboration, at the 18th National Conference on Child Abuse and Neglect. This narrative uses the practical and research experiences of its authors to explore the benefits of interprofessional curricula and interprofessional teams as resources for supporting child welfare and education professionals in their joint service to students in foster care.

Keywords: child welfare; educators; interprofessional collaboration; foster care

Moving Toward a Solution

The literature is rife with evidence of failed collaboration between professionals in the public school and child welfare systems and marked by poor communication, a lack of cross-disciplinary language, and confusion regarding professional practices (Coulling, 2000; Courtney, Roderick, Smithgall, Gladden, & Nagaoka, 2004; Wulczyn, Smithgall, and Chen, 2009; Leone & Weinberg, 2010). Equally irrefutable is the evidence related to adverse implications for the educational experiences of students in the foster care system, often as a result of missed opportunities at the system and professional levels (Fanshel & Shinn, 1978; U. S. Department of Health and Human Services, 2000; Finkelstein, et al., 2002; Altshuler, 2003; Wulczyn, et al., 2009). In fact, much of the research and commentary available on the topic of school success for students in foster care seems so burdened by the existence of the *problem* that one might believe that there are no possible solutions. The following vignettes are offered not as evidence of the problem for students in foster care, but as examples of the ways we tend to get stuck and why we must seek shared solutions for child welfare, schools, and students in foster care.

Maggie:

Growing up in foster care and without support for academic success contributes to generational cycles of disempowerment and life-long struggles for youth.

After a long awaited return home to her mother, stepfather and siblings, Maggie leaves behind five foster care and residential placements and several schools. Maggie is excited to live the life of a child who is not in foster care. Her dream of living with her family and attending a community school is finally realized. Despite her emotional and learning needs, Maggie aspires to join the US Air Force and attend college. Unfortunately, the joy of Maggie's reunification is quickly replaced by the trauma of another removal when she discloses repeated instances of sexual abuse by her stepfather.

Upon re-entry into the foster care system, Maggie spends over three months in a shelter, where her enrollment in a new school district is delayed by several weeks. The task of school enrollment is met with confusion regarding who, child welfare or the shelter staff, is responsible. Despite laws and policies allowing for Maggie's school enrollment, the school claims that Maggie lacks the correct paperwork to be enrolled. By the time Maggie is allowed to attend school, she is emotionally exhausted, worried about her family, and unsure of

her future. Maggie's emotional trauma manifests in her special education classroom through claims of sexual activity with fellow students and pregnancy fantasies. School staff is unprepared for and uncomfortable with Maggie's behavior. Just as Maggie begins to become stabilized, she is placed in a treatment foster home and moved to another state and a new school. Maggie will move to at least three more homes and schools before she ages out of out of care. She will have a baby before she turns 18; she will be forced to rely on public assistance to support herself and her child and inevitably, with no place to live, she will return to her family home where she was abused.

Evelyn:

Growing up in care and without support for academic success causes youth to miss out on their potential and leaves them asking why no one cared.

As the oldest child of parents struggling with addiction, mental health illness, and criminal behavior, Evelyn spends most of her time running her home and caring for her younger sibling. Evelyn's sibling's special needs require special care and Evelyn rises to this challenge with great care and love. Unfortunately, Evelyn enters care shortly after the incarceration of one of her parents and a finding of abuse and neglect on the other. Being placed in a group home is difficult but nothing compared to Evelyn's sense of loss and worry due to her separation from her sibling. Despite being enrolled in school, Evelyn's school activity consists of entering the front door and immediately leaving through the back door. The importance of school pales in comparison to Evelyn's need to make sure her sibling is all right and taking care of her mother, who is still living in their old apartment.

At the age of 18, Evelyn's reading level is that of a third grader, and she has missed most of her high school education. However, on a warm day in June, Evelyn is awarded a high school diploma. It is not until a good three years later that Evelyn realizes the full impact of her lost education. In a group discussion, with a look of sadness and confusion on her face Evelyn says, "Do you know that some mothers read to their babies before they are even born, when they're in the stomach? No one ever did that for me. Why didn't anyone care or miss me when I wasn't in school. By myself, I was more worried about my brother than staying at school. But a grown-up should have cared. Now I'm twenty-something; I can only read as good as a third grader; I want to go to college and do things but I know my brain isn't as smart as other kids my age. It's just not fair."

The stories of Maggie and Evelyn are but a few of thousands belonging to children and youth in foster care. We can sigh, convinced of the enormity of the problem, and give up. Or, we can see the opportunity to look and learn more deeply from what Maggie and Evelyn are sharing with us. The Education Collaboration Project (ECP) invited a group of child welfare and school professionals and a small group of youth with foster care history to look and learn more deeply. Together, this somewhat unsuspecting group came together to explore challenges and to identify opportunities to promote school success for students in foster care. The ECP thoughtfully integrated an interprofessional curriculum at the college level with a built in mechanism for building an interprofessional-consumer team that united professionals from child welfare and schools with youth with foster care histories.

The Education Collaboration Project (ECP) became an opportunity to validate the mutual disempowerment of youth in foster care, as well as that of child welfare and school professionals. Moving beyond disempowerment, the groups were invited to seize their own empowerment through mutual discovery, communication, negotiation, and action. The ECP was delivered over the course of a thirteen-week graduate course and was informed by an innovative theoretical framework that allowed for validation of each individual group and support as they explored their own and then others' connections to school success for students in foster care. Though somewhat unorthodox, the framework wove together, in an intentionally progressive fashion, three core theories. First, critical pedagogy (Freire, 1994) became a resource for defining and building relationships among the constituent groups and engaging them in a process of re-defining their roles and relationships to one another. Second, adaptive change theory (Heifetz & Laurie, 2001; Heifetz, Grashow, & Linsky, 2009) represented a resource for understanding the consequences (disempowerment) of excluding and the benefits of

including the input of youth in care and professionals from child welfare and schools. It is from the integration of critical theory and adaptive change that Wenger's (1998) communities of practice (COP) became a theoretical and practical resource for taking action. Wenger's theory relies on the creation of meaning and resulting changes or action that arise when individuals come together to form a community of practice (COP), which is what occurred with the ECP. This construction of theories formed the foundation of an intervention that honored, modeled, and embraced interprofessional relationships as an essential tool for creating change.

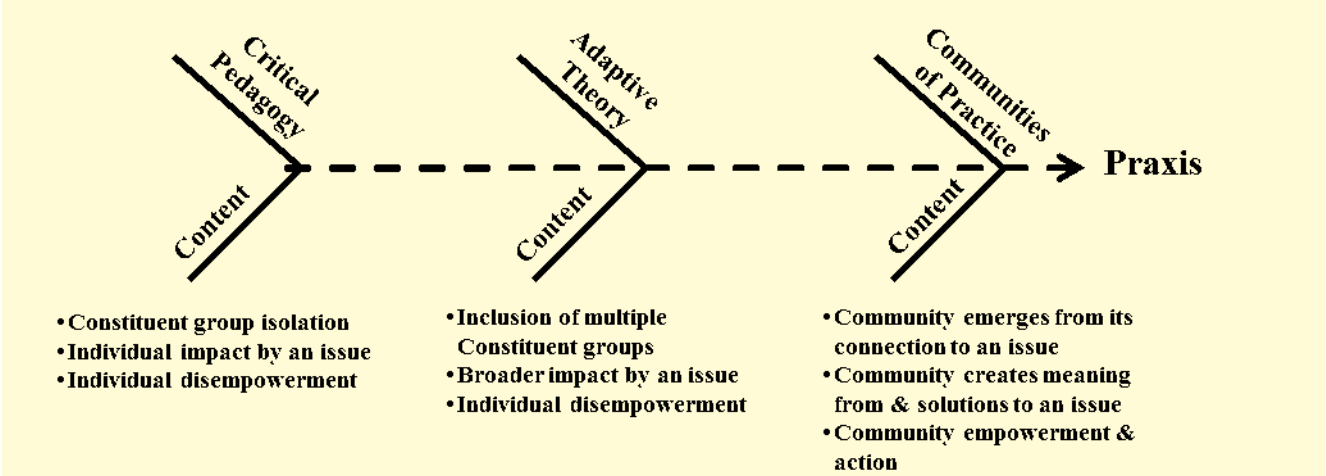

Figure 1. Theoretical Framework and Constituent Context Continuum

Five Stages of Transformation

What follows is a brief overview of the five stages of transformation achieved through the ECP.

During the Education Collaboration Project, it was my hope to fully engage the diverse participant groups in a meaningful and honest exploration and problem-solving process. I was eager to gain insight into the role of training as a tool for conventional education and, more importantly, as a resource for empowerment and change at the personal and system levels. I suspected that the barriers surrounding poor communication and collaboration were less about professional apathy and more about a basic lack of understanding and personal and/or systemic oppression. Because of these concerns, I carefully attended to issues of identity, agency, and power over the course of the ECP. The information that follows provides insight into the ECP participants' journeys from isolation to action. It was from this process that Melinda Gushwa and I decided to collaborate through conferences and webinars to advocate for change and to support the empowerment of professionals and youth involved in this issue.

Submergence- Disempowerment

At the start of the process, the youth, school, and child welfare participants were comfortable in the isolation of their separate groups. The preliminary steps in the ECP process suggested the absence of shared awareness or responsibility by the two professional groups. Instead, there was strong evidence that each group felt misunderstood and disrespected by the other groups or the broader society. These perceptions intensified the feelings of isolation and the projection of blame onto others, which actually increased the feelings of vulnerability and powerlessness among the groups. At the start of the ECP, it was clear that participants had done very little, if any, work to reach out to other groups to better understand or to join forces in support of school success for students in foster care. The two professional groups were entirely victims of their isolation and ignorance. The youth group, while much more globally aware then the professional groups, remained stymied by their lack of voice and access. As a result, the first four weeks of the ECP required engagement methods, where these otherwise submerged participants remained in their separate groups, shared their realities, and received affirmation of their experiences (Freire,

1994). During this time, participants could be characterized by a sense of personal complacency; *this is how it has always been*, with significant fragmentation across the groups and their respective systems. This combined complacency, fragmentation, and isolation contributed to the construction of identities that were closed and lacked access to wider perspectives. It was not until the participants began to be exposed to each other's perceived realities that movement away from their isolation was possible. Much of my 23 years of practice resonates with the experiences of the ECP participants, where systems have worked hard to maintain a distance and territory or silos against collaboration or integration. I am encouraged by the recent movement away from *silos* toward integrated *systems of care* (Pires, 2002) taking place across the country and in State 1.

Youth, School, and Child Welfare ECP Participants

During weeks two through four, ECP participants were able to view and listen to each other's responses to the same exercises. Because, to a certain extent, submergence provides a sense of safety, albeit a false one, I maintained the separation of the groups to afford the comfort of their same-group peers as they confronted the perceptions and words of the other groups (Freire, 1994). Maintaining homogeneous groupings was important at this stage, as it afforded protection and an impetus to move beyond submergence. The information being shared was especially difficult for the child welfare participants to hear, due to the often negative views held by the other groups. Even though the sharing of the other two groups' experiences made the child welfare participants feel badly or angry, the experiences and perceptions were shared in a manner that promoted empathy and critical thinking. One message that carried through the collective groups' pieces of feedback was the undeniable vulnerability of youth in foster care and an equally indisputable link to the efforts of school and child welfare professionals. This information became a focus that began connecting participants to the issue or domain and role or practice within it (Wenger, 1998). During the end of Week Four, the separate groups began to consider themselves as a part of a process and not just as separate (youth, school, or child welfare) participants. At the point when the discrete participant groups became a single group of ECP participants, the whole group's identity started to emerge, as it moved toward the establishment of a *community* (Wenger, 1998).

ECP Participants

During weeks five through nine, ECP participants began moving in and out of allegiance to the group with which they originally identified. A factor that promoted the merging of participants occurred during Week Five, the first time that all three groups met together and participated in an introduction exercise. I would not qualify this first full meeting of the ECP participants as easy or an instant community; however, there was a different sense of knowing and chosen vulnerability that all the participants willingly embraced as they met one another. There was an effort to share space and talking time and a sense of intended equal treatment that I do not think could have existed early in the process when groups were defensive, hurt, and more disempowered. In addition to the introduction exercise, the ECP participants began taking stands on issues that were not always consistent with positions taken in their original group affiliation. For example, one child welfare professional decided to express a very strong stance on the need to disclose a child's foster care status and provide a justification. Her statement was in contrast to the views of several child welfare professionals and at least one of the youth. In the audio recording, there are changes in the speaker's tone and breathing, which signify her nervousness at taking this risk. When the woman did take this risk, the school professionals, who stood with her, supported her. This act of bravery brought the issue to a level of discussion that was not possible before. This one example captures the crossing of territory and the attempt to reach beyond one's self and one's professional group in order to reach out to a broader group to negotiate meaning (Freire, 1994; Wenger, 1998). Subsequent group discussions and exercises afforded additional opportunities for the ECP participants to explore their collective voice, which helped to transform them into more of a community and less of a random group of participants in a shared process.

Education Collaboration Project-Community of Practice (ECP-COP)

With the formation of a community connected to the issue of school success for students in foster care

and a growing consensus of the need to make improvements, the ECP participants began to move into a community of practice (Wenger, 1998). The evolution to an ECP-Community of Practice (ECP-COP) became apparent when members began raising questions about the *status quo* and asking why things couldn't change. The ECP-COP's movement toward collaboration and action intensified quickly following its community formation. I saw this development as evidence of the power of finally being able to consider openly and honestly the realities facing ECP-COP members and what it meant to them and the world that they were trying to improve. The members welcomed the opportunity to meet with a legislator who was co-chairing a task force related to foster care and education. There was a wonderful energy on the day of the meeting, but the energy became even more intense when those ECP-COP members who attended the meeting reported to the full ECP-COP community. This exchange really buoyed the spirit of the group and served as a call to action for them. During Weeks Ten through Twelve, the members worked collectively to identify primary areas to target for change and to define the intricate steps and resources necessary to support their ideas. The conversation during these strategy meetings was powerful because the members, regardless of their youth, school, or child welfare status, equally agreed, disagreed, explored other options, and advocated amongst each other to negotiate and construct meaning for their ECP-COP. From this intense process, evidence of the ECP-COP's work became clear in the reifications and artifacts they produced, especially in their policy recommendations to the state's child welfare and education systems and the *Digital Stories*, recorded narratives of some ECP-COP members linking their experiences with recommendations for change (Wenger, 1998). It was from their work on creating strategies to support change that the members of the ECP-COP truly began to free themselves from the constraints and limitations that burdened them at the start of the intervention.

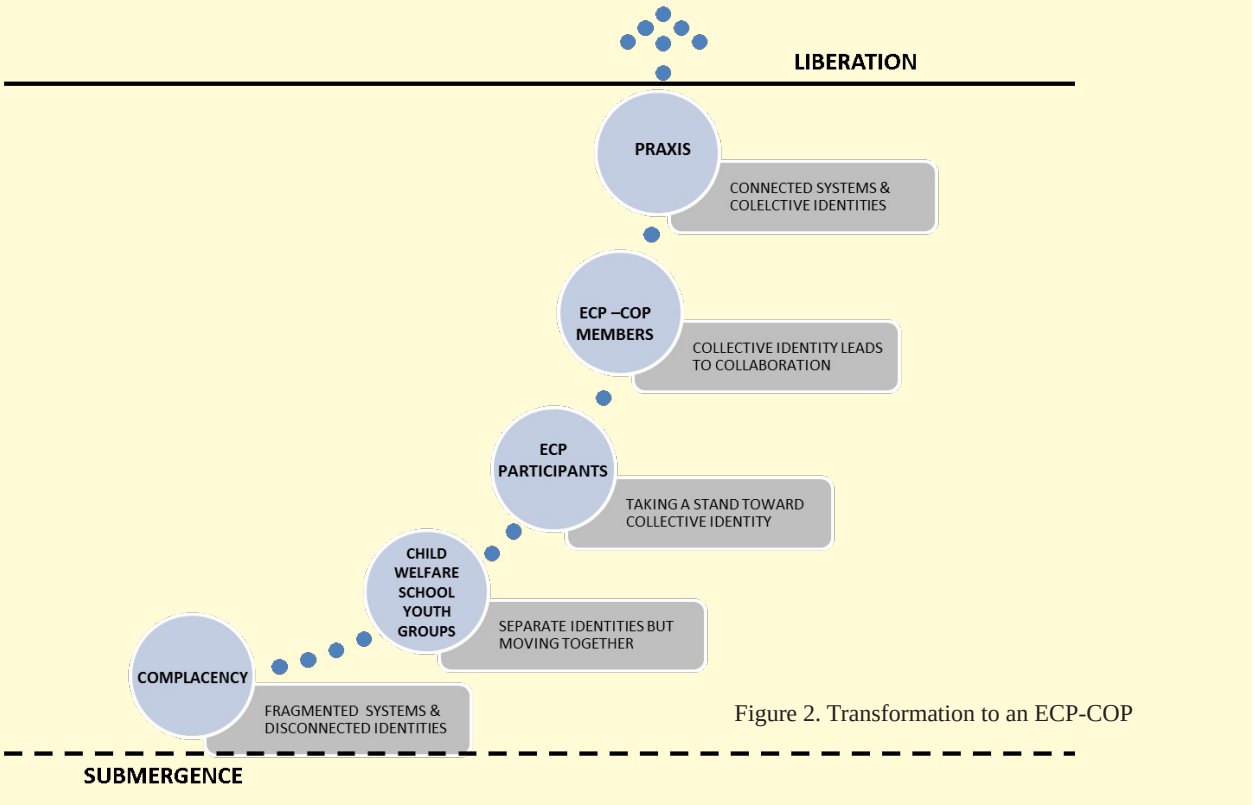

Figure 2. Transformation to an ECP-COP

Liberation

The ECP-COP members hosted a policy forum in support of promoting school success for students in foster care – what I consider their praxis event (Freire, 1994). They took their message to a very broad audience: child welfare professionals, community providers, family court representatives,

higher educators, legislators, school personnel, and other youth in care. As the ECP-COP, they came together and coalesced around the issue of school success for students in foster care. They created a shared awareness of and meanings for this issue and their collective relationship to it and each other, which reinforced a collective identity for themselves. It is as a result of their joining together that their voices and message are strengthened and made more powerful, not only to benefit the ECP-COP but to advance the broader discourse beyond the ECP-COP.

This study and the corresponding three years that went into planning, implementing, and analyzing it was time well spent. While small in scale and limited by sample selection and my role as a participant-observer, the findings from this study have merit to offer child welfare and school systems as they struggle to overcome the inequality of school success for students in foster care. As the Child Welfare Institute, where I oversee training for numerous public and private agencies in State 1, this study affirmed my belief that training, as an empowering intervention, can be a tool for change. This effort represents the power of interprofessional teams and the important role of interprofessional training in bringing otherwise disconnected groups together in shared solution finding. It was the ECP that inspired Melinda Gushwa and I to reach out to a larger audience to the opportunities of interprofessional training and teams.

Spreading the Word

As a newcomer to the State 1 College School of Social Work in 2010, I was eager to meet with Tonya Glantz, given my interests in child welfare. When she first began to tell me about her work with the ECP, I was mesmerized. I traveled back in time to my experience as a child protection worker in Southern California in the 1990s. The issues she was describing did not seem to have changed much, as I recalled debates with school teachers/administrators about our roles, and, sometimes it seemed like we were in a race to prove who had the child's "true" best interests in mind. In reality, it was not a competition about who cared more, yet it often felt that way. And I frequently left work feeling ineffective, misunderstood and frustrated. This brings to mind a quote from Larner, Stevenson, and Behrman (1988), which, I believe, truly encapsulates the experiences of many child welfare workers:

> The stakes are high. Overestimating the degree of danger could needlessly shatter a family and rupture the child's closest relationships. Underestimating the danger could mean suffering or even death. The decisions caseworkers make every day would challenge King Solomon, yet most of them lack Solomon's wisdom, few enjoy his credibility, and none command his resources. (p.19)

Child welfare workers and educators alike often find themselves in no-win (damned if you do, damned if you don't) situations, and while this common experience should have led to a bond among us, instead it led to isolation. I was in fact, a worker confined (as Tonya Glantz described) to the silo of "the child welfare system role," working with educators who were confined in the silo of "the school system role." The only problem was that our silos, while they may have helped to create professional identity, and professional pride (and, perhaps, professional hubris), were, in fact, distancing us from the children that we were charged to protect and educate. It seems like the two systems have been muddling along for years, trying to do the best they can. And while the good intentions are there, the mechanism to best meet children's needs hasn't been adequately navigated, as we know that so many youth in foster care face brick walls in their educational experiences. And these walls become higher and denser as they traverse through their lives. In many ways, education is everything, and without educational achievement, they are stuck. Tonya Glantz's work represents a true paradigm shift, and I remember thinking "this is amazing participatory research, and we can't just keep it a secret here in tiny State 1. The word must be spread." To that end, we decided to work together to combine our areas of expertise and find an avenue to present Tonya Glantz's findings.

This led us to the 18th National Conference on Child Abuse and Neglect, where we had the opportunity to present to a packed room of professionals from key stake holding disciplines: public child welfare, private child welfare,

education, mental health, law, and policy. I started out with some background on the challenges educators and child welfare workers face in their work, particularly issues of burnout and stifling organizational climates and cultures, and then moved on to the multi-challenges faced by youth in foster care with regard to their opportunities for educational attainment and the impact on their life outcomes/opportunities. I responded to the energy of the room, which offered many nodding heads and a seeming chorus of "oh yeah." And then Tonya Glantz began to unfold the story and experiences of the ECP, and the room became rapt in her narrative. The question and answer period that followed was rife with participants wanting to know more about the process and the ways they could potentially start up similar collaborations in their own communities. This was an exciting time, and we were both profoundly thankful to the workshop participants for their enthusiasm and interest. Our conference presentation led to another opportunity to spread the word. In January of this year, Tonya Glantz, Trisha Malloy (a child welfare professional from the community and a graduate of our MSW program), and I participated in a webinar regarding the ECP with The National Evaluation and Technical Assistance Center for the Education of Children and Youth who are Neglected, Delinquent or At-risk. This was an excellent opportunity to spread the word to a larger audience and generate dynamic interest in Tonya Glantz's work.

The pathway to spreading the word has many avenues, and interprofessional education (IPE) collaboratives among social work and education programs represent a promising approach for joining these two strong professional communities at an early stage of their learning. Gillespie, Whiteley, Watts, Dattolo, & Jones (2010) noted that exposure to IPE among these two groups can, in many ways, inoculate future child welfare and education professionals against many of the pitfalls of their professions (burnout, job dissatisfaction, etc). In light of our institution's strong commitment to IPE among nursing and social work education programs (Murphy & Nimmagadda, 2014; Nimmagadda & Murphy, 2014), we definitely have the capacity to expand the ECP to an IPE model in the future. Additionally, given that child welfare professionals frequently interact with other professions such as law enforcement (LE), health care, and others, including other disciplines in future collaborative efforts could help to strengthen the somewhat historically sticky challenges with information sharing among these groups (Ross, 2009). We like the idea of creating a "template" and foundation on which others can build.

Additionally, given that child welfare professionals frequently interact with law enforcement (LE) professionals, including LE in future collaborative efforts could help to strength the somewhat historically sticky challenges with information sharing among the two groups (Ross, 2009). We like the idea of creating a "template" and foundation on which others can build.

Who are we? Each of us should perhaps tell the reader more at this point about who we are.

Tonya Glantz: I have been working in the field of child welfare for 23 years. Over the course of these years, I have worked directly with child welfare involved families as a caseworker, conducted training and completed home studies for pre-adoptive families, and served as a trainer and developer of curriculum for child welfare and other disciplines. Across these roles, the issues of education and the hardship experienced by students in foster care were ever present. After too many years of struggling to understand barriers to collaboration between school and child welfare systems, and the resulting isolation of students in foster care, I decided to stop focusing on the problem.

Instead, I wanted to be part of the solution, a solution shaped by those with the most knowledge, child welfare and school professional and youth with foster care histories. So, I created the Education Collaboration Project (ECP), a research and training process within the RI Child Welfare Institute. The goal of the ECP was to promote open communication and to build relationships among key constituents: (1) youth with foster care history and professionals from (2) education and (3) child welfare systems. The ECP sought to understand the needs of all constituents and to use this knowledge to empower these groups to improve school success for students in foster care.

Melinda Gushwa: My first job in child welfare was

at an emergency placement shelter for children in Nevada. Just out of college and armed only with a degree in English and Anthropology, I was ill prepared to deal with issues of child maltreatment. It was a trial by fire that laid the foundation for a 24-year career devoted to child welfare practice, training, and research.

My areas of interest focus on child welfare workforce issues, child welfare training, and high-risk child maltreatment cases, particularly maltreatment fatalities. I tend to be very risk-focused when I think about child welfare issues—risks that children, youth and families face, as well as the challenges and risks faced by the workers charged to protect and support them. Education is a protective factor for children. It represents hope and opportunity, yet our systems tend to place child welfare workers and educators at odds.

Tonya Glantz's research is particularly compelling, given my interest in organizational and workforce issues in child welfare. Its emphasis on bridging systems issues in service of supporting youth and their pursuit of education is indeed fascinating, and I have been honored to work with her over the years.

We hope to continue to spread this word for years to come.

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Graduate Social Work Students: Reflecting on Inter Professional Education with Medical School Students

Brien Lee Bolin and Sheryl Chapman

Abstract: In her role as the director of a school of social work, one of the authors of this narrative welcomed opportunities to provide students with hands-on opportunities beyond the classroom or their field experience. Summer was coming to a close and the fall course plans were being finalized when personnel at a medical school approached me to discuss social work students participating in an inter-professional educational (IPE) simulation. What resulted was the beginning of a valuable collaboration that provided enriched, applicable, learning experiences for social work and medical students as they prepare for their professional practices.

Keywords: professional education; interprofessional education; medical schools; simulation training; consultation simulations

Social work education relies upon both traditional and non-traditional pedagogies to educate students. The traditional classroom experience establishes a core understanding of the profession's values and knowledge. This experience begins the process of developing competent social workers. However, it is the non-traditional settings of field education where the classroom and real world practice meet. The traditional or formal classroom environment produces a student who "should know" social work skills and who is prepared to be tested for her proficiency. Most social work students will tell you, however, that they did not really learn how to apply their classroom knowledge until they engaged in their field practicum experience. Field education offers social work students the opportunity to refine their communication skills, collaboration skills, and the specific practice behaviors that help lead them to a successful social work career. Inter Professional Educational (IPE) experiences offer a "bridge" between pedagogies; a non-traditional simulated environment with multidisciplinary options, which include instructor and student observations, critiques, feedback, and reflection. Two definitions offer a conceptual definition of IPE for this reflection. First, the Centre for the Advancement of Interprofessional Education (CAIPE, 2002) provides the following definition ". . . two or more professions learn with, from and about each other to improve collaboration and the quality of care." While The World Health Organization (WHO, 2010) offers the following definition of Inter-Professional Education, "When students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (p. 13). These definitions of IPE both share common language about the importance of two or more professions sharing and collaborating toward the goal of effective outcomes. IPE's are a teaching method which can enhance and deepen the knowledge gained in the classroom with tangible skill building which leads to positive learning experience and better prepared students when they enter their professional practice.

Learning skills in an actual practice environment offers a multidimensional experience. Being in the setting where practice occurs, involves subtle nuances of integration of knowledge and perception with the capability of doing the work in the company of other professionals and their work cultures. The traditional classroom experience does not contain these dimensions. The premise behind IPE is to capture these dimensions and allow students to practice in a supportive environment.

IPEs are growing in popularity, as evident through increasing implementation in higher education in recent years (Engum & Jeffries, 2012). IPEs originated with health care professional education as a means to address the problem of preventable patient deaths and injuries attributable to miscommunication among medical professionals (Engum & Jeffries, 2012). Higher education is currently struggling with public perceptions of accountability, the employability of students, the cost of the education, and the practical application of the knowledge gained by students. IPEs offer a declaration that students upon graduation have skills and knowledge that have prepared them for success.

In the summer of 2013 our school of social work was invited to take part in a standardized patient simulation IPE at a local Medical school. The course instructors began meeting with personnel from the Medical School to design and implement social work student involvement in the IPE exercise. Ten students were chosen from the full complement of 60 students. Eight students ultimately participated in the IPE.

Simulation Training and IPE

Simulation training in an IPE model offers medical service students the opportunity to learn the expectations and choreography of teamwork in a clinical setting. From a social work perspective, a medical service team is incomplete without a medical social worker. Social work brings a "Person in the Environment" focus to medical service teams, encouraging medical professionals to consider environmental and relational factors in the patient's life when gathering information or developing a treatment plan. IPE has growing acceptance as a training model in academic settings (Engum & Jeffries, 2012). Chan, Lam, and Yeung (2013) report that interprofessional experiences provide students with an understanding of team work as well as insight into the importance of a holistic approach. The experience of participating in the IPE breaks the silos of different professional preparation, jargon, hierarchical expectations and stereotypes. It allows a student the freedom to question a conclusion or offer a suggestion in a simulated setting without real world consequences. One of the social work students who recently participated in an IPE at a medical school said,

> I enjoyed the experience of other professionals learning the role social workers play in communications and interacting with people. I also liked hearing what medical doctors believed we needed to know prior to making referrals or suggestions. I was shocked at their misunderstandings of our roles in providing services, so I found this highly beneficial experience to be sure…

For social work students, an IPE aligns closely with the National Association of Social Work (NASW) Code of Ethics and the Council on Social Work Education's (CSWE) professional competency expectations. The NASW Code of Ethics (2.03) calls for Interdisciplinary Collaboration as part of social workers' responsibilities for effective treatment of clients. Further, a teamwork approach provides for wellbeing of clients in multidisciplinary settings. The profession's ethical obligations call for social workers to work within their area of competence and to emphasize the importance of human relationships. This is also one of the core competencies of Interprofessional collaborative practice (Interprofessional Education Collaborative Expert Panel, 2011).

Four core competencies for collaboration are identified by the Interprofessional Education Collaborative Expert Panel (IPCEP, 2011). Ethics, roles, communication and team work are the core competencies of interprofessional collaborative practice (IPCEP, 2011). These competencies of interprofessional collaboration parallel with Social Work Education's core competencies. The Educational Policy and Accreditation Standards (EPAS) of the Council on Social Work Education (CSWE), call for the professional use of self (2.1.1) which parallel roles and responsibilities of the core competencies for interprofessional collaborative practice (IPCEP, 2011). While the EPAS call for and critical thinking (2.1.3) and direct practice (2.1.10), the interprofessional competencies of team work and communication. These core competencies when aligned between social work education and health care education enhance the experience for social work students to engage in active reflection of experiences within the field setting (CSWE, 2008).

Reflecting on an IPE with Medical School Students

Eight master level social work students had the opportunity to engage in an IPE simulation at a local Medical School. This group of students participated in an IPE involving standardized patients. The standardized patient simulation exercise involved actors portraying a patient, medical students, and other health professionals all simulating a practitioner-patient interaction. Social work students portrayed hospital/clinic social workers asked to consult on a case involving possible adult abuse and the need for social services to support continued home placement of an elderly patient with dementia being cared for in her home by her daughter. Students wrote an assessment of the IPE

following the simulation. Finally, a debriefing session which included medical students, social work students, and faculty was held to discuss insight gained and lessons of the collaborative experience.

The use of the standardized patient exercises is a regular part of the Medical School's curriculum. In the case that involved the social work students the Medical School faculty wanted to assess the ability of medical students to include consultation with other professionals who would normally be a part of a medical team. Medical students were given a general outline of the patient's background. Social work students were told only that the case involved an elderly person with dementia. This provided for a typical practice scenario from which to gather resources for the simulation. Seven standardized patient teams were trained and twenty-eight medical students interviewed the patient teams, one medical student at a time.

After charting their session, the medical students then assembled in teams of three and consulted one of the social work students. At the conclusion of the medical student/social work student consultations all participants gathered for a debriefing session. Debriefing was enlightening for both sets of students. New insights were gained in how better teaming could have been enacted in the simulations. Social work students and medical students shared their perspectives on how it felt to not have total "ownership" of the interaction with the patient. A particularly telling moment came in the debriefing session when the doctor in charge of the medical students asked them how they had reacted to the fact that the simulated caretaker daughter had presented with a black eye. The medical students admitted they had been unsure of how to address that black eye in their session. One of the social work students spontaneously commented, "Send them to social work, we're trained to ask the hard questions!"

More detailed reflections of the social work students provided insights into their experiences. One student wrote,

> The first things I asked about were related to the patient's home environment and living situation, but the doctors had not considered this. I think pairing with health professionals (for training) could help us understand their approach and help them understand (ours).

While another social work student mused,

> It just seems so obvious to us that if social workers were included in medical teams more often it would result in patients complying with treatment plans because they would be assessed for environmental and support factors. Therefore fewer patients would be coming back too soon and too often.

The social work student comments help us to recognize that what we teach in the classroom can be reinforced in IPE as well as bringing a sense of competence to our students. This experience for our students is the catalyst for proficiency in a multidimensional professional settings. Scenarios are currently being written for IPE's that would include professionals in educational, criminal justice, business and clinical settings.

Conclusions

Videos of the IPE were produced of the consultation simulations and have been studied by social work students and professors for ideas to use in future IPE sessions. The medical school will be expanding the idea of IPE to include the school of health professions and nursing in the near future. Social work students who took part in this initial exercise are unanimous in attributing a sense of professional growth to the experience. One social work student responded:

"This exercise gave us the opportunity to show the skills we have so far. It also gave me a feel of professional importance. It was a very valuable exercise to prepare us for the future."

Additionally, the medical school and their students provided a positive reinforcement in both their reaction to the experience with our students and in the debriefing following the IPE. This helped to expand the scope of the student's (social work and medical) understanding of another perspective. The medical school personnel have invited our graduate social work students to collaborate in developing

new standardized patient case scenarios that would more fully address the needs of diverse patient situations. IPE's offer exciting prospects for social work students and faculty with new possibilities for knowledge, ethics and skill building. Indicators of increased student competence and improved patient outcomes make IPE an excellent opportunity for enhancing social work practice education in other practice areas. IPE is a perfect fit for the pairing of traditional and field training pedagogies of social work in many areas of practice.

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Possible Selves: The Benefits of Interprofessional, Interagency Collaboration

Pamela A. Viggiani, Ellen Contopidis, Dawn Vogler Elias, Jennie I. Schaff, and Nuala S. Boyle

Abstract: This article presents a discussion of interprofessional and interagency collaborative teams that formed to create and implement a post-secondary campus based transition program (CBTP) for individuals with developmental disabilities. The article examines the collaboration and highlights the benefits for stakeholders. It explores the non-summativity and the synergy that resulted from participation in a collaborative team. The article suggests that the collaborative model and the CBTP program allow for the imagining of possible selves for all collaborative partners and program participants.

Keywords: interprofessional collaboration; interagency collaboration; possible selves

"The criteria for a happy life are to set goals, have control, contribute to something bigger than yourself, and to have hopes and dreams." (Weir, 2004)

The Beginnings

This is a story of collaboration both interprofessional and interagency. The interprofessional partnerships formed are characteristic of collaborations that are strength based. The value added by the work reflects the non-summativity of collaborative efforts such that the gains for the various players are larger than any could have achieved on their own as the learning for all is over and above what the original and planned goals of the actual project were.

What started as an interprofessional conversation on a college campus evolved into an interagency discussion and program planning that was actualized into a post-secondary campus based transition program (CBTP). The mission of the program is, "to provide a learning community that allows for the transformation of individuals with developmental disabilities from students to self-determined contributors in our society" (CBTP*, 2011). The program evolution is a result of ground up interprofessional work. The gathering of the interprofessional group was initiated by a faculty member from the School of Education. She had included individuals with developmental disabilities in her college classes in the past and wanted to explore the possibility of a college wide inclusion program.

Strategically, she gathered a group that provided the power of expertise, a position of support on campus and that had the potential to envision the unseen. The group included a faculty from each of the following professional programs at the college: social work, communication sciences and disorders, education technology, inclusive education, and it also included the director of the college's Office of Civic Engagement. The Office of Civic Engagement positioned the possible CBTP program in a college wide office protecting it from the siloed ownership of one department on campus. The four faculty members brought prior experience of working with individuals with disabilities, each with an expertise from a different professional perspective. Together this group began to generate possible designs of what a campus based transition program might look like. The collective professional experiences provided authentic designs all pointing to the need to collaborate beyond the college campus. Thus, the group identified and invited partners from local school districts and local social service agencies serving adults. These agencies were brought to a brainstorming table.

The college faculty members and the invited community members began a conversation related to a potential collaboration. Through the conversation, three agencies emerged into a partnership to design and develop the CBTP. The identification of the three agencies reflects the immediate needs of each organization and a philosophical alignment as to what is meant by inclusion. These three agencies identified needs, within the individual communities they served, that

could be addressed with the establishment of the CBTP. The challenge of addressing these needs is well noted in the CBTP vision statement that includes influencing the collaborative communities by providing...

> opportunities for individuals with (developmental) disabilities to continue in their education and development with peers on a college campus, raising the level of expectation for individuals with (developmental) disabilities, broadening the construct of diversity to include ability, and preparing each participant to obtain meaningful employment (CBTP, 2011, para. 1-4).

At the college, the broadening of the diversity of the student population was in line with one of the college's goals to increase diversity. For the partnering school district, the collaboration reflected its commitment to inclusive education. The CBTP program would allow district students in the 18-21 year age range to be in a less restrictive and more appropriate environment with same age peers for their final years of the education they receive under the Individuals with Disabilities Education Act (IDEA). For the community agency serving adults with developmental disabilities, the CBTP program afforded their clients the opportunity to work and develop vocational skills in a post-secondary educational environment with same age peers.

Possible Selves

The interprofessional interagency collaborative team provided an opportunity to explore possible selves in many realms. The term possible selves are what Markus and Nurius (1986) refer to as the link between one's self concept and the future. Our experiences can either limit or expand our possible selves. The experience of many individuals with developmental disabilities has been one that has narrowed their broad imaging of possible selves or possible futures. Often after individuals with disabilities complete or age out of high school, they are presented with limited options. It is not typical that these individuals are able to experience college and oftentimes their job prospects are limited or nonexistent. The delimited number of options presented to individuals with disabilities may result in a predictable contraction of imagined future selves and prevent many from reaching for their dreams and realizing their fullest potential as both individuals and contributing members to the community. The creation of a CBTP facilitates an exponential expansion of the possible selves of individuals with developmental disabilities.

The cooperative approach also led to an unexpected expansion of the possible selves of faculty, college students, and agencies participating in the collaboration. Faculty accustomed to residing within their discipline can fail to fully understand multiple perspectives and approaches to work. Participation in collaborations expands the faculty's vision of possible selves in previously unanticipated ways that resulted in richer classroom content and delivery as well as further collaborative work. College students too benefit and have their possible selves expanded as they experience interaction with the CBTP students. College students presented solely with similar peers may have difficulty in fully understanding diversity. However when diverse students with developmental disabilities become peers, college students understanding of themselves, diversity and capability are expanded. Like individual faculty and college students, agencies working in the community may lack the capacity to see anything beyond what they currently do, however in collaboration the agencies' possible selves are enhanced.

Benefits of Interprofessional and Interagency Collaboration

The program that exists today reflects months of interprofessional planning at the college campus and a year of interagency planning before implementation. The program has been in place for three years now and the benefits truly are above the goals of the actual project. The gains of working as interprofessional and interagency teams are myriad. Teasing out the benefits becomes difficult in that rather than a cause and effect relationship the benefits are a ripple effect phenomenon. In an attempt to organize our story we will reflect on the benefits to stakeholders first. This would include the CBTP students themselves, the college students, and the faculty and campus personnel. Further, the discussion will include the benefits to the interprofessional and interagency teams as well as the synergy created by the collaborations.

Benefits for CBTP Students

The expertise gathered from each professional perspective and from each community agency partner led to the creation of a holistic, college-base transition program. The CBTP is one that views each student as a whole and looks to further the academic, vocational, social, emotional, and physical goals for CBTP students while tending simultaneously to the desire of students to participate as included, valued parts of the larger college campus. Thus, the CBTP provides opportunities to attend and fully participate in college classes, participate in vocational internships both on and off campus, participate in health and wellness classes, work one-on-one with college student mentors, attend campus wide academic, artistic, and social events and have access to the same resources as other college students. Students' full inclusion on campus is realized through the issuance of college identification tags to all CBTP students. The college identification tag is a tangible manifestation of membership and inclusion. Access to the campus library, recreation facilities, the bookstore and dining halls combined with the freedom to independently navigate the college campus provides CBTP students the opportunity to join in many aspects of college life.

As we look back on both anecdotal information and the actual voice of CBTP students, we have come to realize that this interprofessional program is more powerful than anticipated as these young adults develop in the construct of possible selves. For example, during the first year orientation to the college campus, the faculty liaison welcomed the first cohort of CBTP students to campus asking "What will it mean to come to a college campus?" The expected answers of more independence and free time were heard. What was most telling though was the comment from one student who said, "We will be official adults." The physical positioning of these students on a college campus had a significant influence on their social positioning. This one comment caused all of us to realize that the program benefits were more encompassing than anyone had originally articulated.

As the CBTP students acclimated to campus, the college community began to recognize the "expertise" they brought. The college has many professional service programs (e.g., social work, physical therapy, education, communication sciences and disorders) that educate and train future professionals to work with various populations including those with developmental disabilities. As a result of the interprofessional work that occurred an awareness of the CBTP program was widespread. Thus, CBTP students have been invited into professional service program undergraduate and graduate classes. For instance, one CBTP student who entered the program using a DynaVox (an augmentative communication device) was reluctant to use it as it was clumsy and no one else on campus used one. With support from campus faculty and CBTP program personnel, he transitioned to an iPad to support his communication. Recently, he was invited to speak in a class for college students in the communication sciences and disorders program.

He discussed his experiences regarding the use of Augmentative Communication Devices (ACDs). In his sharing, he conveyed his intense dislike for the DynaVox stating the iPad was his preferred choice of assistive technology. The course professor, an expert in assistive technology, easily lectures on ACDs. However, this college student from the CBTP program passionately and effectively communicated the issues of frustration with ACDs from a user's perspective. His presentation drew attention to the need for professionals to respect each individual's desire for self-determination. This CBTP student was empowered and as a result of being asked to guest speak in a class. The message he spoke was powerful as he presented to the class as a college peer rather than guest speaker from outside the campus setting.

This example of personal perspective expertise is not limited to one story, the stories are abundant across campus. Another particularly powerful story comes from an assignment in the CBTP core curriculum. As part of coursework, the special education teacher for the CBTP required her students to research and prepare a PowerPoint on their disability. This activity empowered the students as they were able to both know and speak to their disability rather than have a professional or parent tell them or not tell them about their disability. The CBTP students were further empowered as they shared their expertise in a graduate course on diverse learners. The ability to

speak to other students and to be the expert was a powerful experience for CBTP students who are often not given a voice. Further, the authenticity of CBTP student presentations and personal perspectives influenced the professional dispositions and perspectives of college students in professional programs that no textbook or lecture could ever provide. After the first CBTP student was invited and presented in the graduate class, he reported back to the others about his experience. This planted a seed of possibility to the other CBTP students, who could now picture themselves as guest speakers in college classes. This resulted in CBTP students approaching the diverse learner's faculty member and offering their expertise to come and speak in her class. This example is a powerful representation of how the collaborative program has provided spaces for all participants to expand their thinking regarding possible selves.

Benefits to College Students

The college students who have had the opportunity to experience CBTP students in their courses have felt enriched by their experiences. The incorporation of a truly diverse group of learners has pushed the college students to understand themselves, diversity, and disability in a powerful and immediate fashion. When asked to provide feedback and comment on the experience of having a CBTP student in their classes the college students have almost universally expressed profound appreciation for the presence of the CBTP students while further expressing a different and more complete understanding of disability and ability. Appreciation for the program was reflected in students' statements. For example, one student said the following, "In high school there were numerous students with developmental disabilities but they were separate from me. I look forward to being able to more fully interact with students who are different than me." This statement illustrates both the student's disappointment at not having been able to interact with students with disabilities in high school and her excitement for having students with disabilities learning side-by-side with her. (Viggiani, 2012). Other students expressed similar thoughts and feelings regarding the program. This was articulated by statements like, "I think the idea of the program at the college is a wonderful idea and I would love for it to become bigger – expanding our student body," and, "make sure the program is open to all student with disabilities." Students expressed their burgeoning understanding of disability in statements such as, "interacting with the CBTP students has taught me a lot about myself" (Contopidis, 2014).

The CBTP peer mentoring program provides further opportunity for college students to be involved with the CBTP. The peer mentoring program involves students who volunteer or apply through work study opportunities to engage with the CBTP students in one of five roles: class ambassador, social buddy, study partner, classroom aide or vocational coach. Mentoring relationships generally focus on the growth and accomplishment of an individual, assisting in professional and career development, role modeling, psychological support, and the development of personal and reciprocal relationships (as cited in Crisp & Cruz, 2009). This conceptualization of mentoring guided the design of the peer mentorship component of the CBTP. The reciprocity in the mentoring relationship is evident in conversation with mentors who have indicated to faculty involved in the CBTP that their work and relationships with CBTP students have enriched them both personally and professionally. One college mentor exclaimed that it represented "one of the defining experiences in her college career."

Mentor comments about the benefits of the mentorship were supported by statements taken from a recent survey. The survey asked students: How has being a CBTP mentor influenced you? Some of the most salient responses included: "It amazes me how motivated, determined and ambitious they (the CBTP students) are" and " I take a CBTP student to work and seeing him take care of his responsibilities, working as a team with co-workers is fulfilling," and "CBTP has taught me patience, sincerity and acceptance of all people." These reflections are indicative of college students benefitting from the inclusion of CBTP students in campus life. The students' comments illustrate how they are enriched in a multitude of ways through the CBTP program.

In general, mentors felt that they developed close relationships through their mentoring connection as indicated by quotes like, "I have really bonded with Paul** this semester, and seeing him smiling and cheering at the first hockey game was one of my

favorite moments of the semester." Moreover, the mentors felt grateful and enriched by their experiences. One mentor says the CBTP, "has been a great experience for me and a huge part of my college experience." Her statement does a wonderful job at expressing the overarching nature of the benefits college students can experience with the inclusion of CBTP students on their campus.

Benefits to Faculty and Professionals

As with any interprofessional experience faculty and professionals were enriched by the disciplines that surrounded them. The interprofessional collaboration that began in the planning and implementation of the CBTP has mushroomed into ongoing collaboration. An example of this collaboration is illustrated in the co-writing of this article. It also includes many other collaborative endeavors from presentations to academic articles to collaborating with other colleges and programs. For instance, a presentation was given at a professional conference by physical therapy faculty, and three graduate students. The presentation discussed the positive effects of a physical therapist (PT) designed wellness program using modified yoga-based exercises on selected aspects of physical, emotional, and psychosocial performance in young adults with developmental disabilities. Those young adults were CBTP students taking a wellness class. Another example includes a social work professor and education professor collaborating with colleagues working within a Leadership Education in Neurodevelopmental Disabilities (LEND) program to conduct a case study on CBTP student growth as it relates to self-advocacy, independence, and the ability to gain competitive employment. This work was presented at the annual conference focusing on disability and is being submitted to a journal.

Aside from the continued academic and professional collaborative endeavors, the collaboration allowed faculty across the campus to be exposed to different ways of thinking and different ways of seeing the CBTP students and others with disabilities. One faculty member wrote,

> Seeing Adam** in my biology class this past Tuesday made me happy and grateful. He continues to be astute and friendly, and he struck me as having a pleasant and affable poise for the more formal classroom environment. Thinking about my first impression of Adam when CBTP began at the college, and my impression of Adam this week in class, I have to conclude that Adam and CBTP are an excellent example of a win-win situation, where each party has brought the best out of the other. I look forward to this semester with Adam and I congratulate you and the CBTP staff for your vision, tenacity and hard work. And I thank you for asking if I would take a CBTP student into my class - in Adam's case, I think this will be an honor.

This faculty member had not previously had interactions with individuals with developmental disabilities that allowed him to develop relationships revealing the abilities of individuals labeled as disabled. His powerful comments are mirrored by faculty across campus who welcomed CBTP students into their courses. Faculty members in all departments, from math to physical therapy, discuss the enrichment they experienced as a result of the presence of CBTP students.

As mentioned, it is difficult to isolate the benefits of the CBTP to one group of stakeholders. This next account related to student voice is a perfect example of the ripple effect of influence that the CBTP has had on the campus community.

The national day for *Stopping the "R" Word* takes place during the spring semester at the college. The CBTP students took a leadership role on campus promoting the awareness of the day and the cause of stopping the use of the "R" word. Posters were made and hung around campus, T-shirts were worn and a table was stationed in the cafeteria where all community members could sign a pledge. The faculty liaison was thrilled to see the CBTP students take on this leadership role, though she did have a moment of hesitation when seeing a sign that said "Flip the Bird, at the Word." Thinking it through, she recognized that this hesitation was no different than when seeing other campus posters that abutted up against her language sensitivity lines. Taking in the generational differences on language use and the campus context, her hesitations were put to rest. That evening she received an e-mail from another

faculty member who spoke of the inappropriateness of the poster. This reopened the internal consideration of her hesitation and brought her to a deeper level of understanding. If a goal of the program is to strengthen the self-advocacy of the CBTP students and their ability to find voice, then censorship of student voices is both counterproductive and unnecessary. It did however provide the opportunity to encourage other faculty members to view CBTP in a college context a bit differently and more expansively.

The faculty liaison had a subsequent discussion with the CBTP classroom teacher to make her aware of some faculty member's concerns regarding the *Stopping the "R" Word* poster. The CBTP teacher brought this up to the CBTP class to consider the reactions of the public to the language of posters. One CBTP student responded saying "Well I would be less offended if someone flipped me the bird, than if s/he called me the 'R' word." The message of how derogatory language impacts sense of self and image came across clearly. No different than when the word *gay* is used with condescending implications. The perspectives of the CBTP students were very passionate and real. The conversation of censorship of individuals with disabilities spread across campus after the story was discussed in a CBTP mentor meeting. The campus community moved beyond the level of "be considerate to others with the language we use to describe them," an important lesson in and of itself , to "is it socially just to censor one group based on their level of ability?" Needless to say the faculty liaison reflected on the process as a win-win for all. A college campus should be a safe place for difficult conversations; all people should have voice in these conversations and the conversations should provoke new thought and awareness for all who engage.

The benefit of the CBTP program and the interprofessional collaborative effort that created and sustains the program is captured in the above story. The authenticity of the campus conversation reflected the actual existence of the CBTP within the campus community. The story illustrates the ripple effect the collaboration and the program have had on the campus. It also exemplifies the synergistic and unexpected effects the program had on the campus community.

Benefits to Collaborative Agencies

Parity, as discussed by Friend and Cook (2010), is more than equal partnership among collaborating partners. It is a coming together with a mutual respect for one another's expertise. Such respect was foundational in the initial relationship building and work among the three agencies that designed the CBTP. Over the past four years, the parity has matured into a deep appreciation for the purpose and work of each agency as a stand-alone in the community. Working together we recognized the different constraints each agency had (i.e., calendars, school, vs. college vs. full year adult agency) and collectively problem solved to find a common ground for operation. Developing the Memorandum of Understanding for the CBTP program was a process that not only provided the partners with insight to one another's communities but enabled us to embrace and transform operational procedures from three different agencies into a procedure for the operation of the CBTP that was in compliance for all the partners. Being involved with one another's agencies on a day to day basis has kept all three partners current on the ever changing regulations that guide school systems and community agencies providing services to individuals with disabilities. Such information allowed the school district to prepare the CBTP students turning 21 to seamlessly transition from receiving school services to adult services. At the same time, the information allowed the adult agency the opportunity to both prepare and greet the CBTP students as they began receiving adult services. This seamless transition benefits all parties involved: CBTP students, the school district, and the adult agency. This example of seamlessness in transition can serve as a model for school systems and adult agencies serving individuals with developmental disabilities.

The operational procedures also kept the college up to date, preparing college students enrolled in professional programs to go out and work in a variety of fields and settings that support individuals with developmental disabilities. Most importantly there was a new level of sensitivity for the process that individuals with disabilities and their families must navigate when they transition from school programs to adult agencies. Schools and adult agencies are two support systems that have different

jargon, levels of support, eligibility requirements and expectations for participation along with other differences that are often overwhelming during a time of transition from adolescent to adult services. The interagency collaboration facilitated new levels of awareness and ability that allowed CBTP personnel the expertise to lead additional workshops for CBTP participants and their families and to effectively support CBTP participants and their families at this time of transition and new horizons.

Benefits to the Interprofessional Team

Working as part of an interprofessional collaborative team proved to be an enriching experience for all members. The different professional perspectives on disability enabled members to better grasp the needs of students with developmental disabilities. Our professional practices have always championed the self-determination of the individuals we support. Facilitating self-determination on a college campus took on a new level of letting go. Working in partnership with one another and listening to and allowing the students in the CBTP to be truly integrated into the larger college campus challenged our beliefs regarding our professional roles with CBTP students. The CBTP students pushed all of us to truly embrace self-determination. The students can and do make their own choices this includes the opportunity to make both good and bad choices without the intervention of professionals. It is through choosing a class that might not be the best fit or choosing to go on a field trip rather than attending class that CBTP students begin to learn about themselves and their capabilities, limitations, possibilities, and desires for their futures. Embracing the independence and abilities of the CBTP students both allowed the students to realize their possible selves and forced our interprofessional team to realize our possible selves as professionals who see individuals with developmental disabilities as independent, self-determined contributors to our campus and the larger community.

This also was a very authentic model for the college students in our professional programs. Each of us desires that the teachers, social workers and speech language pathologist that we send forth do not simply repeat what we do. Our students have seen us break new ground and envision the unseen making it seen. There will be new ground for them to break when they go out. They know ours is a story of collaboration to solve a local problem. We want them to see their possible selves as more than just a professional title. We want them to be responsive to the social challenges ahead and work with others for solutions.

Conclusions

The authors of this article found working together as an interprofessional team enriched our understanding of one another's profession and enriched the integration of interprofessional content into their courses. The knowledge of one another as individuals and professionals allowed us to see our possible selves in new ways just as it allowed the CBTP students to see their possible selves in new ways. The experience has made us richer as instructors not just about disability but about the processes of professionalism, specifically the process of interprofessional work. All of us incorporate the lessons learned into the whole of our work. The desire to have an interprofessional perspective influences our decision making as we reach beyond our disciplines seeking the perspective of others deeply enriching our own understanding and the understanding of those we teach and serve.

It has been difficult to simply summarize the experience because as expressed in the introduction the work has been both non-summative and synergistic. The interprofessional model has infused itself into the thinking and working of the authors and has caused ripple effects resulting in further collaboration in other venues with more disciplines thus influencing those collaborative partners to collaborate with others resulting in rich knowledge and experiences for those we serve and teach.

Cate Weir's (2004) quote at the beginning of the article "The criteria for a happy life are to set goals, have control, contribute to something bigger than yourself, and to have hopes and dreams" has been a mantra for the design and development of the CBTP. Initially it motivated the interprofessional and interagency partners to stretch for a program that crossed the boundaries of discipline and agency. The crossing of these boundaries has resulted in a program that is bigger than any one discipline or agency. It has allowed each member to see her possible professional self in a new light. To parallel the thoughts of Markus and Nurius (1986),

the potential of our professional possible selves has expanded as a result of this collaborative effort.

**All names discussed as examples in this article are pseudonyms.

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How Interprofessional Collaboration Taught Me the Central Importance of Human Relationships

Florence Ellen Netting

Abstract: The central importance of human relationships is a principle of the NASW Code of Ethics. Using organizational culture theory, this narrative focuses on how one social work educator learned lessons about this ethical principle in conducting research with colleagues from public health and veterinary medicine. This early collaboration set the stage for a career in which the central importance of human relationships permeated social work practice and education, regardless of the role being played. The author concludes that whether these relationships are developed through physical interactions or virtual exchanges, they are central to social work practice.

Keywords: ethical principle; code of ethics; interdisciplinary; organizational culture; human-animal interaction

One of the six core ethical principles in the NASW Code of Ethics (1996) is: "Social workers recognize the central importance of human relationships." In considering this principle, I keep thinking about how the organizational culture literature helps us understand the artifacts, values, and underlying assumptions in those groups and organizations in which our daily professional and personal lives are incubated (e.g., Schein, 2010). Metaphorically these cultures can be seen as a tree in which the artifacts are the very visible leaves, held up by a strong trunk of espoused values. Just below the surface and not as visible is the root system, the deeply held assumptions without which the entire tree would fall to the ground. When the tree blows in the wind, some leaves will fall and even limbs may crash down from the trunk as artifacts and values change. But those deeply held assumptions resist the elements and are held on to with tenacity. One of those assumptions in our professional root system is the central importance of human relationships.

We often think of artifacts as concrete, such as the photographs and pictures on the wall, how the physical space is arranged, or what tangible products are produced. But in social work circles, human relationships are the central artifacts of our organizational cultures. They are the way in which we relate to one another, our behaviors, our interactions, and even our body language and nonverbal cues. Thus, the pivotal question for social workers is: Do our behavioral, interactional artifacts reflect the central importance of human relationship? Or does that importance get lost in the frenetic pace we keep, the metrics we use to measure our worth, the push for efficiencies, and the lack of time to nurture those very relationships we say that we value? In other words, is that tree trunk of espoused values reflected in those artifactual leaves of interaction?

Early Lessons Learned

Just as organizations develop cultures; so do teams, groups, partnerships, and collaborations. In reflecting about how these cultures develop I found myself thinking about a collaboration that began in 1981 (almost 35 years ago) when I was a social worker at an Area Agency on Aging in East Tennessee. This was a time when my prize possession was a bright red IBM correcting selective typewriter, when phone calls and snail mail were our primary means of communicating, and when I was teaching as an adjunct instructor at the University of Tennessee.

I had collected my dissertation data in Chicago and we had moved back to Knoxville where I was working part-time and writing my dissertation. One day I saw an ad in the paper for a part-time position for someone with administrative and program development skills, and I thought it would be a good change of pace while I finished my dissertation and before I mounted the long search process for an academic position. This position was the Executive Director of the County Humane Association. I submitted my resume and was invited to interview.

It was a Sunday afternoon. I drove downtown to one of the all-glass, high rise bank buildings where

the board of directors of the humane association was meeting interviewees. We sat high atop the city, in a large board room, and the interview was going well, until the pivotal question was asked "Would you be able to euthanize an animal?" I stopped, stunned. When I found my voice I said, "But why would you even ask me that question? I thought this was an administrative/program development position." The board member responded, "Well, you'd have a small staff, and sometimes people are out sick and no one else might be available."

I must have had a look of stark horror on my face when I replied, "I would have my entire house and yard full of animals if it came to that. How many animals are you talking about?" And the answer almost put me under the table, I didn't pause, "I don't think you want me for this job." The interview ended abruptly, and I cried all the way home.

The next day I had a meeting with a friend and colleague in public health. Cindy was teaching at the University of Tennessee and an avid animal lover. I told her about what had happened and our minds starting working overtime how would we save some of those animals. One of the board members the day before was also the Program Officer of the Levi Strauss Foundation, whom we both knew. I was on the Board of the Senior Citizens Home Aide Service and I knew a number of their clients had been very attached to pets and others wanted pets but could not have them in their public housing units. We came up with a plan, and took the program officer to lunch.

As a result the Senior Citizens Home Aide Service and the Area Agency on Aging were funded to design and implement a human-companion animal program. We found John, a faculty member in the College of Veterinary Medicine to work with us. Soon we had embarked on a project to link animals from the shelter with older people. We knew we needed to carefully assess both the elders and the animals. John knew how to assess the animals for appropriate placements, but Cindy and I wanted to use the Functional Assessment Inventory (FAI) (a short version of the OARS multidimensional assessment tool out of Duke, affectionately called the "son of OARS") to assess the older people. We needed to be trained to use the tool and could then train others. John thought it was important for him to know how we were assessing the human companions, so he accompanied us to the training. And thus began a long series of interactional experiences in which our relationships gelled as a team.

We flew to Florida and rented a car so we could drive to the Suncoast Gerontology Center to attend training for the Functional Assessment Instrument (FAI). John was a big man, and Cindy and I laughed about stuffing him in the back of a compact car as we headed out. As we approached the Center, John scanned the horizon for birds because he was an avid birder, and upon spotting one of great significance, told us to stop the car, unfolded himself from the back seat and leaped onto the side of the road to run after that bird, binoculars beating against his chest. That image remained etched in our minds, as we discovered the excitement of this larger-than-life man, thrilled at the sight of a special bird. Several years later when John came to Arizona where I had taken a faculty position in social work, my spouse took him to Camelback Mountain to see the hummingbirds. Karl recalls that adventure as "this big guy appeared lighter than air as he marveled at the sight of those tiny hummingbirds."

When we arrived at the Suncoast Center, we were met at the door by Eric Pfeiffer, the geriatric psychiatrist who had developed the FAI. He shook John's hand and said, "I've been wondering why you have been communicating with me on College of Veterinary Medicine stationary." John looked Dr. Pfeiffer straight in the eye and said as seriously as he could, "Oh, I'm a veterinarian and I've been wanting to develop a similar assessment tool to use with older animals." Dr. Pfeiffer had a curious look on his face as he considered the possibility of using his tool with animals, a tool that would require asking them questions about their well-being. And it was then that I discovered the mischievous humor of John New. I suspect Dr. Pfeiffer never forgot that introduction. And this was just the beginning of our shared stories that bonded our interprofessional relationship. We would tell this story in our respective classrooms for many years to come.

When we got back to Knoxville, we began the pet placement program with Senior Citizens Home Aide clients. We were trained in how to use the FAI and

we contacted the director of the human services program (which later evolved into the BSW program) at The University of Tennessee. We trained his practice class in the use of the FAI so that they could work with us on assessing older clients. The Home Aide Service had no standardized assessment procedure at the time and the project gave us the opportunity to conduct assessments of all their clients, some of whom might want pets and others who would not. Thus, our team expanded to include students who wanted to work with elders.

We arranged for John to provide in-home veterinary care for any animal that was placed. We petitioned the local housing authority to allow their residents to adopt small animals. John placed over 40 animals the first year of the project. As we conducted reassessments and asked pet owners about the human-animal bond, we received rave reviews. What we discovered is that if you give older women access to a kind and caring veterinarian, you will improve their well-being and quality of life. Cindy and I used to say that John was our best intervention; the animals were a nice addition.

Over the years we joined with others in the country advocating for change in the public housing laws to allow small animals for elders who would not give up pets to move out of substandard housing. We began to train veterinarians to make appropriate referrals to the aging network because they were so often confronted by older pet owners bringing "Muffy" or "Fluffy" into their clinics because "she doesn't seem to be feeling well," and then pouring their heart out to the veterinarian about the loss of a spouse or grief or illness with which they were dealing.

The central importance of human relationships permeated our experience. But just recognizing the centrality of human relationships is only the beginning in the NASW Code (1996). The Code goes on to say that "Social Workers understand that relationships between and among people are an important vehicle for change." My relationship with Cindy and John grew out of our desire to make a change and in the process we developed long-lasting professional and personal relationships. Our interactions with older people who engaged in this human animal interaction program made us fully aware of how central human relationships are as one ages. Students who conducted assessment interviews joined in relationships that enhanced their learning in the field of practice known as social work.

As a community partner, my role as a social worker was respected by my faculty colleagues in public health and veterinary medicine. Years later John advocated for a tenure-track faculty position into which was hired a Ph.D. in Social Work into the School of Veterinary Medicine because he valued the central importance of human relationships in the practice of veterinary medicine.

My memories of John are etched in my mind because they were so important to my development personally and professionally. He was so aptly thought of as a gentle giant because he was one of the kindest colleagues I have known. By recognizing social work as having a role to play in veterinary medicine, he affirmed both me and my chosen profession. Even more significant was that he was part of the first funded research project in which I participated. Our team cut our teeth on presenting and publishing the results of our small study and this launched all of us in our respective fields into an interdisciplinary arena. As we embraced the "publish or perish" ideology of the university, I remember John saying something to me that literally transformed my academic life. Recognizing the potential for work to become overwhelming, he once said when we were racing to get the writing done, "well, it all depends on whether you want your grave littered with reprints." I remember stopping short to digest those words and they have lived with me throughout my professional life. John never forgot what was truly important – it was not about the products, it was about the relationships. How he treated people (and animals) is as much a part of his legacy (how he lived) as what he did. What a role model he has been to so many and how fortunate Cindy and I were to have him on our team.

The Core of Human Relationships

Edgar Schein, the author of *Organizational Culture and Leadership* writes that assumptions about relationships must address these questions: 1) who am I supposed to be in this group and what will be

my role? 2) Will my needs for influence and control be met? 3) Will the group's goals allow me to meet my own needs? 4) Will I be accepted, respected, and loved in this group? How close will our relationships be (Schein, 2010, p. 149)?

I've been thinking a lot lately about these questions because they get to the core of human relationships and whether we feel valued by others. Cindy, John, and I came from different professions and that likely helped us determine our roles. Cindy and John both had public health backgrounds, but hers was focused on human relationships whereas his was focused heavily upon our relationships with animals. My social work practice background was respected by both of them as they allowed me to take the lead on the human side of our intervention. We were young then, just beginning our professional academic careers, all in different organizations which gave us the opportunity to share the issues we confronted within our respective settings without being so enmeshed within the internal policies of one another's domains. We listened and problem-solved with one another. Our project required us to negotiate the community relationships with the funder and the home aide service, giving us experience in what is now toted as "community engagement." We cut our professional teeth on community engagement with our project and knew that relationships with community practitioners were absolutely essential to our work. Even when we moved to different cities and became professors in different universities, our relationships remained close over time, and today Cindy and I are still working on human-animal interaction projects together.

I don't think I realized early on how important this first funded research project was to my professional development, until I encountered situations in which the importance of human relationships seemed to have become subjugated. I've noticed in recent conversations with so many people in multiple types of organizations that I'm hearing these type of statements:

> I just don't feel valued.
>
> Things are changing so fast that I don't know how to keep up.
>
> I feel like I'm becoming marginalized.
>
> I don't even know what I'm supposed to do anymore.
>
> What happened to basic human civility?

These conversational artifacts are reflective of organizational trees blowing in the heavy winds of change. And I believe they attest to the neglect of human relationships that are necessary for working through the process of rapid change and to addressing the social needs of humankind and the quality of life of individuals. I am convinced that it is the centrality of human relationship that will make the difference in both professional and personal quality of life. As social workers we know this, but it seems increasingly important to remind ourselves and others of this basic social work principle.

Organizational culture theorists are attentive to how we transmit and embed cultural norms and values by what we do. The smallest interaction becomes an artifact of the culture. Norms about how we relate to one another grow out of the legends and stories that blossom out of our shared experiences. Thus, people are watching, even when we don't think they are watching. Our interactions aren't just passing artifacts, they are remembered by others, we leave imprints along the way. We have incredible power in what we pay attention to and *just as importantly in what we do not pay attention to.*

What We Pay Attention To

Human service work is relationship intensive, yet in an era of performance-based measurement it is often hard enough to design information systems that will capture the basics of efficiency and effectiveness, much less to capture the quality of our relational work. We often adopt those tools that have been used by the corporate sector and try to adapt them to our human service use. One such tool is the electronic dashboard. One designer explains, "Ideally a dashboard report conveys in one page the key indicators for the organization and relates those indicators to goals, historical information, or benchmarks , the art of creating a good dashboard is identifying what information really matters" (Nonprofits Assistance Funds, 2011).

In the context of human relationships, then what do we pay attention to? What really matters? And does what matters get conveyed on our organizational and programmatic dashboards? Even more importantly, who determines what gets to the dashboard, what gets privileged, what counts? How can we get the principles of our code of ethics onto the dashboard? Are we empowered to influence what goes on the dashboard and even more importantly how can we find ways to measure the importance of quality indicators like the importance of human relationships? This is the challenge and we must not give up *just because* quality is hard to measure.

The central importance of human relationships permeates social work practice, regardless of the role being played. Whether these relationships are developed through physical interactions or virtual exchanges (Reamer, 2013), they are central to social work practice. I owe a great deal to Cindy and John as collaborators who lived the importance of human (and animal) relationships.

This reflection is dedicated to the memory of Dr. John Coy New, Jr. (1947-2013)

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Tales and Trails from Consultation: Improving Interdisciplinary Teams and Collaborative Practices for School Social Workers and Teachers

Mery Diaz

Abstract: Interdisciplinary team collaboration has garnered increasing attention. When team processes are effective, they serve to reduce service fragmentation and duplication of services, particularly in urban school settings. Additionally, interdisciplinary teams promote new professional interactions between teachers and school social workers that reduce feelings of isolation when addressing social, emotional, and behavioral issues of children. This reflection focuses on the author's experience facilitating interdisciplinary team development, her observations of the contexts and group work processes that support collaboration and those that create barriers, and finally, the consequential impact on the teacher and school social worker relationship.

Keywords: Collaboration; interdisciplinary teams; urban schools

Initiation by Fire

In 2006 on a cool March Wednesday afternoon, my co-worker Mark and I walked into the Bronx high school we had been assigned that spring. The building had a somewhat ominous feeling on this day, although we had been there before. The high school, a once thriving institution, was set inside a large pre-war structure and proudly displayed a history of notable alumni that seemed to trickle off by 1970's. As consultants, Mark and I had been to the school on a couple of occasions to meet with the principal and to set goals for our work with the child study team– a team that addressed academic and behavioral issues of students. We worked for a non-profit organization that partnered with high need low-income public schools in order to develop and improve systems for addressing academic and behavioral issues of children. Part of our work involved establishing or reorganizing interdisciplinary teams. Mark was the educational counterpart on our team. An experienced retired public school administrator, he was now consulting as an advisor to public school principals. I had started my new role as social work consultant just a month before, after having worked in direct practice as mental health therapist with children, adolescents, and families in a variety of settings. The principal at the school directed us to go forward in joining the team without any prior introduction to school staff.

Our goal that Wednesday was to introduce ourselves to the members of the child study team meeting, an already established team, and to begin outlining the parameters of our future work together. We were there to support their work and to offer resources and knowledge that could assist in developing strategies for students with academic and socio-emotional challenges. We were the "good guys" for sure.

Despite having two previous meetings canceled and a no-show team at our last scheduled meeting, Mark and I were quite optimistic that this time things would be different. The principal had assured us of member participation and that the group understood the purpose of our joining the meeting. Enthusiastically, we brought gourmet cookies and refreshments, along with a few handouts containing fancy graphics detailing our organization's mission and model for addressing student needs through interdisciplinary teaming. To our surprise, all the members attended the meeting.

Something, however, told me not all was right. The social worker, the team's leader, barely uttered a hello, avoided eye contact, and did not readily respond to our small talk. The psychologist, a man sitting very still at the end of the table, held a quite severe expression. Two teachers, a man and a woman, were fidgety but attempted nervous small talk in any case. What stood out most to me, however, was the small detail of no one eating the cookies. A small detail for sure, but in most settings

where much like mental health settings most welcome these little treates as gestures that are few and far between, participants happily dive into them without much prompting.

Mark proceeded with an introduction providing details of his past professional experience and highlighting some skills that he thought would be of service to the team. I followed by detailing my professional background. Before I was done, the psychologist balked, "None of that matters. You are not welcomed to our team!" I was taken aback, surprised, and made a quick mental review about anything that I might have said to prompt this reaction. Everyone was silent. He continued, "I am not sure what you are doing here or who sent you to observe us? In fact! I want to see your identification cards. I do not know what your agenda is here, but we are not going to be a part of it, and you need to leave."

That was my first and rather abrupt introduction to the essential factor of *trust*, or lack thereof, within interdisciplinary teams. After the psychologist asked us to leave, Mark and I still tried to explain our roles and goals. Without success, we left the school premises feeling deflated and confused. After a final discussion about the event with the principal who disclosed she was also unclear about our purpose, we never regained an invitation to the team, and we were left only with a story that would make for good watercooler conversation for years to come. "But we even brought cookies!" we would jest, eventually separated enough from the event that we could have a chuckle.

As a social work practitioner who facilitated groups in therapeutic settings, I was well versed in the dynamics of group practice. However, working in an organization led by educators for the purposes of consulting with schools, the language of group work was never present. Nor did I initially think about understanding teams through group work principles as I adjusted to the bureaucratic and hierarchical culture common in educational settings. That is, until we experienced roadblocks in our work, observed limited interdisciplinary collaboration among members, and noticed team goals not easily achieved. Other consulting teams in our organization experienced varying degrees of these interactions, and this meant that we had to conduct a deep reflection of our approach. I realized Mark and I were not standing members of the team, but we tried to hit the pavement running without full understanding of the factors and context that would create challenges for our collaboration with the school and the teams. For two years, the Bronx high school had been deemed a "school in need of improvement" and under threat of closure. This is how we came to our work with the school at the directive of the city's department of education. This fueled the fire of distrust and fear. The school eventually was phased out, so the fears of the team members were well founded.

Like *trust*, other critical factors of group work are present in the space inhabited by interdisciplinary teams, and these factors serve to support or create barriers to collaboration. Consequently, these factors also impact the interaction between outsiders and team members, as well as among existing team members. In this narrative I adduce personal experiences from my time as a social work consultant in one high need, urban, public elementary school while developing and facilitating an interdisciplinary team, and what I learned about effective interdisciplinary team processes. I will share my observations of team member interactions, focusing on the challenges of engendering effective team collaboration and the key factors that promote collaboration through the framework of group dynamics (Jacobs, Masson, & Harvill, 2012). Furthering the discussion, I will focus on the consequential collaborative relationship between school social workers and teachers.

In Context: High Poverty Urban Schools and Interdisciplinary Teams

Many children and disproportionately children of color, come to school reeling from the effects of poverty: high crime neighborhoods, disrupted family conditions, poor health conditions, limited educational resources at home, and limitations of non-English language households (Atkins, Frazier, Birman, Abdul-Adil, Jackson, Graczyk, Talbott, Farmer, Bell, & Mckay, 2006). These conditions have a tremendous impact on student achievement and school culture (Ravitch, 2010). For urban schools, where a high concentration of poor minority students attend, limited resources (e.g., manpower, time, effective interventions, systems for effective school practices, and the parental supports

more abundant in suburban school settings) create challenges for addressing student needs and reducing the achievement gaps in academics (Warren, Bohanon-Edmonson, Turnbull, Sailor, Wickham, Griggs, & Beech, 2006; Ravitch, 2013). At the same time, there has been a paradigm shift in public education, one that focuses more heavily on accountability and high-stakes performance evaluations for teachers and administrators. In this light, the federal government has emphasized mandates for standardized testing, common core standards, and response to intervention, all the while schools experience more funding cuts, heavier demands on school personnel, and increasing job insecurity (Ravitch, 2013; Issurdatt, 2009).

The current education environment indeed adds tremendous pressure for schools to close achievement gaps and this pressure is most staggering for high need public schools as these are urged to "turn their schools" around through a variety of programs and interventions (Ravitch, 2013). A relationship between the social-emotional well-being of children and academic achievement has long been asserted, and many approaches have been developed to address this. Some of the approaches have been found to be more effective than others. Collaborative effort of school personnel, consequently, has been noted as one the most influential characteristics for addressing the challenging socio-emotional needs of students (Lynn, Mckay, & Atkins, 2003; Mckay, Stoewe, McCadam, & Gonzales, 1998). To this end, interdisciplinary teams have been considered as one system for collaboration with potential impact on school effectiveness, improved teaching, and improved responses to the overall needs of students (Bronstein, 2003; Mellin, 2009). Teamwork can provide a space for synergy and expertise of different disciplines, and that reduces isolation in the workplace. However, studies have also pointed to the limitations in the process of teamwork as limited collaboration can also be a challenge conflicts and tensions between members arise, moreover, teams retain a restricted focus in how they address student issues.

The Bronx high school experience was the beginning of my journey in gaining a deeper understanding of interdisciplinary team processes. Throughout this journey, I learned that the process of developing trust was important in my own relationship to the teams and that the context in which teams exist matters. These are just a few of the factors that impact on teams. Ultimately, many barriers to developing truly collaborative teams exist. Conversely, there are also many processes that can support collaboration, and both impacts require unpacking in order to improve interdisciplinary team practices. Through my work as a consultant, I was well positioned to observe what took place in and around teams and as a social work practitioner to understand these interactions through the concept of group dynamics. Jacobs, Masson, and Harvill (2012) outline a number of generic factors that are essential to the function of groups and the types of groups that are impacted by these factors. In the case of interdisciplinary teams in schools, considered to be task groups, these factors range from the practical, such as meeting times, location, and membership to more process oriented ones such as engagement, purpose, and commitment. Through this framework of group work, I discuss my experience assisting to develop a team at a public elementary school.

Enabling Collaboration in Interdisciplinary Teams: The Promise School

In 2008, my new educational counterpart, Rob, and I were assigned to work with a public elementary school. The Promise School had signed on to work with our agency for a period of three years in order to develop and reinforce systems that addressed the social emotional needs of students (and this included the involvement of interdisciplinary teams). The principal had been at Promise for only two years by the time we began to work with him. He had heard about the work our agency had been doing with other schools in the area and reached out to us.

We had an opportunity to meet with him and other key staff over a summer retreat before the school year began in order to map out the work we would be undertaking together. It was a quite different experience to partner with a school than to be mandated upon one. We also met with the assistant principals, and the school social worker and guidance counselor. The school as our client, entered in discussions with us to develop shared goals, and this process resonated very strongly with my social work value of partnering and

collaborating with clients.

Leadership, Purpose, and Protocols

The Promise school, with a little over 1000 students, was a considerably large elementary school in light of the small schools movement under Mayor Bloomberg's tenure and control of New York City public schools. Promise had organized itself into four academies based on grade level with four assistant principals, each overseeing one of the academies. The school had a school social worker, a guidance counselor, and a related services team (psychologist, special education school social workers, and speech therapists) for students with special education needs. There was also an onsite community-based organization that provided mental health services for students. For a school of its size, the staff-to-student ratio may appear appropriate, and to be fair, Promise had resources many others in the area lacked. However, when urban school settings experience a little more than half of their students exhibiting disruptive and externalizing behavior that require disciplinary action compared with only 1-7% of students exhibiting similar behaviors in average school settings, the resources at Promise were still limited (Baker, Kamphaus, Horne, & Windsor, 2006; Walker, Horner, Sugai, Bullis, Sprague, Bricker, & Kaufman, 1996; Tolan & Henry, 1996). Similarly, the staff at Promise had identified behavioral problems and social-emotional concerns of students as significant issues for teachers in and outside of the classroom. The school did not have a dean of discipline, so the task of addressing behavioral concerns was relegated to the assistant principals, teachers, and in a less than ideal manner, frequently delegated to the school social worker and guidance counselor- the latter two being redirected from their crucial roles of addressing social emotional issues of children to a role that posed a conflict to their counseling functions.

The school agreed to develop two interdisciplinary teams to address separate, but intersecting academic (ACT) and social-emotional concerns (SET) of students. During the first year at Promise, the principal assigned a diverse set of staff members to the team. The standing members consisted of assistant principals, a school social worker, a guidance counselor, a school psychologist, a speech therapist, a special education social worker, and my team. Teachers, the parent coordinator, and the school-based community organization social worker would be invited when students they serviced came up for discussion, as were parents and relevant outside service providers. Having had previous interactions with the core members of the team, I had begun working on establishing rapport. I was no longer a stranger or seen as an intruder that helped me learn about their thoughts regarding the team. Most shared that they felt the focus of the team would be to address significant issues for students, they had hopes for its success, and ultimately, the improvement of children's conditions. Others shared that they thought the team would be an avenue for placing special needs students in more appropriate settings. Contrary to this latter belief, the agency I worked for and Promise's principal intended the team to address student concerns through classroom interventions, school counseling services, and linkages to social service agencies, but not serve as a step for special education referral education which had its own set of protocols. A cohesive understanding of the team goal was not immediate and would take some time to gain.

The team start-up required much pre-planning. I worked closely with the school social worker who was the in-house team facilitator, to develop the SET team. Rob would work with the literacy and math coaches to develop the ACT team, and it was intended that the two teams would communicate with frequency as many students required interventions in both areas. The SET team was designed to ultimately address the needs of a smaller group of students with behavioral and social emotional concerns, but first we had to gather and discuss information on all the students that had been identified with concerns. The school social worker and I began by triaging a list of students that had multiple school suspensions, excessive absences, those who were known to staff for behavioral issues, and those with other relevant social-emotional concerns (exhibiting disruptive or angry behavior, withdrawal and isolation, suspected of experiencing abuse or neglect, school phobia, or an inability to remain in class). Students were given a priority status from severe to minimal concerns and were then assigned a date to be brought up in the SET team. Key stakeholders would be sought to provide information on each student.

Teachers were provided with a referral document with information regarding student observations in the classroom, student strengths, concerns, and past classroom interventions. Outreach to parents or guardians and completion of social histories were pursued whenever possible– a challenge, when many parents whose children had been identified with concerns had a distrust of the school system themselves. Getting the information from staff in a timely manner would also prove to be a challenge and this was in part due to non-team staff's limited understanding of the team function or because they had yet to see any evidence of success. I often visited with teachers to discuss their students before the SET team met to review the referral forms with them. In that first year, some teachers were receptive, and other times I got the impression some thought the process was a waste of time. A handful of teachers would take very long to complete the referral form or would leave some forms incomplete. One third grade teacher told me she had implemented many of the interventions that would likely be recommended by the team, so there was no point in referring to the team. Selling the team as an effective process to overwhelmed and overworked teachers would be very challenging when it presented extra work on their part. We found, however, that the first number of teachers that used the team process would prove to be the most important promoters as they worked through interventions with the team and received support from related staff.

One first grade teacher in particular was a staunch supporter of the team after she found support addressing a student who had difficulty following directions and completing assignments. The student would get upset when being reminded to complete tasks, begin new work, and would storm out of the classroom. The student, as reported by the teacher, was bright and was academically on track, but she feared the behavioral issues would sooner or later impact his academic standing. The teacher outreached to the child's parent who appeared to be frustrated with being called so often about her child's behavior. The parent did not see any of these behaviors at home. The teacher discussed her system for addressing behavior which included a class chart that had student goals for the day; every time a student committed an infraction she would move a fish further down until the student lost privileges. The school social worker and I suggested we would go into the classroom to observe the student to get a better sense of his response. The teacher agreed, but said we would not see anything other than what she had reported.

After our observation, we noted the student would react to changing activities, and the teacher agreed. We all came back to a second SET meeting and after some discussion, we began to identify moments that preceded the behavioral issues and moments when the student's behavior was appropriate. The team assessed that the student had difficulty with transitions. Many children can engage in challenging behavior in group settings and at school, but not at home, because the rules and routines may be more demanding in the different environments. The team suggested that the teacher minimize some transitions for the student and reduce waiting time for activities. Since the teacher also identified other potential students that could benefit from restructuring the class schedule, the assistant principal offered to help in developing a new schedule for the class. The teacher was also advised to note and verbally reward the student when he was engaging in appropriate behavior. The school social worker would meet with the teacher to implement a positive reinforcement system in the classroom rather than one that penalized students for negative behavior. The teacher would send a note to the parents home noting some positive behavior from the student. Finally, the school social worker and teacher would meet with the parent to discuss any concerns and support and engage the parent in reinforcing positive classroom behaviors. Things improved considerably for this teacher, and she would encourage her close peers to utilize the team.

In the subsequent years, the school social worker and guidance counselor would also implement a newsletter that included the goals of the team as well as an agenda for the coming school year. They would also present at the initial faculty meeting of the year and review the referral process. After which, they would provide each teacher with referral forms and asked them to identify anyone they were concerned about from the previous year. A pre-referral discussion would also take place as the school social worker and guidance counselor strengthen relationships with teachers and visited classrooms.

Much of the team energy during the first year, however, also went into establishing clear and essential protocols: consistent meeting dates and times; established location of the meeting; team member attendance; and ensuring the completion of required student information for case presentation. These protocols are important decisions that depend on the availability of resources, goal of the team, and ultimately affect the life of the team (Jacobs, Masson, & Harvill, 2012). Often, when groups are not seen as the primary function of the agency they can be relegated to less than ideal spaces or moved around, which ultimately creates instability and devalues the team function. At Promise, the school social worker, as the in-school team facilitator working in concert with the guidance counselor, was instrumental in establishing these routines, by emailing agendas to the team, maintaining records, and reviewing paperwork. An attendance sheet with expected members was created, and meetings were rarely, if ever, canceled even in that first year. The group leader attitude demonstrated commitment to the team to other team members.

Another significant factor for the development of the team was the administrative support from the principal. Although the principal was not present in all the meetings, the team did meet weekly in his office. This provided another emphasis on the value of the team, privacy of discussion for sensitive student information, and helped in troubleshooting team issues. On a handful of occasions, the related service providers did not attend the meeting. At the beginning of one of our meetings the school social worker, guidance counselor, and I were having a brief discussion about how to improve attendance when the principal walked in. He looked at the attendance sheet for the team members and then proceeded to call the missing team members to tell them the meeting was about to start. The missing members came to that meeting and were present at all subsequent meetings, highlighting the importance of administrative support for the work teams undertake. Administrative presence sent the unequivocal message that it was a valued process for addressing student needs. It also served to reinforce that all standing team members were important to the process. It was clear though that at the time the related service providers did not see the value of their role on the team and that was something that we had to address together.

Jacobs, Masson, & Harvill (2012) note that members should feel that they are owners of the team, that the team purpose is clear, and that the process has relevance for them. In the early stages of the team, the members who identified with the mission of the team and understood their contributions were the most vocal in discussing cases. However, not all members felt this way, in particular, the related service providers who appeared to be more turf-oriented, spoke only about the children they serviced and not about children that were out of their purview. One strategy we implemented to ensure that all members contributed was to institute a type of “round-robin” approach so that each had an opportunity to contribute to assessing the student cases. This process would be repeated when the intervention portion of the case came up. What started off as mechanistic and conscious act became an unconscious activity for the team-members by the middle of the second year. This proved to be extremely useful in that the related service providers who would initially only enter the team discussion when it pertained to familiar students with special education services, would soon contribute to the brainstorming sessions for all the students that came up with the SET team. Also, the team was able to gain from diversity of perspectives about student concerns given the different disciplines at the table.

Other processes remained underdeveloped during this time a well. Follow-up on the status of cases was not consistent for all students. Sometimes a team member would not follow through on their part of the intervention plan, and feedback from external interventionists such as mental health practitioners was not received in a timely manner. In order to work through these challenges we would adapt the referral and follow-up forms documentation to clearly identify members who would undertake and act on behalf of a case, and we would also assign case-coordinators to support and follow-up with interventions prior to bringing up a student for review. Admittedly, not everyone liked this process initially, but it was eventually seen as helpful in troubleshooting interventions and actions.
For example, there was a 10-year-old girl who required multiple interventions. The student had been struggling academically and was at-risk for repeating the year; she presented somewhat unkempt a number of times a week, was withdrawn

and isolated, and had trouble relating to peers. While not overly defiant in the classroom, she often did not follow directives. The teacher had also noticed that at one point the student had glasses, but she no longer brought these to school. The school social worker had been able to bring in the parent who disclosed she had been struggling to care for a number of children in the home of which many had behavioral and academic problems and had no real support from relatives. The parent had a history of depression but was not receiving any services and welcomed any support and resources that the school recommended. The SET team recommended a home-based family support program and the school social worker was to make a referral to a known provider and monitor the services. The SET team outlined classroom behavioral strategies for the student's classroom teacher to implement and the assistant principal was identified as the person to help her do so. The student was also referred to the ACT team where a recommendation of at-risk academic interventions to be provided as push-in classroom supports. The guidance counselor would include the student in a four-week socialization group. There would be a referral to the school nurse for helping the student with health and hygiene issues and referral to the on-site school clinic for medical follow-up, including an eye exam. These multiple interventions and linkages required a high level of coordination and monitoring that can often be a challenge in light of the volume of children's needs that must be addressed. Thus, the case-coordinator role was essential.

Commitment, Feedback, and Reflections

Engaging members in the process of teaming is challenging. Members want to know that the time and energy invested will pay off. Members want opportunity to voice suggestions about the team and in turn have a responsive team facilitator. They also want to understand and feel comfortable with the parameters of their role. Jacobs, Masson, and Harvill (2012) identify these processes as member commitment, attitudes towards leadership, and reflection of roles.

Over the course of time, most team members in the SET team at Promise felt that the interdisciplinary nature of addressing student issues provided support for managing the work, and ultimately that it had an impact on their students. Not all members felt this way, and it was crucial to making adjustments. During the second year, in order to be more efficient with time, the SET team members decided that the assistant principals would alternate their attendance to the meetings every week. This was done so that those whose academy students were not on the agenda could use this time to attend pressing administrative duties. One assistant principal whose attendance was already limited, and whose demeanor and lack of contribution to the team indicated that she was not aligned with the team function. Ultimately opted to leave the team. She found it more useful to address student issues in her academy directly and to use the time she spent in the team meetings instead attending to other matters. While her disinterest and eventual exit from the team may have appeared to undermine its value, members that do not align with the purpose of the team may need to leave in order for the team to be more effective, positive, and cohesive.

The team also addressed the length of sessions and reflected on member roles. As the number of cases decreased over time due to initial triaging of cases from highest-risk to low in the first year, and with the reorganization of meeting by academies, the amount of time necessary from the team meeting went from three hours to 45 minutes per academy. As mentioned before, feedback was enhanced through redesign of referral forms and by creating a case coordinator role. Initially, the case coordination was delegated to the school social worker and the guidance counselor, but was later extended to other members of the team as were the recording of the meeting minutes and form updates. A review of all cases would be held every three months to ensure that all interventions were in place, to discuss student's ultimate progress, and whether cases should be closed or remain open with a new set of interventions.

As programmatic processes were resolved by the third year of the team's existence, team members were also beginning to think about and intervene outside of their discipline-driven roles. For example, an assistant principal might spend lunch time with a student that required either acknowledgment for behavioral progress or positive behavioral interventions when they struggled with peer-interactions in the lunch room. A gym teacher would serve as a mentor for a student who had

trouble with social interactions. The school social worker might help a parent understand instructions provided by a teacher for helping their child with homework. Members were beginning to see themselves outside of the strict parameters of their job titles. According to the literature, breaking through the barriers of the rigidity of disciplines is a main feature of collaboration (Mellin, 2009; Bronstein, 2003). This process was particularly evident and powerful between teachers and the social worker at Promise, who were implementing truly collaborative interventions to meet student needs.

School Social Workers and Teachers

> Alone we can do so little; together we can do so much.
> — Helen Keller

As the number of students coming to school manifesting complex issues increases, so increases the focus on schools to do more. As such, teachers certainly face multiple demands in their classrooms and are expected to be many things to the children. They teach for which they sometimes have limited preparation and resources to do so (Hennessy & Green-Hennessy, 2000). One writers summarizes these sentiments:

> An issue that cannot be neglected is the acknowledgement that funds, resources, and staffing for public schools continue to be less than ideal, which leads to the expectations that teachers should just "do more." Teachers must not only be good teachers and motivate their students, but also, rally parents, ensure safety, and identify children who may need services for mental health or behavioral problems, in addition to countless other duties. (Williams et al., 2007, p. 104)

School social workers, consequently, are being prompted to support teachers in addressing social-emotional concerns of children (Lynn, Mckay & Atkins, 2003). Teachers are also seen as an important role that school social workers must, both, support and collaborate with. Franklin (2002) movingly behooves the social work field:

> As we explore new roles in the 21st century, we must revisit our mission as social workers and see the opportunities that exist for us to meet the human needs. For example, teachers are perhaps the most important and yet the greatest neglected of school personnel who could benefit from our services and help. (p. 130)

Indeed collaboration and support are perceived as inherent in school social work practice and significant to school social work's ecological framework (Kane, 1975; Graham & Barter, 1999). Reasonably, a strong focus on collaborative capacity between the two disciplines has developed and also an interest in the vehicles by which to support these goals (Lachini, Anderson-Butcher, & Mellin, 2013; Berzin, McManama O'Brien, Frey, Kelly Alvarez, & Shaffer, 2011; Diaz, 2011) has grown. As a consultant, I was able to observe how interdisciplinary teams became a vehicle for school social worker and teacher collaboration and the consequent impact of effectively addressing student needs.

Through the SET team, the school social worker and teachers would discuss strategies for how to address individual student behaviors in the classroom. This process helped leverage their communication out of the team where consequently they communicated on student progress for students who had been recommended for counseling with the school social worker that reduced unrealistic expectations of their intervention's impact on students. The school social worker and teachers also co-led family meetings with students' guardians. Often, these functions are seen as role specific (Diaz, 2011), but because the team allowed room for discussion and exploration for how to best intervene with students, teachers and school social workers had the opportunity to build a bond that promoted mutual respect, and "we are on the same side" attitude.

At Promise, the interdisciplinary team discussions brought up student issues that individual teachers were challenged to address within their classrooms, as well as school-wide culture and behaviors that many teachers confronted. The individual challenges presented opportunities for the school social worker to collaborate with and support the teachers while the school-wide issues presented with a call for mezzo and macro level interventions for

the school social worker. A number of bullying incidents that had escalated throughout the school brought the need for a macro-level intervention that involved the collaboration of school social worker and a number of teachers. The school social worker and I researched conflict resolution programs that could be implemented within the classroom through a social-emotional learning structure. The school social worker brought one of the programs to the teachers she had been working with through the SET team. Three teachers were on board to pilot the program. The school social worker would deliver the conflict resolution program three times a week for a series of six weeks while the teacher was in the classroom.

Ultimately, the teachers would take over the conflict resolution curriculum with their students and would receive ongoing support from the school social worker to support the use of the skills in and outside of the classroom setting. This process involved trust and true collaboration because it required the teachers to open their classroom doors and provide time for the school social worker to deliver and experiment with a classroom intervention, and involved both the teachers and school social worker in the implementation and troubleshooting of the approach together.

The teachers and school social worker had fused their roles and eliminated the perceived restrictions. In this respect, the school social worker was able to see the classroom setting as an appropriate space for intervention, and the teachers were able to implement social-emotional skills. The teachers saw positive outcomes of this collaboration and the conflict resolution program and subsequently promoted the programs with their peers. This resulted in the implementation of the program in three new classrooms every year after the initial pilot process.

Being a part of the day to day activities of interdisciplinary teams and working closely with school social workers and teachers provided me with a unique view of the demands of their work. Additionally, I was able to see the conditions that supported their activities and those that created barriers. Working through teams provides schools with an efficient and effective way to leverage in-house staff in addressing student needs and also readily provide support for one another. However, in order for teams and school staff to be truly collaborative the processes of collaboration must be consciously developed.

Conclusion

Interdisciplinary team collaboration has garnered increasing attention over the years as a structure that serves to address student functioning and reduce practice isolation. Particularly relevant for school social workers and teachers as primary interventionist, interdisciplinary teams that are effective in engendering collaborative practices can offer support for addressing the complex social-emotional issues of children. Given reductions in funding that more deeply affect high poverty urban schools, interdisciplinary teams can also help reduce the nimiety, by decreasing fragmentation and duplication of services in these schools. Additionally, teams can serve to highlight discipline-driven skills and strengths, and develop mutual respect among professionals while harnessing the potential of newly created cross-discipline roles and interventions. For all the potential benefits of interdisciplinary teams, attention must be given to the processes that unleash these supports for students and school personnel. Several factors affect the capacity for interdisciplinary teams to be truly collaborative, and when addressed, teachers and school social workers can find a space to enhance their relational interaction to best meet the needs of students.

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