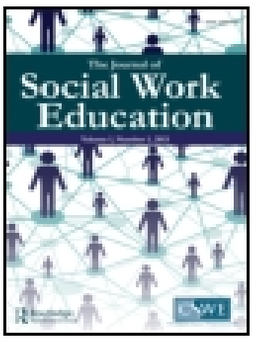

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A Template for Implementing Interprofessional Education in Child Advocacy

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ABSTRACT

While there is an urgency to offer graduate students' inter-professional education (IPE) in child advocacy, there are no templates for educators to utilize. Participants (n=34), inclusive of students, community stakeholders, and faculty from a northeastern university, participated in focus groups to describe what IPE should entail. Grounded theory was used to distill the data, which revealed themes about what participants would value from an IPE program barriers to implementing IPE, and recommendations for implementation . We next developed a template for implementing an IPE curriculum. Participants agreed in-person pedagogical approaches were more desired than online learning, and expressed a need for educators to simulate "real-life" IPE exposure. Future research is needed to examine whether the proposed template promotes professional collaboration.

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Public systems that serve marginalized children and families struggle to engage in interdisciplinary collaboration to adequately address the holistic needs of at-risk youth and their families (Palinkas et al., 2014). Enduring silos create barriers that impede youth and families from accessing evidence-based interventions and services to prevent involvement with child welfare and juvenile justice systems and promote well-being (Garcia et al., 2015). Professionals who serve children and families train largely in isolation from one another, despite decades of calls by the Institute of Medicine (1972, 2011, 2016) for interprofessional education (IPE). The children and families at greatest risk need not only the specialized expertise of individual professionals, but also professionals well-versed in collaboration (Institute of Medicine, Board on Global Health, 2013). Drawing on focus-group data collected from alumni, graduate students, faculty, and community stakeholders representing different disciplines, we propose a template for IPE in child welfare and child and family advocacy.

What is IPE?

Interprofessional education—also referred to as multiprofessional learning (Walsh et al., 2005), multiprofessional education (Barr & Waterton, 1996; Page & Meerabeau, 2004), and collaborative education (Wakefield & O'Grady, 2001)—can vary in meaning and application from one institution and one discipline to another, but there is some consensus about its key characteristics. In what has become the generally accepted definition of IPE, Hammick et al. (2007) described it as situations where "members (or students) of two or more professions learn with, from, and about one other to improve collaboration and the quality of care" (p. 736). Research underscores that, to be effective, IPE is not simply a situation in which students from different disciplines enroll in common courses; rather, IPE must create authentic opportunities for interactive learning and the active exchange between learners

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from different professions (Hammick et al., 2007; Reeves et al., 2008). For IPE specifically within social work education, this is especially important, for "while social workers are well-versed in principles of interdisciplinary, collaboration, and multidisciplinary practices, they are rarely paired with other professions in the classroom or intentionally taught about counterparts' roles and expertise over the course of their baccalaureate and graduate education" (Rubin et al., 2018, p. 20).

Although improved outcomes and better practice for clients and patients is a significant driver of IPE, an additional goal of IPE is to help break down the silos in which much professional education is conducted and to foster informed and trusting relationships among the disciplines (Frenk et al., 2010). Because interprofessional collaboration is reliant on the establishment of shared goals, trust, and skills to implement collaborative practice (Thannhauser et al., 2010), effective IPE must cultivate an understanding of other professions' knowledge, roles, and competencies *in comparison to one's own* profession. The difficulty, however, is that because preservice professionals are still developing the knowledge, roles, and competencies of their own discipline, they will struggle to comprehend others' roles without time to reflect on their developing professional knowledge, roles, and competencies (Whiteley et al., 2014). As such, learning outcomes will evolve as students become more experienced professionals (Freeth et al., 2005; Thistlethwaite & Moran, 2010). Charles et al. (2010) therefore posited that IPE be a scaffolded experience, beginning with exposure, followed by immersion, and culminating in mastery.

Benefits of IPE

Learning through collaboration and teamwork as part of professional socialization reaps numerous benefits. In one study (Carlisle et al., 2004) of IPE, focus-group data were collected from health service scholars, clinicians, consumers, and students. Researchers found a benefit of instituting IPE early in students' training, noting that it may help them develop and embrace ongoing learning, and disrupt the mentality of "tribalism" (or a tendency to remain situated within the confines of one's own professional identity).

Additional studies corroborate findings that IPE encourages positive interactions that engender mutual trust and support; promotes respect and collaboration between professions; and reduces stress, increases job satisfaction, and improves recruitment and retention (Barr et al., 2005; Lalayants & Epstein, 2005; Morrison & Glenny, 2012; Oandasan & Reeves, 2005). In essence, IPE's goals are twofold. First, as Barr et al. (2005) asserted, IPE works to "counteract the professional, organizational, and structural barriers to effective interprofessional practice" (as cited in Whiteley et al., 2014, p. 149). Second, IPE aims to "'decenter' cognitive and normative maps grounded in specific professional perspectives and to strengthen reflexive capacity" (Clark, 2006, as cited in Whiteley et al., 2014, p. 149).

Prepractice IPE and on-the-job interprofessional practice are thought to socialize professionals to work together more effectively, to develop mutual understanding and respect for various disciplines, and to impart collaborative practice competencies (Olenick et al., 2010). Social workers trained in clinical and community practice, child protection, and policy development are often pigeonholed as undermining the preferences of families and unjustifiably characterized as uncompromising and callous (Rubin et al., 2018). These social work researchers and educators, in their article on social work and IPE, assert that the "goals of learning with and from each other is to dispel misunderstanding, expand knowledge of each other's expertise and scopes of practice and ultimately efficiently work together to improve the quality of health and well-being for all people" (Rubin et al., 2018, p. 22).

There is evidence that more robust IPE involving social work students is gaining traction. In 2016, the Council on Social Work Education was named a supporting organization of the national Interprofessional Education Collaborative (IPEC; Rubin et al., 2018). The researchers, all social work educators, wrore that "with the advent of recent health policy initiatives as well as inclusion as a fully represented IPEC member organization, impetus for social workers to ascend as leaders in IPE has surged" (Rubin et al., 2018, p. 19). Further studies support their assertion that schools of social

work are collaborating with other national and international health education organizations to mitigate siloed approaches and promote interprofessional learning opportunities (Johnson et al., 2012; Reeves et al., 2012).

IPE in child welfare

How then might principles of IPE apply to child welfare and child and family advocacy? It was widely recognized decades ago "that the institutionalization and replication of interdisciplinary training in child maltreatment was ' . . . not only desirable, but necessary' by the U.S. Advisory Board on Child Abuse and Neglect" (Gallmeier & Bonner, 1992, p. 520). This was why, in 1987, the federal government—through the National Center on Child Abuse and Neglect—provided financial support to 10 geographically diverse universities to establish interdisciplinary graduate-level programs. According to Gallmeier and Bonner (1992), only one interdisciplinary graduate program in "child abuse and neglect" existed in the late 1970s, which is what prompted the new funding for training. The fields of medicine, psychology, and social work were specifically targeted, using the model from the University Affiliated Programs, an interdisciplinary training model in developmental disabilities (Gallmeier & Bonner, 1992).

Ten universities—Indiana University, New York University, Ohio State University, Temple University, University of California at Los Angeles, University of California at San Diego, University of Michigan, University of Oklahoma, University of Pittsburgh, and University of South Carolina—received $150,000 per year for 3 years (Gallmeier & Bonner, 1992). Three programs were based in medical schools, four in either social work or psychology departments, and three in specialized centers. The majority had interdisciplinary faculty, including the above disciplines, as well as law, public health, child development, nursing, dentistry, anthropology, theology, and education. Participating students received stipends ranging from $531 to $7,000 - per year. Training was anywhere from nine months to two years, and the credit equivalency ranged from nine to 15 hours (Gallmeier & Bonner, 1992).

These programs, based primarily in schools of medicine or social work, included broad faculty participation, and attracted students from diverse fields of study. After Gallmeier and Bonner (1992) reviewed initial outcomes for this pioneering initiative, they concluded that the programs, which trained over 400 students in the first years, resembled the initial process for institutionalizing interdisciplinary graduate education in child maltreatment. A subset of students support this conclusion, noting that their training left an indelible mark on the direction of their careers in child abuse and neglect. Unfortunately, funding for the original 10 IPE programs in child welfare and advocacy ceased after the first 3 years, and with one exception—the University of Oklahoma—none of these programs still exist. Currently, most IPE programs in child welfare are short term and limited in scope (Yamaoka et al., 2019). Despite the clear need, most professionals who work with children and families are educated without the critical interprofessional knowledge and skills needed for effective, impactful work (Christian et al., 2020).

A recent evaluation of the sole remaining Interdisciplinary Training Program (ITP) for Child Abuse and Neglect, offered at the University of Oklahoma Health Sciences Center since 1987, suggests that IPE in child welfare resulted in sustained contributions to the field through clinical work, treatment, prevention, and research (Yamaoka et al., 2019). Specifically, Yamaoka et al.'s (2019) evaluation unveiled that ITP alumni (a) were highly satisfied with the training they received; (b) believed that it contributed to advancing the field in clinical treatment, research, and child advocacy; and (c) continued to see the importance of the ITP to their career.

Barriers to implementing IPE

The lingering question is why something that appears so beneficial has been so difficult to envision, implement, and sustain. Despite institutions such as the National Academy of the Sciences, the National Academy of Engineering, and Institute of Medicine providing recommendations to academic universities in facilitating effective IPE, sustained programming (and funding) has struggled for decades to take root. Page and Meerabeau (2004) pointed out the paradox that while IPE could play a fundamental role in cultivating fruitful collaborations between professional child advocates across different disciplines, the stark disciplinary differences with respect to core mission, ethical boundaries, goals, and approaches to engaging clients or patients pose challenges to implementing effective IPE programs (Barnsteiner et al., 2007).

Many of IPE's known barriers are offshoots of existing constructs of graduate education. Rubin et al. (2018) explained that IPE remains an abstract ideology, partly because campus-based learning does not reflect clinical realities. Integrated IPE in the field is not yet well-established or standardized in practice, and thus, a huge gap exists between what IPE students learn in the classroom and clinical training they receive during their internships (Morison et al., 2003; Rubin et al., 2018; Salfi et al., 2015). Other such barriers include conflicts in degree requirements, course scheduling and content, as well as differences in promotion requirements, institutional policies for sharing course credit among schools, and financial funding across disciplines (Barnsteiner et al., 2007; Gilbert, 2005a; Mitchell et al., 2006). Within disciplines there may be few faculty members with interest or expertise in IPE (Cooper et al., 2005; Ho et al., 2008). However, where faculty members are interested and able to provide IPE activities, programmatic and institutional barriers may inhibit IPE development and implementation (Gilbert, 2005a, 2005b). Additionally, students who are in professional training programs are subject to the accreditation standards and licensure requirements for their respective disciplines—and following certification, professional silos continue to be reinforced by organizational and structural factors within interprofessional practice settings (Oandasan & Reeves, 2005; Willumsen, 2008).

Delivering effective IPE in the field of social work, particularly, has been described by leaders in the field as a "conundrum," because "social justice and human rights are at the heart of its professional mission, social work educators are tasked with ensuring that collaboration with other professions doesn't exclude advocacy on behalf of clients, especially those perceived as vulnerable or otherwise affected by adversity" (Rubin et al., 2018, p. 19). These authors go on to assert that IPE in the field of social work "must address the intersectionality between collaborative competencies and sociocultural factors such as oppression, poverty, racism, sexism, and heterosexism that affect practice access and efficacy" and that graduate and professional educators must work to "design authentic, interactive interprofessional learning opportunities commensurate with the social work profession's identity and values" (Rubin et al., 2018, p. 19). However, this barrier is one faced by many disciplines as we seek to provide authentic training and practice to an ever-widening culture of clients and communities.

The local context

The next logical question is how best to address barriers to developing and implementing IPE in general, and IPE in child welfare and child advocacy in particular. Although Rubin et al. (2018) illuminated some of the challenges highlighted above, we have yet to explicate the perceptions of those who (a) implement IPE (i.e., university faculty, community stakeholders/alums), and (b) the primary consumers of IPE education in child well-being and child advocacy (i.e., students). They may contribute additional barriers, offer guidance on how to address these barriers, and make suggestions for what IPE education and training should include.

To that end, we rely on focus-group data collected from alumni, graduate students, faculty, and community stakeholders to inform the development of an IPE template. A private, Northeastern university is replete with academic and research faculty and staff invested in child advocacy, well-being, and community engagement. The university also has a reputation for attracting students and

faculty interested in working across disciplines to address complex problems that continue to vex American society. As an exemplar, an interdisciplinary research and practice center draws faculty and students from social work, law, medicine, nursing, and psychology to advocate for children in creative partnerships with community agencies, to bring together stakeholders to consider new ways of breaking down disciplinary silos, and to inform policy and practice through lasting collaboration.

Hoping to build on the successes of the interdisciplinary research and practice center, as well as child well-being advanced curriculum for Master of Social Work (MSW) students, our cross-disciplinary workgroup seeks to develop and implement IPE at our university, and to enhance child advocacy work locally and nationally. Long committed to child welfare and child abuse prevention, individually and as a group, our work has addressed the many upstream variables, such as poverty and systemic racism, that hinder attempts to maximize the potential for every American child (Finck et al., 2017; Jaffee & Christian, 2014). For example, in addition to detailing current issues, we charted some of the structural barriers to serving children and families by marrying historical analysis with contemporary qualitative and quantitative research, clinical experience, and legal theory (Garcia et al., 2019; Noonan et al., 2012; Watts & Buckner, 2007). Yet even at our university, there are reasons why interdisciplinary education remains an elusive goal, despite the robust body of literature pointing to its advantages. Like other spaces of higher education across the country, there are no established rubrics, templates, or models for IPE. We therefore conducted focus groups to help inform the development of IPE in child advocacy, with the goal of creating a replicable model for IPE in child and family advocacy.

Research aims

The current study involved conducting focus groups with nursing, social work, education, counseling, medical, psychology, and law students, alumni, faculty, and community stakeholders from a large and diverse city to inform the development of a template for IPE. Inclusion criteria were defined broadly to include professionals and those in training who have expertise in children's health, well-being, and social welfare policy and practice, such as nurses, social workers, teachers, school counselors, medical doctors/pediatricians, lawyers, and behavioral health specialists. By drawing on their expertise, we addressed the following aims: (a) to illuminate what participants value and expect from an interprofessional training program or certificate; (b) to identify what participants perceive to be potential barriers to implementing the program, and how to mitigate them; and (c) to gain insight into what tools or methods of pedagogy should be included in the design and implementation of the program.

Methods

Recruitment

Each faculty member from the interdisciplinary research and practice center identified three to five students to participate in focus groups in January 2018. The recruitment process included a combination of nonprobability convenience and purposive sampling. Initially, faculty representatives cast a wide net by posting flyers in their respective home departments or by e-mailing the faculty and student body. The faculty representative then selected students who would show promise for, and strong interest in, successfully engaging with and completing an interprofessional certificate in child welfare/advocacy. In addition, faculty recruited community stakeholders (current social workers, medical professional, lawyers, nurses, and teachers) to participate in the data collection process. They recruited stakeholders with whom they have collaborated with in the past, in a child practice or clinical capacity or due to prior or current research projects focusing on children, youth, and family well-being. Semistructured interview guides (see the Appendix) for the focus-group meetings with current graduate students and alumni/community stakeholders were developed to illuminate their perceptions, preferences, and perceived barriers to engaging in IPE.

Sample

Twenty-four graduate students, including those enrolled in schools of law (n=2), nursing (n=4), education (n=6), social work (n=2), and medicine at the Children's Hospital (n=10) participated in the focus groups. All the students, reporting a mean age of 27.5 years (SD=3.66), identified as female. One student self-identified as African American; the remaining identified Caucasian. At the time of reporting, four graduate students had already earned a master's degree, while the rest of them earned a bachelor's degree and were pursuing their advanced degree in their respective field.

In addition, 10 alumni/community stakeholders inclusive of social workers (n=2), psychologists (n=1), public health officials, (n=1) lawyers (n=2), nurses (n=3), and teachers (n=1) participated in the study. They were, on average, 49 years of age (SD=13.42), and most of them identified as female (n=14), while three self-identified as male. Three of the alums/stakeholders self-identified as African American and 10 reported being Caucasian. Most of them solely earned a bachelor's degree (n=7), five earned a master's degree; two earned an associate's degree, one obtained a doctoral degree, and one acquired both a Juris Doctor and MSW degree. On average, they had been working with children and families for over 20 years (SD=13.13). Data on race, gender, age, and education were missing for three students and three stakeholders/alums, despite multiple efforts to collect this information from them.

Data collection

Focus groups convened either at a campus location or at their place of business and lasted between one and two hours long. One of the graduate student research assistants attended the focus groups to assist with preparation, help with the consent process, and take observational notes. Prior to collecting data, a consent form approved by the Institutional Review Board was distributed to and signed by each participant.

Data analysis

At the conclusion of the focus groups, the digital recordings were transcribed by a professional transcriptionist. Afterward, research assistants checked the transcripts for accuracy by comparing them to the corresponding recordings. Following the procedures outlined by Strauss and Corbin (1990), themes were generated by relying on content analysis. The first step involved open coding, at which time efforts are devoted to identifying and labeling phenomena line by line, culling out ideas, actions, or behaviors that first come to mind. During the second step of "focused coding," the most significant or frequent codes are identified. Finally, during axial coding, each code is then categorized into groups representing similar ideas or concurrent patterns to "reassemble" the data. Methods to increase rigor involved engaging in reflexivity (e.g., memoing and maintaining records of personal biases or reactions to participants' experiences), and by reaching consensus among members of the research team regarding the selection of codes, themes, and quotes to support them. Special attention was devoted to identifying common and unique categories between each of the focus-group meetings with students and community stakeholders/alums. Negative cases (categories unique to a focus group) were also noted when/if applicable.

Results

Our results illuminate three major themes: (a) the value of IPE, (b) the barriers to implementing IPE, and (c) the importance of implementing effective interprofessional pedagogical tools and methods. Categories, main points, and key quotes for each of these themes are summarized in Table 1.

All the participants, irrespective of role or professional identity, conveyed how valuable interprofessional education would be (Theme 1) for several reasons. First, they believe IPE would equip them with the capacity to identify and define the mission, priorities, responsibilities, and tasks of other

disciplines; and, by doing so, gain a clear understanding of what interprofessional education entails. Second, they underscored that IPE would help them acquire knowledge and skills to implement trauma-informed care that is culturally driven and holistically addresses the needs of clients and organizations across child-serving systems of care. In an IPE curriculum, this would involve learning how to communicate and ask questions of professionals across disciplines to gather pertinent knowledge or information about the client or patient's target population trauma history, strengths, and lived experiences. Last, they valued the idea of participating in opportunities to network with and learn from students, faculty, and stakeholders from different disciplines.

The second theme, barriers to implementing IPE, included three categories. The first category, concrete implementation barriers, included lack of support from systems and traditional modes of higher education, enduring silos in child-serving systems of care, and varying state and local regulations across disciplines—all of which participants underscored are not conducive to implementing IPE. The second category delved into subjective implementation barriers that only students highlighted: (a) the hierarchy of professions and professionals, with social work students reporting that they are not as highly regarded or respected as their peers in other disciplines, such as medicine and law; and (b) fear that clients may feel unsafe to disclose confidential information to numerus professionals, representing different disciplines. Engagement with client/patient strategies may differ across disciplines, thereby creating disagreements about how to address or treat presenting issues of concern. The third category identified circumstances in which knowledge is not always used in practice settings.

Finally, theme three focused on effective interprofessional pedagogical tools and methods. The discussions were primarily centered around perspectives of online or hybrid learning formats, noting that a hybrid framework may address IPE implementation barriers. While some participants agreed that online learning might be beneficial in some circumstances, in-person collaborative pedagogical approaches are desired by all. They expressed a need for educators to rely on mixed methods (refer to Table 1) to simulate "real-life" exposure to interprofessional practice in the classroom, and to incorporate experiential interprofessional learning and community engagement. All participants agreed that students learn best when they have opportunities to practice or engage in the work they will implement after graduation. Community stakeholders noted that students need to gain and refine reflective practice skills, and students expressed a need for academic institutions to organize and institutionalize interprofessional student cohorts. Students agreed that they would learn best by training alongside other students enrolled in other disciplines—that, in fact, this represented their preferred and most successful learning experiences, regardless of discipline.

Discussion

The current study sought to elicit the perspectives of students, alumni, community stakeholders, and faculty representatives from different disciplines to inform the development of an IPE template. Above all else, participants value and desire to (a) learn how other disciplines advocate for youth and families, (b) gain practical skills to engage and communicate with providers across child-serving systems, and (c) deepen their capacity to use these skills to gain a more holistic understanding of clients and patients' psychosocial history (theme 1). However, our study identified many of the same IPE barriers noted by others, such as Barnsteiner et al. (2007) and Rubin et al. (2018) that may hinder their ability to achieve these goals (theme 2). For example, graduate professional education is freighted with required course and fieldwork necessary to meet licensure or accreditation standards. Despite IPE's recognized importance to students and its potential to strengthen professional partnerships in ways that enhance role satisfaction, it is difficult to implement for many of the reasons outlined in Table 1, including lack of support and capacity within agencies to engage in IPE, siloed approaches, and policies (e.g., the Health Insurance Portability and Accountability Act and other policies to protect

Table 1. Interprofessional child advocacy: Themes, categories, and quotes.

Theme	Category	Main Points	Quotes
Value of interprofessional education and practice	Opportunities to gain a clear understanding of what interprofessional education entails.	Defined by exchanges or collaboration with professional service providers from different disciplines.	*Student*: When I see interprofessional educational practice, I think of people from different professions who are not necessarily students but could be students sharing their work on one project, maybe multiple projects, but there needs to be operational overlapping on this project, so there's the interprofessional aspect of it. If I have to be simple in my definition, it's like exchange between different professionals with a purpose, a goal in mind, hopefully a project goal or something.
			Medical student: I think it gives you the vocabulary to be able to confidently interact with other professions, because I think there's so many words we use in medicine that no one else understands at all. . . . [T]here's also complete vocabularies of other fields that we just don't know or aren't taught, so having that interdisciplinary education helps you to learn that vocabulary to be more confident in those interactions.
			Medical Student: I think there was so much frustration amongst the hospital and the Child Protective Service system. . . . [T]here was so much time wasted on everyone saying what each other should have been doing, all this back and forth. It took so much sorting out to explain roles. I think the hospital just assumed the DHS could just sign for things and DHS just assumed that hospital can just emergently do procedures, so there's all this miscommunication; and meanwhile, there's a child waiting and getting nothing done. . . . [I]t took the next day of me networking and knowing people to say, "I know who to call," and that's the way it got sorted out, simply because I knew someone and they helped me.
			Community stakeholder: With all the demands of child welfare and social services they sort of get laser-focused on two or three things and then forget to think about wait a minute, we might need to leverage this or that, and that's why you have supervisors and support at work, but to get that practice now [from this certificate] could be really, really helpful.
	Opportunities to garner the skills, information, and knowledge to address client need and the needs of organizations serving youth.	Underscores the salience of teaching students to learn how to collaborate and gather pertinent knowledge or information about client or patient target population.	*Community stakeholder*: If they had an educational component to what they have learned, their value would be through the roof because they understand schools, they understand urban education, they understand what the challenges are in urban education, so then you're coming with this wealth of knowledge perfect for a school setting. Because doing social work in a school has its challenges and it looks different than doing social work at the hospital. They look different, they are different. So talk about value added—it's huge!
			Medical student: I've been struck over the years, especially when I was working with child welfare, how every single day investigators are asked to make decisions about accident, medical diagnosis, abuse, without input from people who have knowledge about child development and injury mechanisms and epidemiology of trauma of children, and so I think one of the things that is important for anybody working in this field, we're not going to teach them all the medicine that anybody would need to know, right, everybody has their role, but I think having everyone understand the importance of getting the correct information from professionals who can give them the best answers possible is incredibly helpful. I always wonder how anyone can just try to make these decisions. You might as well flip a coin sometimes with the decision making.
			Medical student: I think in addition to sort of the child abuse aspect, I think it's important when we think about our foster care population, the common medical problems that children encounter. For a child who has asthma, they need to have their medication. For instances for DHS who's going into the home and even for school providers and things like that, some basic knowledge about general medical conditions would be important. I feel like that gets lost a lot, at least in what we're seeing.
			Student: One of the first cases of seeing the impact of systemic barriers trickle down to impact a child was when I met a first grader who was being disruptive in the classroom and she was urinating under her desk, and she was having extreme reaction to the trauma, and she was in the foster care system. She was six years old, but she had already been in nine different homes, and the teacher had no idea about any of her history, so she was disciplining the child in an authoritative kind of way—sort of how she was trained to discipline a child who was disrupting the classroom, but really, she was doing more harm than good even though her intentions were good. I was an undergrad at the time, and that was mind-blowing to me to see the lack of communication across all of these different major players that are working with a child.
			Student: I think if you have families who went through poverty, trauma, violence, that is complex and you need a lot of skills to be able to effectively work with these families and help them heal. When you add the child welfare system to the mix or the juvenile justice system, it makes it much, much more challenging. . . And that's why I like this idea [of this certificate] because I'm optimistic and I think there's a lot of great people in all the systems. . . . [I]t's just a matter of helping them how to work together.

(*Continued*)

Table 1. (Continued).

Theme	Category	Main Points	Quotes
Barriers to implementing interprofessional education and practice	Concrete implementation barriers	Graduate training and child-serving systems of care are not conducive to implementing interprofessional practice (alums, students, and community stakeholders).	(2) **Lack of support**: *Community stakeholder*: At the community mental health organization, our school-based teams partner heavily with the school superintendent, the commissioner, and the deputy commission. There has been a lot of efforts for integration. I remember back in Kensington I used to do a lot of presentations for teachers about exactly what I just mentioned—and I think my experience is not that they didn't have the willingness to understand or learn this information, for some of them it was very obvious and they already knew it. It's just that so many of the public schools mostly were overwhelmed, understaffed, and overworked that they saw it as yet something else that someone is requiring them to do and they don't have the resources. I can't focus on this one kid who needs to do deep breathing in order for him or her not to fall apart because I need to focus on the other 29 students in my classroom. At a system level I think there's a lot of things that need to change. We may have two or three teachers who follow up telling you, "I used the strategy you told me and it worked, the kid was able to calm himself down." But you're right, we need more systemic system change. *Alum*: I came in wanting to do a minor and was told basically that it's impossible. I'd have to stay longer but you can't really do that if you want to practice, you need to just finish and take your boards, and it's impossible to fit it into the curriculum that you already have. *Alum*: I actually did do a minor, but I started my program kind of with my minor. I did the transformative nursing education program because I wanted to do nurse education. And some of the people that were in that course with me already worked at the hospital so they had a stipend to be able to take the course. I don't think it covered all of it but that was just something that financially was easier for them. For me, I was just like oh crap, I just pictured $15,000 in my debt, but to me it was worth it. (3) **Siloed approaches endure in child-serving systems of care** *Community stakeholder*: I think there's been a lot of efforts in trying to integrate care but yeah, somebody mentioned people need to learn to leave their egos behind before doing this work. . . . I can see that siloed approach as being a big barrier to integration. (4) **Varying state and local polices across disciplines** *Student*: There are so many different local and state policies around child welfare and around education and schools from the school level, throughout the state level, and I think that makes it really challenging, at least at a large-scale level to make all of these different intricacies work together in tandem. I think this certificate is such a great start to getting the different players to talk and working together, but that's one of the challenges I had to wrap my head around was how do we make this work within all the different political and systemic barriers. *Medical student*: The limitations of what we can and cannot say is a barrier [due to HIPPA and patient confidentiality]. For example, child protective services kept asking us if the alleged report was an accident or abuse. We kept saying, we can't say, but we can give you some information, and then you can go get more information and maybe we can come together.
	Subjective implementation barriers (students only)	Students highlighted subjective barriers, including hierarchy of professions, decreased "safe" spaces for clients as their information is shared between more professionals, and professionals across disciplines tend to rely on different strategies to engage clients.	(5) **Hierarchy of professions and professionals** *Student*: I think placing social workers at a more equal level with other professionals should be a priority because a lot of times social workers are underestimated and underappreciated and especially in the medical field, you value a doctor's opinion more than a social worker even if the social worker sees someone on a daily basis or a weekly basis. There should be an emphasis on collaborating and learning about what are the strengths of the professions and what each of them has to offer and how they should be viewed more equally. (6) **Decreased "safe" spaces for clients** *Student*: I think the flipside is just the number of people who are involved. We take care of such sensitive stuff. I know we've had cases where the room seems packed because we have so many learners in there, and we have social workers and this student and that student and this student, and we're asking these highly sensitive questions about domestic violence and substance abuse and it becomes very—I don't think that's a safe space for the patient's family. I don't think we are creating a safe space for them to feel they can share their deep, dark secrets. (7) **Engagement strategies may differ across disciplines** *Student*: I also think in terms of how much time I might be spending with my clients, which is usually about weekly for an hour, hour and a half, for the little ones maybe half an hour but it's weekly, and so in my experience working with medical professionals that see somebody maybe once a month for 15 minutes isn't exactly my idea of . . . getting a sense of who the client is and their environment. *Student*: We get so many different types of clients that the approach for each of them is different, so when I work with my child clients, I feel like I approach it more from my teaching experience, but then with a business client I might worry more about coming off as intellectual and I'll just do a lot of research in advance of meeting with that client.

(*Continued*)

Table 1. (Continued).

Theme	Category	Main Points	Quotes
	Lack of opportunities to translate knowledge in practice settings	Leaders are not disseminating and implementing knowledge in ways that promote interprofessional practice.	*Medical student*: Child Advocacy Centers have been around for years. They are multidisciplinary, they are interprofessional, and they are very dysfunctional, and they don't heed to the expertise of one another on a team. We see that locally. We see that nationally. I would think that perhaps even looking at that model, figuring out why that has been such a problem might inform this effort moving forward, because what I think is out of the equation or not included in the equation for a certificate, you can give the knowledge, but then how do you implement that knowledge if you don't have leadership opening those doors? So there's got to be something like that at least at the local level, and I think we could potentially influence it at the local level to make this have half a chance of successful implementation. *Student*: Related to that is just how one makes a diagnosis. What is a diagnosis? How does a physician or healthcare professional go through the process of a differential diagnosis, what is our leading diagnosis when we refer to those terms, it's within to use the court standard: within a reasonable degree of medical certainly, that's not what we're applying here, and yet, eventually we do. You're required to engage in that system, but in terms of the health sector and the way in which we think, it's going to be different and that's a hard one for colleagues to understand.
Interprofessional pedagogical tools and methods	Perspectives about online leaning format	Agree that online learning might be help in some circumstances. In-person collaborative approaches are desired.	*Students*: *Student #1*: I did a wellness course that was all online, and I feel like it could be helpful, it was easy to do, but I don't think I got as much out of it as I could have in person, because it became sort of a task that I needed to complete rather than something that I really engaged with. *Student #2*: I feel like if the goal is to work with different professions than doing it online would take that away. *Student #3*: If you wanted to have everyone have a baseline background set of knowledge that's kind of a good place to start. The thing I would say is there has to be some measure of whether or not you've absorbed any of it, because otherwise, it's just how fast your index finger works. *Student #4*: I think for a certificate like this you definitely have to have real life practice. I think part of the program can be online, because it's certainly convenient, low cost, and very accessible to students, but at the same time, it should be combined with other real classroom interactions and also online/offline collaboration—also practice-based. *Alum*: We're all interested in this because of unique opportunities to discuss these issues with other students from other disciplines as opposed to online modules where you're still in your silo.

(*Continued*)

Table 1. (Continued).

Theme	Category	Main Points	Quotes
	Simulate "real-life" exposure to interprofessional practice in the classroom	Mixed methodological approaches are preferred (e.g., case studies, breakout sessions, and in some limited cases, online learning).	*Students* (8) **Recognize that not all students prefer or benefit from similar teaching methods.** *Student*: For me, I'm a good listener, but I'm very much a visual learner, so I need something, whether it's a piece of paper, PowerPoint or something that I can look at that I can remember and that's how I learn best, but somebody else learns best by listening, so I think having different options is needed. (9) **Introduce case studies and require students from each discipline to approach the case from its perspective.** *Student*: I think keeping things case-based in multiple cases gives you the opportunity as an interprofessional group to look at all of the different ways that things can kind of go sideways or whatever different nuances, "Oh, this case normally we do this, but here in these kind of cases we do that and this is why." It kind of helps the group see how this thing functions in real time. (1) Convene during nonconventional times: weekends, week-long intensive workshops to address conflicting schedules. (2) Gain interprofessional feedback—whether it's research, or an advocacy project and presenting cases and findings to a group to gather that interprofessional feedback would be helpful and would help cultivate collaborations. (3) Attend other disciplinary professional development conferences and symposiums. (4) Invite professionals to discuss career trajectory. (5) Invite adults who were formerly involved in child-serving systems to discuss what they wish was different, what they (service and care providers) did, and what we should be doing for our current clients. (6) Gain knowledge of philosophical approaches or research paradigms from other disciplines. (7) Discuss what's going on in your placement and problem solve with students across disciplines. (8) Gaining training in how to develop goals to achieve intended outcomes and implement them as a group. (9) Gain increased knowledge and understanding of organizational dynamics. (10) Focus on integration of micro (direct service work) and macro (policy) integration. *Community stakeholders* (1) Learn from instructors who are skilled in facilitating and moderating content inclusive of different disciplines—involves sharing experiences. (2) Encourage teachers and other students to share their experiences about their career, acknowledging that students tend to learn from other people's experiences. (3) Learn how to ask questions of families to elicit their experiences. (4) Gain skills in how to dialog with intra- and interorganizational colleagues. (5) Gain skills in writing grants. (6) Integrate a trauma-informed lens across all disciplines, underscoring "that abnormal behavior is normal in an abnormal situation." *Community stakeholder*: "I think the basic thing that people don't understand about children is that abnormal behavior is normal in an abnormal situation, and I think that's the core of child welfare. But when I go to team meetings and I go, "Well, look at age 12 she was sexually abused, what do you expect? And here she is acting out, running away. Well did she ever get any kind of counseling? Did anyone work with her?" And people are like, "Oh, but her behavior is bad."

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Table 1. (Continued).

Theme	Category	Main Points	Quotes
	Experiential interprofessional learning and community engagement	All agree that students learn best when they have opportunities to practice or engage in the work they will implement after graduation.	*Medical student*: I entered child advocacy with my own preconceived biases and notions about what children who are abused looked like and where they came from and what their families were like—based on *Law and Order*, which was the only place that I saw child abuse growing up was what did I see on TV. So I think having some experiential exposures to clarify what is the reality of child advocacy and what is the reality of child maltreatment as a very foundational experience, I think is important across all fields. *Medical student*: I think the best learning comes from experiential learning and stepping outside of the classroom. For a decade, a law professor and a social worker and I led an interdisciplinary course in child welfare and advocacy, where law students were assigned to actually represent children in family court, independency court, and they worked with the medical students, and the master's-level social policy students to represent children, so they would make home visits, and the law students were very inexperienced in talking to their clients. . . . [S]o they kind of learned from each other going out into the community and actually kind of learning by doing together and then coming back. So, to me, I always think that anybody learns best by doing. . . . [Y]ou kind of can learn your foundations, but it's not until you go out and you can do things that you really I think kind of gain the best knowledge. *Alum*: Federal policy is large and slow moving but sometimes working on a "locally" based issue or state-based project and working toward actual policy change in education or healthcare or the intersection of the two could be really cool from an interdisciplinary standpoint. . . . So having some kind of practical project with an actual organization. *Community stakeholder*: When I was in law school I interned at the Defender's Association—I think that the experience was helpful for me in the sense that I got a chance to not only sit aside attorneys who were in the courtroom daily but also actually doing the work. And I think that that's important not just to observe it but also get a hand in the pot and say prepare this or write the opening statement or I want you to actually be involved with the actual process and not just sitting and taking notes. . . . I got a chance to actually argue before a judge and actually do the work that I eventually was able to do. *Student*: It's hard sometimes in clinical practice to know when to make a call to somebody else. . . . I might use them at Field but they're not really being taught at school and we're not really talking about that so much as much as we're talking—Most of the simulations are just focused on one-on-one, so to have different kinds of simulations that have different players or different roles would be helpful.
	Gain and refine reflective practice skills (community stakeholders only)	Learn how to engage in reflexive practice to prevent judgment and biases and promote cultural humility.	*Community stakeholder*: I think that's a new development of self-awareness that's also being able to develop your ability to be forgiving and appreciating those things and people who don't quite work well and how are we gonna move it forward as opposed to coming from a judging place and a controlling place or a criticizing place. *Community stakeholder*: And someone who is culturally competent, I think I couldn't emphasize that enough, which means, again, knowing which are your limitations and knowing that you won't be able to know every single culture out there, the ins and out, but being open and mindful of differences and diversity and allowing that diversity within your organization.
	Organize and institutionalize interprofessional student cohorts (students only)	Students agree that they would learn best by training alongside other students enrolled in other disciplines.	*Student*: We talk a lot about intentionally creating groups of students, like if we know a student has a strength here and another has a strength there and you kind of make them responsible for each other. . . . I'm wondering within this program maybe there has to be a lot of intentionality of the numbers of students from each discipline you're letting in, so that way you can build these teams where you do have somebody that's from law school, from social work, from nursing, and all the other programs. *Student*: I really like the cohort idea, and I think even if you're somebody who doesn't really love group work, I think just having those contacts and those relationships will just make everybody's job ultimately easier once they enter those professional roles, and even just having somebody you can text and be like, "[H]ey—I'm having this issue with my students, can you maybe come in to give a seminar on some sort of health-related from a nursing student?" I think just the networking aspect of it, I guess, too, through having a cohort could be really powerful.

DHS = Department of Human Services; HIPPA = Health Insurance Portability and Accountability Act

patient confidentiality) that prohibit information sharing and interprofessional communication Creating spaces for IPE students to shadow workers at agencies that value and adhere to IPE training would help students shift away from traditional siloes.

Subjective barriers perpetuate division between professions. Social work students underscored that a hierarchy of distinction exists between professions, where they believe that their expertise and voice are not as valued as their peers from other disciplines, such a law and medicine. Enriching students' understanding of the valuable role all providers fulfill would likely challenge these hierarchical assumptions (Meleis, 2016; Rubin et al., 2018). While professionals across disciplines may rely on different practices and policies to engage clients and promote child well-being, learning what are those practices and policies and how they may benefit clients and patients is an imperative component of IPE training (Christian et al., 2020; Whiteley et al., 2014).

Table 1 also outlines the tools or methods of pedagogy (theme 3) that the participants believe should be included in the design and implementation of an IPE curriculum—and, in turn, would mitigate many of the barriers they discussed. We relied on these recommendations to propose a preliminary IPE template.

Revisioning training in child and family well-being: A preliminary IPE template

Our research adds to the sparse literature regarding IPE certificate programs described by other researchers in child welfare–related disciplines, such as nursing, education, and social work. In one of the few available published peer-reviewed descriptions of child welfare–related IPE, Whiteley et al. (2014) found results similar to ours. In that study, workshops targeted to undergraduate students in the above fields identified the importance of a number of student-identified IPE variables, such as teamwork, communication, and self-reflection (Whiteley et al., 2014).

In addition to adding to the limited research available on this topic, our study affirms the importance of IPE to current and former students, as well as community stakeholders. As such, based on the findings from this study, and after mapping a potential curriculum across the graduate programs in education, social work, nursing, medicine, law, and psychology, we propose an IPE template, highlighting what components to include in a certificate in child advocacy. Our certificate, grounded in a social justice framework, addresses the themes identified in the literature as well as those identified by our focus groups. The program adheres to participants' preferences for offering a hybrid online/in-person pedagogical approach for part of the program. Furthermore, the program incorporates a multitude of opportunities for interprofessional cohorts of students to learn and to practice together as part of the certificate's requirements.

A first course, Foundations of Child and Family Advocacy, will offer the general level of educational and professional exposure to the issues and topics in child welfare and child advocacy essential for all learners interested in the advanced certificate. Designed to address a major barrier identified in the literature as well as our focus groups—scheduling challenges—the course will include synchronous and asynchronous components. Specific content relevant to child and family well-being, such as trauma-informed care and the science of adverse childhood experiences, will be detailed to ground all students with a common vocabulary and background knowledge.

The foundational course will provide insights on how each profession defines child well-being and how their mission, philosophies, ethics, and ideological approaches, while varied, aim to achieve similar outcomes. Students will be challenged to articulate and embrace an interprofessional identity through debate and dialog with multidisciplinary faculty, including how to navigate and overcome disciplinary hierarchies through teambuilding. By opening the asynchronous section to students, practitioners, and citizens beyond those enrolled in the university-based certificate, we aim to broaden the discussion of IPE beyond that of one university or set of constituents.

Those graduate students enrolled in the certificate will gain more in-depth knowledge of fundamental content areas and core competencies by enrolling in a preapproved child-focused elective course that fulfills a competency area not previously explored through other coursework. (Please refer to Christian et al. (2020) for a more comprehensive review of child and family advocate core competencies.) Participants, particularly community stakeholders, underscored the need for graduates to be prepared to engage in trauma-informed practice, and embrace cultural humility and reflexivity; this is an example of a core competency area supported by an approved elective. The courses herein would provide foundational knowledge and awareness of these particular practice constructs.

The final requirement is an interprofessional experiential internship. A group of three to five students from different disciplines (e.g., social work, education, law, medicine) will receive ongoing mentorship and guidance from leaders/field instructors within a partnering child-serving organization or agency that engages in interprofessional practice. In this setting, the students would have opportunities to hone their discipline-specific skills within a structure supporting interprofessional collaboration and practice. As recommended by students and community stakeholders in this study, as well as other researchers, they would learn alongside each other as they each share knowledge about the mission, vision, principles, and ethics of their own respective profession in an integrated practice environment (Carlisle et al., 2004). Supervision will help students be able to articulate the utility and application of both discipline-specific and integrated cross-disciplinary knowledge, skills, and dispositions.

The internship will also include an experiential seminar component through which students will process cases they are assigned to in the field. To that end, scholars from the aforementioned disciplines would partner in the classroom to model the principles of interprofessional practice and ensure students learn to engage in debate, compromise, and consensus. Participants in our study groups expressed the need to observe how IPE is implemented, and this is yet another opportunity for that kind of observation to merge the theory aspects of their learning in child and family advocacy with practice. As part of the seminar, students will complete a capstone project that would involve reviewing prior literature and collecting primary data to address gaps related to an issue of concern for a specific or targeted segment of the child and youth population. Relying on their results, they would be asked to develop recommendations for improving interprofessional practice and systems-level policies. The capstone project builds on the courses and internship requirements, providing students with an opportunity to reflect on a particularly vexing issue in child and family advocacy in greater depth and with an explicit interdisciplinary focus.

Limitations

Our findings, used to develop the IPE template, should be considered preliminary, given the limitations of the study. First, this qualitative research study is small, and represents a nondiverse gender, racial, and ethnic sample. All the students, for example, were female, and all but one of them identified as Caucasian. More efforts must be devoted to eliciting the thoughts, experiences, and preferences about IPE from diverse samples, particularly students from different disciplines, racial/ethnic and socioeconomic backgrounds, and schools. With more data, the template should be modified to reflect their needs and preferences, while at the same time providing higher educational contexts a working and evolving template to (a) challenge existing "ways of knowing and learning," and (b) reframe or revision how to train interprofessional child advocates to play a critical role in promoting social, racial, and economic justice. A major strength, however, is that providers and advocates from multiple disciplines (nursing, social work, education, medicine, and law) as well as community stakeholders informed and eventually approved the final version of the IPE template.

Future directions for research and educational practices

While much more IPE-related research is needed, more evidence will be required to institutionalize and sustain IPE. First, clinicians, researchers, and stakeholders need to continue to advocate for mandates on the part of accrediting and licensing bodies as well as reliable funding streams for their support. Models of faculty workload compensation need interrogation to promote faculty engagement and interest in IPE.

Second, researchers need to continue to investigate new programmatic IPE designs and implementation strategies. Our data suggest, however, that differences in disciplinary values might generate tension in an interprofessional context and prevent educators from achieving this goal. For example, social workers are obligated, as per the National Association of Social Workers (2018) *Code of Ethics*, to address sociocultural barriers, such as oppression, poverty, racism, sexism, and heterosexism, that affect practice access and efficacy (Rubin et al., 2018). To what extent do other professions value and adhere to these social justice principles in practice? Even if they all value these principles, their articulation in practice may complicate social workers' ability to adhere to them in the way the social work profession believes is most ethical. To this day, it is an open question as to whether those tensions might be reduced by IPE training, the goal of which is to educate participants about differences across disciplines in values and to train participants to work collaboratively even when values differ.

Additionally, questions about how and to what extent university intradisciplinary collaboration (or lack thereof) affects IPE are left unaddressed. From an empirical standpoint, what happens if different departments/professions are constantly competing for favored status within universities? Pragmatically, how can we begin to shift the paradigm from an individualistic or competitive structure to a more collective and collaborative academic environment that squarely aligns with how interprofessional training and practice should be implemented?

Finally, building on recommendations proffered by the Institute of Medicine (2016), more research to connect IPE interventions with long-term changes in practice and outcomes needs to be generated. Large-scale, controlled studies to minimize confounding variables using objective outcome measures chosen prior to interventions need to be undertaken. This multifaceted research needs to build on sound theoretical underpinnings, collect pre- and postintervention data at multiple times over the course of years, and observe and measure in-practice team behaviors. The National Center for Interprofessional Education and Practice has formed a national innovation network to analyze collaborative work across and within healthcare practices (https://nexusipe.org), providing a potential structure and roadmap for future interprofessional efforts that may finally be sustained.

Conclusion

While there is no one right way to undertake inclusive and collaborative IPE, the strategies arising from this research draw on the experiences of students, alumni practitioners, faculty, and community stakeholders at one private university (Barnsteiner et al., 2007). The authors do not assume that the proposed program will overcome all the challenges that have hampered past efforts to establish interdisciplinary practice. Given the potential benefits of IPE to children, families, students, and practitioners, however, we should push to disrupt the standard approach to graduate education and practice in our respective fields. As such, this initiative represents a concerted, ambitious, and concrete attempt to implement IPE in the training of students across a number of child-serving disciplines.

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Appendix: Focus-Group Guides

Graduate Students
Interprofessional Education

(1) How would you define interprofessional education or interprofessional practice across disciplines?
(2) What kind of experiences do you have with interprofessional education or working with an interprofessional team?
(3) What are your thoughts or feelings about the benefits and challenges of interprofessional education?
(4) To what extent do you think a certificate like this would address barriers toward collaboration across disciplines?
(5) What knowledge do others need to know about the field that you're in?
(6) What does or does not interest you in an interprofessional certificate in child welfare?

Learning Formats

(1) What are the formats of learning that you most enjoy and why?
(2) What are the formats of learning that you think are the most effective and why?
(3) Do you think an online learning component for a child advocacy certificate could be effective? Why or why not?
(4) If you believe online education to be effective, in what context? If you don't believe it to be effective, why not?

Value/Impact

(1) What do you think is the value of this proposed certificate?
(2) What kind of impact do you think the proposed certificate would have on your future work, after you graduate from your program?
(3) Would you be more inclined to enroll in a graduate program that had a certificate program for interprofessional child advocacy?
(4) What kind of skills would you like to gain from the proposed certificate for your future career?

Training

(1) What kinds of experiential/field/clinical experiences have you had?
(2) What kind of training have you had thus far that you think will be useful after you graduate?
(3) What kind of training do you think you need for your work after you graduate?

Conclusion

(1) Do you have anything else to add?

Community Stakeholders and Alumni
Interprofessional Education

(1) How would you define interprofessional education or interprofessional practice across disciplines?
(2) What kind of experiences do you have with interprofessional education or working with an interprofessional team?
(3) What are your thoughts or feelings about the benefits and challenges of interprofessional education?
(4) To what extent do you think a certificate like this would address barriers toward collaboration across disciplines?
(5) What knowledge do others need to know about the field that you're in?
(6) What are your thoughts on hiring employees with a certificate in child welfare and advocacy?

Learning Formats

(1) What are the formats of learning that you have enjoyed the most now and in your past?
(2) What are the formats of teaching and learning that you think are the most effective and why?
(3) Do you think an online learning component for a child advocacy certificate could be effective? Why or why not?
(4) If you believe online education to be effective, in what context? If you don't believe it to be effective, why not?

Value/Impact

(1) What do you think is the value of this proposed certificate?
(2) What kind of impact do you think the proposed certificate would have on the future work or job prospects of those who pursue it?
(3) How do you think the proposed certificate could improve clinical practice?

(4) What kind of skills would you like students to gain from the proposed certificate for their future careers?

Training

(1) What kinds of experiential/clinical/field experience have you had?
(2) What kind of training did you have in school that was useful once you entered the workforce in your field?
(3) Now that you are working, what kind of training do you wish you had had while in school?
(4) What kinds of expertise would you like to see in future practitioners?
(5) What other kinds of professionals would it be useful for you to collaborate with?

Conclusion

(1) Do you have anything else to add?