

Shared Expertise: Family Participation in Interprofessional Training

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Family-professional and interprofessional collaboration have been increasingly emphasized in children's mental health since the advent of federal legislation requiring parent participation in planning services for children with disabilities and the Child and Adolescent Service System Program. However, professional training programs have been slow to incorporate attention to such collaboration. In this article we report findings from a survey of 51 university and agency-based interprofessional training programs. The purpose of the survey was to learn about interprofessional education programs that prepare professionals to work in interagency, interprofessional environments and to collaborate with families. Family member involvement in the planning, implementation, and evaluation of interprofessional training and curricular attention to family-professional collaboration were found to be present in a small number of interprofessional education training programs. These findings are presented, along with recommendations for increased attention to family-professional collaboration in professional training.

Professional practice in children's mental health has been revolutionized in the past decade, with the families of children with serious emotional disorders (SED) playing significantly greater roles in designing, planning, implementing, and evaluating interventions with their children (Friesen & Huff, 1996; Koroloff, Friesen, Reilly, & Rinkin, 1996). Professionals in the system of care in children's mental health and family members are pooling their knowledge to better meet the needs of children with SED and to locate and develop supportive services (Friesen, Griesbach, Jacobs, Katz-Leavy, & Olson, 1988). With these developments, family members and professionals are becoming increasingly aware of the limitations of traditional training approaches in preparing professionals to collaborate with family members. The urgent need to enhance the quality of training for professionals preparing to work in children's mental health was highlighted by Hanley and Wright (1995). There is also a growing awareness of the interprofessional and interagency context within which professionals are being called on to work and the need for training to better prepare professionals to collaborate with each other as well as with families whose children have emotional disorders (Casto, 1987; Casto & Julia, 1994; Duchnowski & Friedman, 1990).

In this article we focus on training for two kinds of collaborative roles for professionals working with children with SED and their families: (a) collaborating with members of other professions and (b) collaborating with family members to secure adequate services. We believe that when they participate in interprofessional training, family members can help professionals to better understand the challenges facing families and gain the skills to collaborate with family members and with members of other professions. We briefly examine the rationale for interprofessional education, review the history of family participation in children's mental health, and offer suggestions for active involvement by family members in planning their children's care and planning and implementing professional training.

Findings related to family participation from a survey of interprofessional training programs and principles for training for family-professional collaboration in interprofessional/interagency contexts are presented. We conclude with recommendations for training content and methods related to family-professional collaboration.

INTERPROFESSIONAL AND INTERAGENCY COLLABORATION

Because the system of care in children's mental health is characterized by the coordinated participation of mental health, educational, social, health, vocational, and recreational services (Stroul & Friedman, 1986, 1988), and because it is staffed by psychiatrists, psychologists, teachers, social workers, counselors, physicians, nurses, and members of other professions, interagency and interprofessional collaboration is necessary. Within agencies there are multidisciplinary teams; there are also collaborative efforts across agencies that may present both interorganizational and interprofessional challenges.

Interprofessional collaboration is the communication, cooperation, and coordination that occurs between members of two or more professions when they are dealing with family concerns that extend beyond the usual area of expertise of any one profession (Houle, Cyphert, & Boggs, 1987). Interagency collaboration extends the concept of teamwork across agencies with explicit definitions of responsibilities, regular meetings of professionals and families to plan services, joint system planning and financing of services, and collaborative programming at state and community levels (Duchnowski & Friedman, 1990). The advantages of interprofessional and interagency collaboration in addressing the complex needs of families are emphasized in the literature (Casto, 1987; National Mental Health Association, 1993). For example, a growing number of universities are responding to the demand for professionals to have skills in collaboration by training human services professionals together, offering interdisciplinary content, and using interprofessional trainers (Billups, 1987; Casto, 1987; Casto & Julia, 1994; Snyder, 1987). However, there continues to be a need for training to better prepare professionals for practice in children's mental health (Abramczyk, 1989; Friesen, 1989; Hanley & Wright, 1995).

FAMILY-PROFESSIONAL COLLABORATION

Family-professional collaboration in children's mental health has been a focus of attention since 1984, when the Child and Adolescent Service System Program (CASSP) was created at the National Institute of Mental Health, and there has been both conceptual and empirical work around this concept. A successful collaborative relationship is identified as one in which parents and professionals develop mutually agreed goals, share responsibilities in planning and decision making, are seen as mutually respected equals, and engage in open and honest two-way sharing of information (Vosler-Hunter, 1989). DeChillo, Koren, and Schultze (1994) identified four empirically distinct dimensions of collaboration between professionals and family members: support and understanding, practical assistance, open and clear exchange of information, and professionals' willingness to modify or change services based on feedback from parents. Despite considerable attention to promoting family-professional partnership in the service arena parents report that professionals' inability or unwillingness to collaborate often results in insufficient opportunities for families to participate in planning, implementing, and evaluating services (Friesen & Huff, 1996). In a study of parents' views of professional behaviors, Friesen, Koren, and Koroloff (1992) found that parents of children with SED identified honesty and inclusion in decision making as key professional behaviors, but that their expectations for these behaviors were only partially met.

A partial explanation for the apparently limited practice of family-professional collaboration and family participation in services may be found in the neglect of this issue in professional education. For example, in a study of social work education for working with children and adolescents with SED, Friesen (1989) found that social work education programs provided minimal content in children's mental health, family participation, and family-professional collaboration. In a survey of schools of social work, special education, psychiatry, child psychiatry, and nursing, Friesen and Schultze (1992) found that only special education training programs incorporated attention to family-professional collaboration, probably because of the mandatory nature of parent participation in planning special education services under P.L. 94-142, in contrast to other fields where such participation is entirely voluntary.

To learn about professional preparation for collaboration with families and other professionals, a survey of interprofessional/interdisciplinary education programs was conducted. The purposes of the study were (a) to identify and examine family-centered education and training programs in which instructors and participants represent different disciplines/professions and training content addresses the knowledge and skills needed for interprofessional collaboration and (b) to identify best practices for involving family members in program planning, implementation, and evaluation and providing training content on family-professional collaboration.

METHOD

Participants

Participants in the study were the directors or senior faculty members of 51 family-centered interprofessional education or training programs. Sixty-five potential participants were identified using a snowball sampling methodology that included contacts with educators and mental health administrators around the country. Personnel from the 65 programs participated in a telephone screening interview to determine whether their programs met the criteria for inclusion in the survey: (a) the program provided training content on interprofessional/interdisciplinary collaboration, (b) instructors were drawn from more than one profession/discipline, and (c) participants came from (or were entering) more than one profession. After the screening, 51 programs were determined to meet the criteria for inclusion in the study.

Training programs identified in the study included 25 university preservice and professional education programs and 26 agency-based continuing education programs. Eight education programs specifically focused on children's mental health were identified.

Instrument

Based on a review of the literature on interprofessional/interdisciplinary and interagency education and family-professional collaboration, a tentative model of education incorporating attitudes, knowledge, and skills for collaboration was developed to guide the development of survey instruments. Two parallel versions of a questionnaire were developed for (a) university-based preprofessional and interprofessional education programs and (b) agency-based continuing education programs. Early drafts of the questionnaires were reviewed by faculty, professionals in children's mental health, and family members, and revisions were made in response to their feedback. The questionnaires were pilot tested with staff from local interdisciplinary training initiatives, and further revisions were incorporated. The final versions of the questionnaires included a mix of open and closed-ended questions designed to examine in detail program development, implementation, and evaluation, with particular attention to the involvement of family members and consumers of services in the provision of training.

Procedures

A nominating form and explanatory letter were sent to educators and mental health administrators around the country asking for nominations of family-centered interprofessional training programs. A telephone screening interview with the director or representative of each of the 65 nominated programs was conducted and the screening interviewer determined that 51 programs met the criteria for inclusion in the study. Agreement was reached between the interviewer and respondent about which program representative would be the most appropriate respondent for the telephone interview (usually the program director), and an appointment for the interview was scheduled. A letter was sent to the respondent to describe the purposes of the study and confirm the appointment for the interview, and a copy of the appropriate version of the questionnaire was included so that study participants could prepare their responses. Telephone interviews lasting 1 to 1 ½ hours were conducted between March 1993 and December 1994 and the first author monitored the collection of data.

Data Analysis

Participants' responses to survey questions were noted by the interviewers during the scheduled telephone interviews. Quantitative and qualitative data were sorted for analysis using the computer program Paradox (Paradox Version 4.0, 1992).

RESULTS

Detailed findings of the entire study are reported elsewhere (Jivanjee, Moore, Friesen, & Schultze, 1995). In this article, we specifically address the following questions:

1. How are interprofessional education and training programs developed?
2. To what extent are consumers of services and family members involved in any aspect of preprofessional and continuing education programs?
3. To what extent are professionals of different human services disciplines/professions being trained to collaborate with families?
4. What efforts do interprofessional training programs make to recruit consumers, family members, and culturally diverse community members as participants in training?
5. What training content and methods are used to prepare professionals to collaborate with families?
6. What are the strengths and benefits of interprofessional family-centered training programs?

Program Development

Almost all the education programs surveyed were of recent origin. Only 5 education programs (3 agency-based and 2 university) had been in existence for 20 years or more. Twelve university programs (48%) and 14 agency-based programs (54%) had been in existence for 3 or fewer years. Nineteen agency training programs (73%) and 16 university programs (64%) were described as ongoing; the remainder were funded by grants and therefore were time limited.

In response to a question about why their programs began, program representatives gave a variety of explanations. Eight university respondents and 4 agency respondents indicated that their interprofessional/interdisciplinary focus developed out of growing awareness of the need to prepare professionals to work collaboratively and to provide integrated services. Nine university respondents and 10 agency respondents said that their interprofessional focus had emerged during the development of a training program to serve a specific population such as infants and preschool children with disabilities, rural populations with limited access to health and mental health services, or children with SED and their families. The development of interprofessional education emerged from general efforts to improve the quality of their existing training programs, according to 6 respondents. Eight respondents (3 associated with university programs and 5 with agency-based programs) developed their training in response to pressure from external groups, such as family advocacy groups or neighborhood associations; 3 of these described the pressure as coming from federal mandates to provide services in specific ways.

Consumer and Family Member Participation

Respondents were asked about the extent of consumer and family member involvement in any aspect of the planning, design, implementation, and evaluation of training. Training programs focused on preparing professionals to provide services to adults and older youth tended to involve consumers of services in planning and implementing training, while those focused on children and their families were more likely to include parents and other caregivers. Family members were involved in some aspects of the planning and implementation of training in 52% of university training programs and 65% of agency-based training programs. Consumers of services were involved in 64% of university programs and 69% of agency-based programs.

A variety of roles for family members and consumers at various stages of the planning, implementation, and modification stages were mentioned by respondents. Examples of the activities of family members and consumers across all training programs include (a) involvement in needs assessment in both university and agency-based programs; (b) participation in program design, planning, continuing oversight, and evaluation; (c) membership on advisory groups and committees; and (d) training in a number of capacities. Family member and consumer involvement was more extensive in the agency-based training programs, with family members and consumers participating in multiple activities in some programs.

Family members and consumers played significant advisory roles in the development and ongoing evolution of some training programs. Twenty university interprofessional education programs (80%) had an advisory group; of these, 30% included representation by family members and 40% included representation by consumers of services. Eighteen of the agency-based programs (69%) had advisory groups; of these, 56% included representation by both family members and consumers.

Responses to specific questions about the involvement of family members and consumers in providing training indicated that 48% of university programs and 58% of agency-based programs used family members and consumers as trainers. Family members and consumers tended to have more extensive responsibilities in agency training programs than in universities. Responsibilities of family members and

consumers in providing training included developing and reviewing curricula; acting as lecturers, presenters, trainers, or co-trainers; presenting the family perspective, including their experiences with the service system and discussing family needs; facilitating seminars and group discussions; and giving feedback. In a few notable agency-based training programs, family members and/or consumers were paid as regular staff and had responsibilities for planning curricula and conducting training.

Training Program Participants

The professions of social work, psychology, education, and nursing were most frequently represented among the trainees in interprofessional education programs included in the study. A summary of the responses to questions about the disciplines/professions of these participants is provided in Table 1.

TABLE 1
Percentage of Interprofessional Programs with Professions/Disciplines
Represented by Trainees

| Profession/ Discipline | University programs^a (%) | Agency-based programs^b (%) | Total^c (%) |
|-----------------------------------|--|--|----------------------------------|
| Social work | 80 | 88 | 84 |
| Psychology | 64 | 85 | 74 |
| Education | 60 | 73 | 67 |
| Nursing | 68 | 65 | 67 |
| Special education | 48 | 77 | 63 |
| Social administration | 24 | 58 | 41 |
| Sociology | 27 | 50 | 39 |
| Law | 24 | 46 | 35 |
| Other ^d | 56 | 31 | 43 |

^a n = 25. ^b n = 26. ^c n = 51. ^d Participants represented in the "other" category are drawn from a wide variety of disciplines and professional identifications, including medicine, child psychiatry, juvenile justice, community action, drug and alcohol counseling, and family therapy. Paraprofessionals and nonprofessionals also participated in some training programs.

Recruitment of Training Participants

To gain understanding of the efforts of training programs to increase their responsiveness to families, respondents were asked about their efforts to recruit family members and consumers as trainees. Respondents indicated that participation of family members and consumers in training was not a priority for most university programs; only five university respondents (20%) reported that their training programs made any special efforts to recruit family members or consumers as participants in training. In contrast, more than half of the agency-based respondents reported special efforts to promote and encourage family member and consumer participation. Recruitment occurred through contacts with state and local affiliates of the National Alliance for the Mentally Ill, the Federation of Families for Children's Mental Health, other parent and consumer advocacy organizations, and neighborhood and community associations. Family members on the advisory boards of three agency-based training programs were reported to be actively involved in recruiting family members as participants.

Respondents from 19 university programs (76%) and 17 agency-based training programs (66%) reported that they made special efforts to recruit people of color as participants. Recruitment strategies that were most frequently mentioned included newspaper advertisements, magazines and journals with a cultural focus and/or targeted to specific cultural groups, promotional features on radio and TV stations with diverse audiences, contacts with ethnic organizations, outreach to targeted communities and school districts, and word of mouth. The success of these strategies varied widely: more than half of the agency-based respondents reported that their recruitment efforts were effective; only one fourth of the university respondents said that they had culturally diverse participant groups. Personal contacts were reported by some respondents to be the most effective strategy for the recruitment of culturally diverse participants.

Training Content

Specific questions were addressed to respondents about specific content of family-professional collaboration and consumer-professional collaboration. The presence of course content on cultural competence, which can be conceptualized as cross-cultural collaboration, was also assessed as a way to take account of cultural diversity issues as they may relate to collaboration. The results are presented in Table 2.

As a predominant mode of delivery, the integration of content on collaboration and cultural competence throughout the curriculum and in field practice experience may represent considerable emphasis on preparing professionals to collaborate with families and members of other professions. However, these findings may also reflect lack of specific attention to these topics. The options (entire course, integrated throughout the curriculum, field practicum) were generated by the researchers, and respondents may have been inclined to make positive responses to the questions when specific course content was not present.

TABLE 2
Percentage of Interprofessional Training Programs with Family-Professional and Consumer-Professional Collaboration and Cultural Competence Content

| Training approach | Collaboration | | Cultural competence (%) |
|--|-------------------------|---------------------------|-------------------------|
| | Family-professional (%) | Consumer-professional (%) | |
| University programs^a | | | |
| Entire course | 16 | 8 | 32 |
| Integrated throughout the curriculum | 44 | 52 | 60 |
| Field practice experience | 52 | 48 | 52 |
| Agency programs^b | | | |
| Entire workshop | 4 | 4 | 16 |
| Integrated throughout the curriculum | 58 | 50 | 62 |

^a n=25. ^b n=26.

Program Strengths and Benefits

Responses to a question about the major strengths of their training program indicate that staff of several interprofessional training programs believed that their emphasis on family-professional collaboration was exemplary. Examples of two university responses follow:

[We are] preparing people to serve the community, taking what the community thinks is important, and then training people to meet those needs.

. . . empowering families and professionals alike; less professional burnout because of increased resources; families know better how to access solutions to family problems; brings together supervisors, workers and students to collaborate.

Two agency-based respondents mentioned their programs' strengths as follows:

Our focus on interdepartmental planning and transdisciplinary training with a parent advocacy focus is significant.

[We are] broadly inclusive . . . linking professionals and family members; not tied to any specific discipline.

Other respondents reported that staff of their training programs had become more aware of the importance of family member and consumer participation and had made plans to increase this focus, as well as to increase content on cultural diversity and family preservation.

DISCUSSION

This survey was designed to learn about interprofessional education programs that prepare professionals (a) to work in interagency, interprofessional environments and (b) to collaborate with families. Indicators of a family focus in interprofessional education are (1) the extent to which family members are involved in the planning, implementation, and evaluation of training and (2) explicit curricular attention to family-professional collaboration. Fifty-one interprofessional education and training programs were identified nationwide. Of these programs, 25 were university preservice or professional education programs and 26 were agency-based training programs.

Approximately half of the university programs and two thirds of the agency-based programs involved family members in some aspect of program planning, design, implementation, or evaluation; in many instances their involvement was minimal. Almost half of the university programs and nearly 60% of the agency-based programs used family members as trainers in at least some part of the training. Family-professional and consumer-professional collaboration and cultural competence were the focus of an entire course or workshop in only a few of the interprofessional education programs identified in this study. A larger proportion of respondents reported that their programs integrated this content throughout the curriculum or in field practice, but it is difficult to assess the emphasis given to these topics.

Survey findings suggest that only limited attention is given to interprofessional education for human service professionals across the country. The 51 interprofessional education programs that were identified represent only a small proportion of all professional training programs, many of which prepare students for practice within one discipline. This suggests that many professionals are not being explicitly trained to collaborate with other professionals and agency representatives. Within this selected group of training programs, the limited involvement of family members and consumers in program planning and the lack of specific training regarding family-professional or consumer-professional collaboration is disappointing, given the growing recognition of the need for professionals to be able to collaborate with each other and with families. If professionals are to be able to function effectively in interprofessional and interagency settings, and to collaborate with consumers and family members, we need to discover and disseminate the most effective educational strategies.

This survey clearly represents a beginning step in developing knowledge for improving professional education. In addition to the limitations of self-reporting, the snowball sampling methodology used with key informants to identify interprofessional education programs could not provide a complete picture of interprofessional education. Currently, no national sampling frame of such programs exists. Anecdotal evidence suggests that there may now be up to 100 interprofessional training programs in existence, some of which were started after the survey was completed. We do not know the extent to which the surveyed programs are representative of this larger group, either in relation to their interprofessional focus or in their attention to family-professional collaboration. The clear focus of this study also represents a limitation because it was specifically interprofessional education. Because the survey was not designed to examine the larger field of uniprofessional training programs, we are unable to comment on the extent to which they are preparing professionals to collaborate with consumers and family members.

Ongoing research is needed to develop and maintain a more complete understanding of professional preparation. Our review of the literature and informal contacts with professionals, educators, and family members suggests that the quality of practice with children with SED and their families is likely to improve if professionals are specifically trained to collaborate with family members and with members of other professions. We entered this study with a belief that professional education will be enhanced if family members are involved, but there is a need for empirical evidence to support this belief. Researchers need to address the following questions:

1. In what ways do professionals perform differently after receiving training in interprofessional and family-professional collaboration?
2. What kinds of educational/training experiences are most likely to prepare professionals to collaborate?
3. What kinds of family and consumer involvement in all aspects of education and training programs are likely to lead to professionals gaining better understanding of family perspectives?
4. How can family members play active roles as trainers in professional training?
5. What kinds of preparation do family members and consumers need to be able to participate fully in all aspects of training program development and implementation?

Assessment instruments are needed to evaluate the outcomes of professional training and to assess the impact of different types of training on family-professional collaboration. A measure of family-professional collaboration such as the Family-Professional Collaboration Scale developed by DeChillo, Koren, and Schultze (1994) might be used to measure the quality of professional practice before and after training for collaboration. There is a need for instruments to measure the components and outcomes of interagency teamwork and for further development of preliminary measures of interprofessional/interdisciplinary collaboration (Abramson & Mizrahi, 1996; Mizrahi & Abramson, 1994; Sands, 1989). Such instruments could be useful tools in evaluating training program outcomes.

A potentially useful focus for research would be on the benefits of collaboration training for family members, either alone or jointly with professionals. Williams-Murphy, DeChillo, Koren, and Hunter (1994) reported on positive training outcomes for both parents and professionals when pairs of family members and children's mental health professionals received joint training based on a specific collaboration curriculum. Heflinger (1995) reported that parents' knowledge of the mental health system and personal efficacy increased following their participation in a parent empowerment training group.

As a beginning step toward learning about ways to improve professional education and ultimately children's mental health practice, the findings of this study point to the need for further research into the effects of training for interprofessional and family-professional collaboration. Researchers need to address the questions we have raised and to assess the extent to which a family focus in professional training ultimately leads to services that are truly supportive to families. Hanley and Wright (1995) urged that quality training for children's mental health professionals become a national priority with new training practices demonstrated, evaluated, and disseminated in order to enhance the quality of children's mental health services.

We believe that interprofessional education that emphasizes family-professional collaboration is likely to improve the quality of family-centered services. We know that, in general, families prefer professionals who collaborate with them, and they think that family-professional collaboration is a respectful form of practice. The next step is to develop new approaches to professional training for children's mental health and carefully evaluate the extent to which changes in professional training enhance the quality of practice with families.

Authors' Notes

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