## Using Focus Groups to Design an Interagency Training Program for Child Welfare Workers



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| **Journal:** | Professional Development:<br>The International Journal of Continuing Social Work Education |
| **Article Title:** | *Using Focus Groups to Design an Interagency Training Program for Child Welfare Workers* |
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| **Volume and Issue Number:** | *Vol. 3 No. 3* |
| **Manuscript ID:** | *33018* |
| **Page Number:** | *18* |
| **Year:** | *2000* |

Professional Development: The International Journal of Continuing Social Work Education is a refereed journal concerned with publishing scholarly and relevant articles on continuing education, professional development, and training in the field of social welfare. The aims of the journal are to advance the science of professional development and continuing social work education, to foster understanding among educators, practitioners, and researchers, and to promote discussion that represents a broad spectrum of interests in the field. The opinions expressed in this journal are solely those of the contributors and do not necessarily reflect the policy positions of The University of Texas at Austin's School of Social Work or its Center for Social Work Research.

Professional Development: The International Journal of Continuing Social Work Education is published three times a year (Spring, Summer, and Winter) by the Center for Social Work Research at 1 University Station, D3500 Austin, TX 78712. Journal subscriptions are $110. Our website at www.profdevjournal.org contains additional information regarding submission of publications and subscriptions.

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ISSN: 1097-4911

**URL: www.profdevjournal.org** **Email: www.profdevjournal.org/contact**

# Using Focus Groups to Design an Interagency Training Program for Child Welfare Workers

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Interagency practice has been common in social work for decades. More recently, a new emphasis on collaboration has taken interagency practice in new directions. This paper reports the efforts of one university-based training project, which offered a five-day series on interagency collaboration for public child welfare workers and staff in the fields of substance abuse, mental health, and domestic violence, and summarizes lessons learned and suggestions for continued work in this area. The project, funded by a grant from the U.S. Department of Health and Human Services, was conducted six times during a two-year period. After a review of key themes in the literature on collaborative practice, we will summarize the project's objectives and methods. Specific attention will then be given to the focus group process, which was used to inform program curriculum and design, as well as the results of the groups. We will describe how the focus group results were used in the design and implementation of the program and will briefly review program outcomes. Finally, lessons learned and implications for similar continuing education programs will be presented.

## The Need for and Benefits of Collaborative Practice

The need for interagency training is greater today than ever before. The mandate for concurrent case planning, as well as the fact that children needing child protection increasingly come from families with multiple needs and problems, are two trends that bring this need into focus. This complexity has demanded more comprehensive assessments and service planning on the part of professionals working with children and families than ever before (Tracy & Pine, 2000).

A new approach to service delivery has emerged in the past decade that favors a partnership model in which public child welfare sheds sole responsibility for child protection and shares that responsibility with a wide variety of community partners to provide a more differentiated response to children who are at risk of being maltreated. This differentiated response enables social workers to have access to the services that can respond to the wide range of problems found in Child Protective Services (CPS). Case managers are often faced with difficult decisions regarding removal of children and provision of services because of the uncertainties of prognosis. For example, a CPS case may involve substance abuse, mental health, and/or domestic violence (DV) issues, resulting in confusion about the appropriate ordering of services. Thus, in addition to mastering the knowledge, skills, and attitudes unique to social work, the social worker must also possess knowledge about, and respect for, what other professions have to offer as partners in service delivery and be skilled in interagency communication and collaboration.

In social work, interagency collaboration has been a fundamental, albeit not always cherished, component of practice. Despite the importance of collaboration, social work educators have offered minimal training in the development and maintenance of effective collaboration in education and practice (Andrews, 1990). Although social work traditionally has been the primary profession in public child welfare, the prevalence of domestic violence, substance abuse, and mental health problems in the typical caseload requires effective collaboration with others within and across service agencies. Many communities, counties, and states are moving toward collaborative models of service coordination, which cannot be developed and implemented without parallel cooperation among the disciplines or service providers involved (Baglow, 1990; Chadwick, 1996; Knitzer & Yelton, 1990).

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*This project was funded by a grant from the U.S. Department of Health and Human Services, Administration for Children, Youth, and Families.*

Some of the identified benefits of a collaboration approach include:

- more accurate and comprehensive assessments, especially of complex cases, allowing multiple problems to be addressed;
- more creative and effective interventions;
- less fragmentation and duplication of services;
- a more "user-friendly" system of integrated services for families;
- fewer cases being overlooked;
- reduced traumatization of children;
- less contamination of the evidence gathered;
- less role confusion;
- enhanced interprofessional communication;
- greater advocacy and emotional support for clients;
- improved ability to influence public policy;
- enhanced ability to overcome professional stereotypes;
- enhanced professional development and working environments; and
- a greater sense of accomplishment among the professionals involved

(Berg-Weger & Schneider, 1998; Marett, Gibbons, Memmott, Bott, & Duke, 1998).

Team approaches to child abuse assessment have been used successfully by both hospital-based teams and community-based interagency teams over the past ten years (Kaufman, Johnson, & McLeery, 1992; Scarnecchia, 1997). Collaboration has also been demonstrated to be a successful secondary intervention for high-risk parents in preventing child abuse (Schoor, 1989; Holden, Willis, & Corcoran, 1992). Interagency teams have demonstrated their utility in providing consultation to child welfare practitioners, who can draw from varied areas of expertise when needing to make assessments and treatment plans for high-risk families.

### Barriers to Collaboration

Despite the obvious benefits of collaboration, significant barriers to collaboration have been identified. For example, the relationship between advocates for victims of domestic violence and child protective service workers has historically been adversarial, even though both are committed to stopping the violence. Explanations for these tensions include high caseloads and differences in perspectives, approaches, terminologies, and mandates. It is also important to note that these agencies compete for scarce funding (Schechter & Edleson, 1994).

In the past, DV advocates usually adopted a domestic violence, victim-centered approach, charging that the child-centered approach of protective services results in social workers de-emphasizing the impact of domestic violence. DV advocates claimed CPS workers often placed the burden of protecting the children on the mother. They asserted that CPS workers "blame the victim" for being passive and not protecting her children, and that CPS workers should focus on protecting the mother because that will help ensure the safety of the children (Schechter & Edleson, 1994). Some critics of CPS workers have maintained that these workers often fail to identify domestic violence in their caseloads (McKay, 1997), perhaps because of inadequate training (Mills & Friend, 1997). Advocates also claimed that battered women are not offered supportive services and that their children are often removed by CPS workers. After the removal of the children, the victim is still left at the mercy of the perpetrator. The threat of removal of their children is cited as a reason why many women in abusive relationships do not report child abuse by their partners (Jones, 1993). However, little empirical data are available to describe CPS practice with domestic violence, so it is impossible to verify these charges.

Additionally, Child Welfare workers also have limited exposure to the areas of substance abuse identification, intervention, treatment, and recovery, and feel unprepared or inadequate in intervening with clients' substance abuse (Curtis & McCollough, 1993). Even those workers who have received some in-service training on substance abuse may be reluctant to implement this know-

ledge (Young, Gardner, & Dennis, 1998). Research suggests that this may be due to attitudes, such as negative views of treatment, or to fear of confrontation (Gregoire, 1994).

In the field of alcohol and other drug treatment, addictions counselors often have little knowledge about child abuse in particular and the Child Welfare system in general. Neither system is exactly sure what the other has to offer, and they tend to be wary of each other (Dore, Doris, & Wright, 1995). This wariness not only comes from lack of knowledge but from differing philosophies around areas such as who the client is (parent versus child), harm reduction versus the need for total abstinence, and timelines regarding treatment interventions (Young, Gardner, & Dennis, 1998). While CPS workers may have six to twelve months to reunify a family or place the child for adoption, addiction counselors believe that this amount of time in recovery for a parent is only the beginning of a difficult journey.

### The Benefits of Collaborative Training

The vast pool of topical and change-process knowledge needed by the various professionals involved in child welfare practice consists of segments unique to each discipline or field of practice. Some practice knowledge is borrowed from areas other than one's own, while some belongs to the common body of knowledge about family life and child rearing that everybody "owns." Lines separating these domains of knowledge are hard, if not impossible, to draw, causing uncertainty and sometimes conflict about what constitutes appropriate use of this conglomerate of knowledge.

Special care in use of borrowed knowledge is called for when selecting cases for multidisciplinary or interagency collaboration. In both forms of collaboration, the professionals involved agree upon shared case goals, yet in the former, they act independently — but parallel to — one another to arrive at these goals, while in the second approach, the professionals work collaboratively as an interagency team in order to arrive at shared case goals. Collaboration is distinct from other forms of collective actions (e.g., cooperation and coordination) that many people believe constitute collaboration. These choices and their collaborative implementation require more than acquired cross-agency knowledge; they require development of a collaborative attitude and skills in interagency communication and collaboration.

The positive act of interagency training on professional practice was documented in a 1985 study (Harbaugh, Casto, & Burges-Ellison, 1987), in which 196 students and professionals from eight disciplines identified training benefits as: (1) an easier transition from professional school to practice; (2) greater use of interagency treatment approaches; (3) more effective client care; and (4) greater use of referral sources. Other studies cite increased cooperation between agencies and greater participation in interprofessional activities as benefits of interprofessional education (Edelstein et al, 1990; Spencer, 1987). Kolbo and Strong (1997) reported the value of training team members in overcoming obstacles to successful implementation of treatment plans (1997, p. 70).

### Program Description

This paper reports on the results of five focus groups conducted with community groups/agencies to gain input on what should be taught about collaboration, domestic violence, mental heath, and substance abuse in a training program for CPS workers, mental health workers, domestic violence service providers, and community workers. The training curriculum consisted of five one-day (six hours each) modules taken as a single course.

Specifically, this training project had two primary objectives:

1. To develop a competency-based curriculum aimed at building knowledge, attitudes, and skills to strengthen the capacity of child welfare staff for collaboration with community-based agencies to provide services to at-risk

families to prevent child maltreatment and prevent the recurrence of such problems for children reunified with their families.

2. To provide training in domestic violence intervention, substance abuse, and mental health for Child Welfare practitioners and community-based providers, which facilitates interagency collaboration and practice.

The major need addressed by the program was to increase the ability of Child Welfare practitioners and community professionals to respond effectively to complex family problems of child abuse and neglect, resulting from substance abuse, mental illness, and domestic violence.

## Methodology

The principal investigators on this project used their own experiences and the relevant literatures to develop a broad outline of program content. They recognized, however, that any training on such a complex topic as this would need to be tailored to the specific needs of service providers in the target community. The focus group process was chosen as an efficient way to gather broad-based, yet specific, data on appropriate training content and delivery methods.

Focus groups emerged as a research method in the social sciences in the 1940s. They were initially most frequently used in the military and in the marketing profession, though recently they have been increasingly used in the human services as well (Krueger, 1994; Simon, 1999). For example, four schools of social work and Child Protective Services in Texas used focus groups to help develop a statewide CPS training institute (Urwin & Haynes, 1998).

Focus groups, typically comprising six to ten people who have some common characteristics (in this case, working in programs serving children and families) but do not necessarily know each other, are used to gather qualitative data on a specific subject. Multiple groups are usually done to avoid single groups which may not be representative for some reason (being too quiet or overly influenced by a dominant member). After the purpose of the groups is determined, questions and participants are selected, and logistics (location, agenda, and schedule) are planned. Data from the groups are then coded and collated for patterns and themes. Debriefing between both moderators/facilitators helps to avoid selective perception and to verify the relevance of the data. Results are used to provide information for consideration by decision makers, in this case, the team that was designing a training series (Krueger, 1994).

The team conducted five focus groups with 52 participants. The purpose was to provide program planners with feedback on curriculum needs of the service community. The service providers were expected to provide data on specific curriculum content needed by agencies, the format of training, and ideas of how to attract their workers. The groups were conducted by a two-person facilitator team. Group participants were chosen purposefully. The team developed a comprehensive list of interested parties from among various program directories. Potential participants were contacted by mail with a follow-up phone call. Prior to the sessions themselves, participants were mailed both the focus group questions and a summary of the proposed outline and objectives of the five training sessions. The focus groups were augmented by interviews with several county staff, who were heavily involved with training in interagency collaboration, including a CPS trainer, the County's Director of Community Initiatives, the director of a local collaborative children's mental health initiative, and a group of county mental health trainers.

Groups were held in different regions of the county in order to insure a proper representation. Participants included direct service and management personnel from many County and community-based programs, as well as community leaders involved with current collaboration initiatives. One group was held for managers of one of the County's Children's Services regions to gather data from a management perspective.

At the group sessions, participants were asked the

following question and instructed to write their responses on a questionnaire form: "Given your understanding of the objectives and content of the five modules, list for each module: (1) The top five subjects I and/or my staff need to know more about; and (2) The top five subjects that other professions/disciplines need to know about my discipline." This was based on the expectation that each training series would have staff from child protective services and providers in the areas of domestic violence, substance abuse, and mental health, and that there would be variations in learning needs based upon a participant's field of practice or profession. The researchers then asked participants to suggest any important items or areas missing from the curriculum, keeping in mind that sessions needed to be one day per subject. Members shared their individual responses and the group prioritized them.

Other questions asked regarding the training design and delivery included: (1) "What would be the best format (full days or half days; consecutive days or sessions spread out over several weeks)?"; (2) "What would be the most effective teaching methods (lecture, role playing, case discussions, etc)?"; (3) "Considering staff levels, what would be the best way to group sessions (i.e., with workers and supervisors at the same or at separate sessions)?"; and (4) "Do you have any other suggestions which would help make the project more useful to you?"

Each group took about 90 minutes to complete. Eight to fifteen participants attended each session. Groups were audiotaped, and facilitators recorded notes on chart paper that were displayed to participants. The audiotapes and chart notes insured accuracy of the transcription of participant comments.

After a focus group was completed, a transcript based on the notes and audio record was produced. A coding scheme was developed to reduce the data into content units for analysis. Content units were defined as any statement or idea. Data then were coded into specific categories and recurring themes. Content was selected for the curriculum according to the frequency mentioned across the five groups.

### Findings and Uses of Focus Group Results

Tables 1 through 4 list curriculum content recommended by the five groups. The data gathered generally validated the overall strategy and objectives of the project, reassuring staff that the design was relevant and would not need major changes. Nevertheless, the focus groups provided suggestions on content and training design that would not otherwise have been considered. For example, those skills necessary for collaboration, management meetings, and trust building were noted as key skills that may have otherwise been left out of the training design. Also, while the original design included attention to cultural factors, the focus groups emphasized the importance of this subject, prompting augmentation of this part of the curriculum. As might be expected, themes emerged regarding suggested content in the areas of domestic violence, substance abuse, and mental health. In

**Table 1: Input on Collaboration Content**

**A. Basics of Collaboration: Getting Started**
- Definitions
- Roles in collaboration
- Purpose and function
- Benefits
- Expectations
- Principles
- Barriers & Opportunities
- Beginning a collaboration
- Selecting partners for collaboration
- What to do after you get started
- Logistics and organization

**B. Communication among Partners**
- Boundaries
- Conflict resolution
- Consensus building
- Participation
- Confidentiality
- Cultural issues
- Team building
- Effective meetings
- Trust building
- Mutual respect

**C. Using and Maximizing Resources**
- Learn how the service system operates
- What resources are available

**D. Consumers**
- Involving consumers as participants
- Understanding the priorities of low income families
- Cultural issues

### Table 2: Input on Domestic Violence

| | |
|---|---|
| **A. Definitions and Basics** | |
| • Epidemiology of domestic violence | • Causation |
| • Differences from others forms of violence and family assault | • Batterers and their belief systems (including women) |
| • Differentiation: Distinguishing between different levels of violence | • Dynamics; why women stay |
| **B. Assessment Skills** | |
| • Initial assessment | • Impact on children |
| • Pregnancy and risks | • HIV and risks |
| • Lethality Assessment | |
| **C. Intervention** | |
| • How to bring up the subject | • Safety planning |
| • Empirically successful models | • CPS reporting |
| • Working collaboratively with everyone involved | • Court mandated vs. voluntary treatment |
| • Controversies about treatment (and our own biases) | • Temporary restraining orders |
| **D. Resources and Systemic Issues** | |
| • Barriers to use of services | • Other agencies involved and their approaches |
| • County and state laws | • Safe houses/confidentiality |
| • Court process | |

addition to cultural factors, the areas of definitions, assessment, intervention methods, and available community resources were noted in each area. This provided clarity on specifics that should be included and led us to address resources in two ways: (1) having all participants provide their business cards and program summaries to be compiled, copied, and distributed to all participants; and (2) including Internet resources in each session.

Regarding substance abuse, input went far beyond what would be possible to cover in a six-hour workshop. The task of the trainer, then, was to determine how to best fit the requests of the focus group into a coherent, one-day training. The groups did not provide any new insights into important areas of content; however, the breadth of information requested did indicate a high demand for knowledge that the trainer was used to teaching in a 45-hour, semester-long course.

Key areas from the focus group data were selected for the training outline, with several areas combined into various exercises to save time and integrate the content. The focus was on learning several key areas of knowledge that would be most useful (in this instance, substance use, assessment, and referral) and then practicing skills to utilize this knowledge.

Input on domestic violence also resulted in extensive suggestions. The topics most frequently mentioned included the dynamics of domestic violence, interagency intervention, effects of exposure on children, assessing dangerousness, and effective interventions with victims and children. These topics were then synthesized into coherent themes and then integrated into the broader picture of the need to train the participants in an interagency framework. Interactive exercises were created to encourage a teamwork approach to skill-building exercises. To interweave domestic violence with the other training topics, interactive exercises using a sample case spanned all five days' trainings.

Focus group participants also provided helpful suggestions on the training design and factors, which may enhance interest and attendance. For example,

### Table 3: Input on Mental Health

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|---|---|
| **A. Assessment** | |
| • Assessment skills | • Normality and development |
| • Discussion of labeling | • Psychopathology |
| • ADHD | • Family systems; how affected |
| • Abnormal development | |
| **B. Treatment** | |
| • Differential treatment | • Interaction among drugs |
| • What is treatable | • Treatment of substance abusers |
| • Suicide prevention | |
| • Basic pharmacology | |
| **C. Cultural Definitions and Assessments** | |
| • Societal influences and definitions | • How other cultures define mental illness |
| • Workers values and mental health | • Differential assessment and treatment |
| **D. Resources** | |
| • Availability | • HMO's |
| • Access rules | |

**Table 4: Input on Substance Abuse**

| | |
|---|---|
| **A. Basics on Substance Abuse** | |
| • Costs of various drugs | • Disease vs. Behavioral Model |
| • Lingo/language | • Drugs-health impacts; including HIV |
| • Paraphernalia | • Cultural definitions and issues |
| • Drugs of choice by population | • Definitions-use, abuse, addiction |
| • Alcohol | • Lifestyles of substance abusers |
| • Abuse of legal drugs | |
| • Causation and effects | |
| **B. Treatment** | |
| • Successful empirical models/ modalities | • Family intervention |
| • Holistic assessment | • Denial |
| • Dual diagnosis | • Relapse |
| • Court mandated vs. voluntary | • Twelve step |
| • Treatment of non-abuser | • Recovery, life after....early stages |
| **C. Family and Child Impacts** | |
| • Effect on child by type of substance | • Effect on the extended families |
| • Family dynamics | • Adolescents and teens |
| | • In-utero exposure |
| **D. Resources** | |
| • Availability of treatment | • Access rules |

free meals, continuing education credits, and a pleasant training site were seen as effective marketing tools. All of these were used, and demand was so great that each training series had a waiting list. Suggestions were also offered regarding ways to identify participants and other professions to invite (e.g., school and justice system personnel).

## Lessons Learned and Implications

The focus group process used here was a very effective augmentation to the original program design, which was based primarily upon the relevant literature and the principal investigators' knowledge of the community and its needs. Certainly staff could have delivered a very adequate training program, but the data from the focus groups provided both detail and suggestions on content, which may not have been included otherwise, as well as priorities on what should be covered. Recognizing the wide range of knowledge and skills, which were seen as necessary for effective interagency collaboration, as well as the limits of a five-day training series, the priority-setting process used by the focus groups helped narrow down possible subjects for inclusion.

The focus group process also seemed to serve an energizing and marketing function. It built awareness of the upcoming training program in the child welfare community and enabled many service providers to get a better feel as to how the sessions would be conducted. Those who later attended the sessions included some focus group participants and many staff from their agencies, although we cannot definitively say that the focus groups were a key factor here. Another dynamic which may have operated, but which cannot be proven, is the notion from research on decision making philosophies in management that suggests that people are more supportive of decisions or programs in which they had a decision making or input role. More specifically, one model (Miles, 1975) suggests that getting input should be done not only to develop "buy in," but also because it will lead to a better product. Staff on this project believe that this operated here: the training, as ultimately delivered, was better due to the input provided by the focus groups.

The focus group process had some unintended effects that turned out to be useful. First, the fact that the training had been designed with provider input gave the trainers and their work added credibility. There were times during the sessions when a trainer would introduce a subject by noting that it had come up during a focus group, underlining the importance of it from a provider's perspective. Since three of the five trainers were academics, albeit with significant practice experiences, this may have further reassured participants that they were not getting just theoretical content devised in the proverbial ivory tower. Also, in addition to serving as a marketing tool for the training series, the focus group process enabled participants to become acquainted with the faculty who would conduct the training. Some in the community had not had contact with faculty from the School of Social Work for many years, while some remembered past faculty who were seen as out of touch and

non-responsive to community input. The positive reactions to this series of groups suggested that views of the school were changing in a positive direction. Finally, all training sessions received very favorable participant evaluations, in terms of the accomplishment of session objectives and the value of specific session activities. Pre- and post-tests showed increases in collaboration knowledge, skills, and attitudes (full evaluation results are available from the authors).

The findings from this process may have relevance to others in two areas: (1) the specific content areas suggested for interagency training in child welfare; and (2) the process of using focus groups in training design. There is a growing literature regarding interagency and collaboration competencies (some cited above), and the findings here may be of use to others designing such training programs. Of course, any training design should be based on locally identified needs and goals, and the identified outcomes found herein should not be adopted without consideration of local situations. The areas listed above can nevertheless be used to stimulate or focus thinking in another context. More important, perhaps, is the example of the successful use of the focus group methodology. This can be replicated by trained researchers (see Krueger, 1994; Greenbaum 1993; Simon, 1999; and Templeton, 1994) for any training content and can be expected to result in more relevant and complete content than would otherwise be provided. Finally, the process can serve a useful function in building relationships between the university or training institute and the community, and among community members who become involved in the process.

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