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INTERPROFESSIONAL PRACTICE OF SOCIAL WORKERS AND EDUCATORS: FACTORS THAT INFLUENCE THE COORDINATION OF THE SAFE AND DRUG FREE SCHOOLS PROGRAM IN OHIO

DISSERTATION

Presented in Partial Fulfillment of the Requirements for

the Degree Doctor of Philosophy in the Graduate

School of The Ohio State University

By

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* * * * *

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I thank my growing family for the sanctuary of your presence and the time to simply be. With so much to be thankful for, I am very wealthy.
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CHAPTER I
INTRODUCTION

Social workers have collaborated with other professionals since the early days of the settlement house. The social work goals of system change on behalf of clients led social workers into institutional environments considered to be other professions' domain. Social workers, as advocates for children, have entered the education domain of the schools, exemplified by social workers who work with educators to provide full services to special needs children (American Disabilities Act), to facilitate comprehensive programs (e.g., Head Start), and to provide substance abuse prevention services.

In the last fifteen years, the phenomenon associated with the collaborative efforts between professions has been characterized as interprofessional practice. Differentiated from other collaborative techniques, interprofessional practice is characterized by component parts of: (a) a common purpose; (b) the diversity of professions involved; and (c) the interaction patterns of the professionals as a team.

Collaborative efforts have occurred recently in the areas of substance abuse prevention. Change had been occurring in the conceptualization of and
interventions with substance abuse prevention through continued research to understand the complexity of substance abuse etiology. Furthermore, increased awareness of the dramatic effects of substance abuse as a social issue led government officials to assign some responsibility to social institutions for prevention efforts.

In the late 1980's, federal legislation created financial provisions for school based prevention programs. The influence of interprofessional practice as a mode of intervention was recognized in the legislation's guidelines established for community based advisory boards. Implementation of the legislation led to the school based prevention programs and ultimately to the current Safe and Drug Free Schools legislation.

The interface between interprofessional practice and the Safe and Drug Free Schools initially occurred in the mandated composition of Safe and Drug Free Schools advisory committees. Enhanced knowledge of substance abuse etiology and the development of multi-faceted intervention strategies has further encouraged the use of interprofessional practice (Public Law 101-226).

This research explores the interprofessional practice of the Safe and Drug Free Schools program in Ohio. The research measures the extent of interprofessional practice as it is implemented in practice. Furthermore, the research explores the factors that influence the extent of interprofessional practice as identified by the human ecological model.
Mandates for Interprofessional Practice

Social work is distinguished from other disciplines in terms of training and practice with the client system, influencing the individual, and fostering an environment accepting of positive change (Kane, 1983). It is believed this value and action orientation distinguishes social work from other professionals (Treger, 1979) and interprofessional practice. When the interaction involves social institutions and organizations, social workers will be interacting with individuals from other professional backgrounds. This interaction opportunity is the foundation of interprofessional practice (Moxley, 1989).

Current social conditions continue to reflect the complexity of social issues (Weissbourd, 1992). Interprofessional teams are perceived as desirable modes of service delivery with complex social concerns. The complex strategies of interprofessional practice makes this form of intervention more desirable than single strategy intervention.

The social work profession recognizes the complexity of social issues (Kane, 1983; Julia & Thompson, 1994a; Platt, 1994) and advocates for diverse and creative strategies to serve client’s needs (Treger, 1979; Hallett, 1980). Social workers are increasingly using interprofessional practice to address the complex needs of clients (Casto & Julia, 1994). For example, social workers have historically interacted with physicians (Kane, 1983), mental health practitioners (Kane, 1983), and school professionals (Kane, 1983; Tomkins & McGill, 1989) to serve clients.
The environments in which social workers are employed often require interprofessional practice. For example, school social workers working within education's domain, social workers must collaborate with teachers, counselors and administrators (Kane, 1983). This collaboration is characteristic of interprofessional practice which requires working with individuals from diverse professional practice orientations.

Institutional mandates in the form of legislation, policies, or funding requirements often demand interprofessional practice (Bope and Jost, 1994). Legislative components are reflected in the services of interprofessional teams (Kane, 1983; Casto & Julia, 1994). For example, schools and school social workers have been affected by regulatory and/or funding legislation that includes elements of interprofessional practice (Lie & Maroney, 1992; Weatherley, 1985; Leone, Walter, & Wolford, 1990). The American Disabilities Act requires schools to provide special needs children with an education in the least restrictive environment. 'Least restrictive' environment is determined for each child by an interdisciplinary team which includes social workers.

**Human Ecological Model**

The human ecological model, derived from systems theory, provides a framework for anticipating and organizing the environmental and personal factors related to interprofessional practice. Derived from systems theory (Smith & Reeves, 1989) and ecological theory (Micklin & Choldin, 1984; Netting, 1977;
Theodorson, 1982), the human ecological model is based on a holistic interaction of systems and subsystems are conceptualized. Bubolz, Eicher, & Sontag (1979) describe the human ecological model as including four categories of consideration: (a) the individual - attributes of the unique person; (b) the human constructed environment - elements of the environment which are part of the structures and infrastructures created by human effort (i.e., clothing, technology, roads and buildings); (c) the human behavioral environment - all human interactions with other individuals, groups or institutions (i.e., schools, family, religion); and (d) the natural environment - elements of the earth and biosphere which are not controlled by humans.

**Safe and Drug Free Schools Initiative**

The Safe and Drug Free Schools program, amended in 1989, is a federally funded, state administered substance abuse prevention program targeting children and adolescents (Ohio Department of Education, 1992; Public Law 101-226). The educational program includes a wide range of curriculum and supportive intra and extra curricular activities. Comprehensive integration of the Safe and Drug Free Schools Program in a school requires an interprofessional practice focus in the administration and implementation of each program (Ohio Department of Education, 1992). Recognition that substance abuse and prevention are complex and multifaceted issues (Sutker & Allain, 1988) and the economic incentives of the federal mandates (Ohio Department of
led to widely implemented interprofessional practice.

However, the extent and form of the interprofessional practice differs between school systems (Ohio Department of Education, 1992). The breadth and depth of interprofessional practice varies among schools, over time, and among programs. One explanation for the diversity of programs is based on social work's conceptualization of the individual in the environment. It is hypothesized that each coordinator with individual characteristics interacts with the environment (i.e., the school and the community) to create unique interprofessional practice programs. Therefore, it is hypothesized that environmental and personal factors contribute to the strengths and limitations of interprofessional practice.

**Interrelationship of Concepts**

The Safe and Drug Free Schools initiative targets youth in the education context and addresses individual and social influences which increase the risk of substance abuse behaviors. The diverse influences individuals face, reinforces multifaceted approaches of the curriculum and program implementation. In order for programs to be comprehensive, many diverse individuals and professional affiliations must contribute expertise. The context of the comprehensive approach and diverse professional contributions that interprofessional practice contributes can be observed.
This link of Safe and Drug Free Schools and interprofessional practice occurs in a context. The coordinators, their respective professions, the nature of the programming, and the nature of the support they receive are influenced by the social, cultural, and economic contexts in which they collaborate. The human ecological model provides categories which assist in the recognizing the influences in situations that would otherwise be difficult to recognize. In this manner, the human ecological model is linked with the conceptualization of interprofessional practice within the Safe and Drug Free Schools initiative.

**Problem Statement**

Social workers have decades of interprofessional experience with teachers, physicians, mental health professionals and others in the human service field. Recently this experience has been directed toward the complex etiology of youth substance use and to develop comprehensive strategies of substance abuse prevention. These comprehensive strategies have been a common stimulus for many professions to consider their role in prevention. Interprofessional practice has been developed as a specific strategy for comprehensive program development and implementation.

Social work and other human service literature abound with personal testimony and program descriptions (Lie & Moroney, 1992; Weatherley, 1985; Leone, et al., 1990) which describe coordination, collaboration, and interprofessional teams which serve diverse and complex client needs. Careful
definitions and characterizations of types of programs are included in these descriptions. Similarly, the literature provides details of 'how tos' for interprofessional teams; 'How to' initiate, implement and monitor interprofessional programs (Julia & Thompson, 1994b; Casto, 1994), and 'How to' educate developing professionals toward a positive attitude of interprofessional practice (Kane, 1983; Waugaman, 1994; Casto, 1994).

The research literature provides little information on the patterns of interprofessional practice implementation and key factors related to interprofessional practice as it occurs in service delivery. Social work educators do not know if programs featured in the literature are isolated cases or standard practice. Further questions that need to be asked:

1. Are similar characterizations of successful programs described as effective due to coincidence or some underlying influence?
2. Does the environment support or hinder the implementation of interprofessional teams or their initiatives?
3. Are differences between programs a function of the unique individuals who participate on the team?
4. Does the philosophy and training of social work professionals make important contributions to the team?

The Safe and Drug Free Schools programs offer an ideal format for evaluating the factors which enhance or restrict interprofessional. Literature on substance abuse prevention among adolescents advocates for diverse
strategies (Pandina, Labouvie, Johnson, & White, 1990; Calabrese, 1987; Gibbs, 1982) and comprehensive community involvement (Hawkins, Jenson, Catalano, & Lishner, 1988; Newbrough, 1987) by including diverse professional expertise in the programming. The Safe and Drug Free Schools initiative is funded through Federal laws of The Drug Free Schools and Communities Act Amendments of 1990 (Public Law 101-647) and The Crime Control Act of 1990. The legislative acts include provisions for programming in each school district of the country and contains provisions for interprofessional practice.

In Ohio, an official effort has been made to identify and publicly recognize exemplary Safe and Drug Free School Programs. Those responsible for the state recognition program have discovered that interprofessional practice varies within the state. (Ohio Department of Education, 1992). Since influences beyond legislation can hinder or enhance the interprofessional practice initiatives of each program, Ohio offers an opportunity to explore other variables which influence interprofessional practice.

The problem for this research is to articulate what is known about interprofessional practice in substance abuse prevention. The problem is that adequate knowledge of the extent of interprofessional practice as it occurs in the practice arena is unavailable. Similarly, empirical information on factors which influence the extent of interprofessional practice (i.e. what helps and what hinders) does not exist. The lack of empirical evidence on this issue is addressed in this research.
Purpose

The purpose of this research is twofold: (a) to explore interprofessional practice; and (b) to use the human ecological model to explain the differences in the interprofessional practices of the Safe and Drug Free Schools initiative. To achieve this purpose, this research will synthesize three knowledge bases: interprofessional practice, the human ecological model, and the Safe and Drug Free Schools initiative. This will first be accomplished by identifying each of these terms and reviewing the literature.

Objectives

The objectives of this exploratory and descriptive study is to:

1. Assess the extent to which interprofessional practice was used in the coordination of Safe and Drug Free School Programs.
2. Identify relevant human and environmental factors which help or hinder interprofessional practice.
3. Evaluate the utility of the human ecological model for describing interprofessional practice.

The major research question was:

4. What factors influence the interprofessional practice of social workers and educators in the coordination of the Safe and Drug Free Schools programs in Ohio?
To answer this question, the following sub-questions were also posed:

4a. To what extent is interprofessional practice occurring (breadth and depth)?

4b. What personal and environmental factors do coordinators identify as hindering or helping interprofessional practice?

4c. Can social workers be distinguished from other professionals in the performance of interprofessional practice?

4d. Can hindrance or enhancement factors as identified by the human ecological model be used to describe categories of interprofessional practice in the Safe and Drug Free Schools initiative?

**Significance of the Study**

This research will contribute to a better understanding of interprofessional practice. This is important because mandates exist for interprofessional practice in the form of legislative requirements (Drug Free Schools and Communities Act Amendment of 1990). In addition, comprehensive services provided in the context of interprofessional practice are identified as more valuable than single services (Johnson, Davis & Denniston, 1991). The trend is continuing which involves social work collaboration with other professionals.

This research is important because it provides information for practice, particularly those planning or involved in interprofessional research and social workers in the Safe and Drug Free Schools programs. Social workers in
practice need to know if interprofessional practice is occurring and what environmental factors support or hinder interprofessional practice. The individuals involved in Safe and Drug Free School and other substance abuse prevention programs also need to know which other professions are helping to provide comprehensive services in order to identify potential resources for their own efforts.

The results of this research will strengthen social work practice in interprofessional teams by recognizing the supports and limitations of this approach. Recognizing obstacles and accentuating the strengths of the environments' support of interprofessional practice will encourage an appropriate investment of resources into the team construction (Casto, 1994; Kane, 1983). Social workers will be able to recognize personal and environmental resources available for innovative practice.

In addition, this research will assist social work educators in implementing interprofessional training in direct service to clients. The recent trend to implement interprofessional education programs (Julia & Thompson, 1994a; Kane, 1983), suggests a growing need for students to have skills working with other professionals toward a common goal. Benefits of this research will further the development of social work curricula which reflect realistic practice conditions. Social work education curriculum can assist student skill development in addressing complex issues within the social environment.
Curriculum which builds skills in recognizing and facilitating interprofessional practice better prepares students for employment and service.

**Definition of Terms**

**Interprofessional Practice:**

Interprofessional practice is defined as a group of two or more individuals from differing professional affiliations who work together to plan, implement, and/or evaluate services to meet the common goal. In addition to collaboration, a team atmosphere with a shared set of values is developed in terms of professional practice and desired outcomes.

**Safe and Drug Free Schools Program:**

The Safe and Drug Free Schools Program is a federally funded, state administered substance abuse prevention program targeting minors. The educational program includes a wide range of curriculum and supportive intra and extra curricular activities (Ohio Department of Education, 1992).

**Etiology:**

Etiology is the science of causes or origins (Neufeldt & Guralink, 1988). Etiology in the social sciences often focuses on locating the cause or origin of a particular social phenomena.

**Professionalism:**

Professional is the distinguishing of identity in terms of nuances of discipline knowledge base and practice orientations. Professionalism can be defined in
terms of collegiality, commitment, and the use of a specific knowledge base
(Mitchell, 1993).

**Limitations**

The researcher recognized that the study had the following limitations:

1. The study was limited to the respondent's understanding of the terminology used in the questionnaire.
2. The study was limited to quantitative and brief responses to complex concepts.
3. Generalizability to national populations was extensively limited.
4. Time frame of data collection was limited to six weeks, and occurred at the end of the academic year. Coordinator's may not have had adequate time to complete the questionnaire simultaneously to completing their end of the years assignments.

**Assumptions**

The following assumptions were identified in conducting this study:

1. The respondents completed the survey with responses reflecting their true perceptions.
2. The persons participating in the study were involved in the Safe and Drug Free Schools Program.
3. A written questionnaire could adequately measure the independent and dependent variables.
CHAPTER II
Theoretical Background

The foundation for this research is divided into three general areas: (a) interprofessional practice in social work and related disciplines; (b) substance abuse prevention programs of the Safe and Drug Free Schools Programs and; (c) the constructs and utility of the human ecological model.

Interprofessional Practice.

Harbaugh (1994) distinguishes between multi-professional, transprofessional, and interprofessional practice. Multiprofessional is used when more than one profession is interested in a particular issue. Transprofessionalism indicates professionals use the knowledge base from their own and other professions to examine an issue. Interprofessional practice involves professionals from different speciality areas utilizing their profession's knowledge base to work together to examine an issue. Successful interprofessional practice is dependent on an identified purpose, mutual respect, and commitment to an issue. The collaborative efforts of
interprofessional practice ideally produce a better response to an issue than any profession could accomplish alone (Casto, 1994).

The key elements of interprofessional practice originate from its structure and function which is differentiated from other professional interactions. Kane's (1983) structural definition of interprofessional practice includes a common objective, the recognition of differential professional contributions, and a communication system. Kane's structural definition is a synthesis of earlier definitions of an interdisciplinary team (Luszki, 1958), interprofessional team (Briggs & Van Voorst, 1974; Powers, 1973), teamwork (Konopka, 1959) and collaboration (Aradine & Pridham, 1973).

Kane's (1983) functional definition of interprofessional practice focuses on the professional internal and external processes that contribute to quality service. The internal processes or team interaction patterns focus on communication, decision making, leadership, group values and norms, conflict resolution, and maintenance (Platt, 1994; Julia & Thompson, 1994a). External processes or task functions focus on problem solving, coordination of plans, referring and consulting, fulfilling institutional functions, adapting to the environment, and sharing information (Platt, 1994; Julia & Thompson, 1994a).

Julia & Thompson (1994a) describe interprofessional practice as a group process possessing developmental stages. Stages of group development include: orientation, accommodation, negotiation, operation, and dissolution. Kane (1983) identifies two types of groups commonly found participating in
Interprofessional practice. One type of group is characterized as a coordinated team with a designated leader. The coordinated team members function with independent roles with the social worker’s role predominantly focused on casework and functions as gatekeeper of the team. The second type of small group is described as an integrative team which does not designate a leader to facilitate the team process. Integrative team members function as a whole making decisions by consensus.

Interprofessional Practice and Social Work

Social work has a history of interprofessional practice, particularly in the fields of health, mental health, geriatrics, mental retardation, early childhood development programs, urban planning, and schools (Kane, 1983; Treger, 1979). However, interprofessional teamwork has emerged only since the 1970s as a specific strategy for intervention (Julia and Thompson, 1994a).

Social workers have been found to display unique patterns of participation in interprofessional teams. Kane (1983) states that social workers are the most frequently represented profession on interprofessional teams in human service environments. Social workers typically perform casework functions including: facilitating the initial introduction of clients, initiating the formation of the interprofessional team, and adapting the traditional social work roles and techniques as the situation demands. When social workers are involved in interprofessional teams, they generally are not in leadership positions. However
when social workers are found in leadership positions, their leadership style is characterized by process orientation, consensual decision making, and overlapping roles (Kane, 1983).

The role of social workers in interprofessional teams continues to evolve. Social work as a profession struggles with its professional identity in areas of functional specificity, broad scope, and philosophical differences (Etzioni, 1969; Kane, 1983; Toren, 1972; Treger, 1979). Collaboration with other professions on single issue concerns, challenges each profession to maintain its professional identity, autonomy, and skills. The challenge is for team members to simultaneously work with common interests while maintaining commitments to their individual professions (Kane, 1983).

**Complexity of Issues**

The complexity of social issues has increased the need for interprofessional practice. High stress environments created by the current social, cultural, and economic events have created problem situations for youth (Van Hook, 1990). Personal challenges confronting youth stem from biological development (Arnold, 1983) combined with environmental influences, social change (Arnold, 1983), and changes in family composition (Pardeck, 1978). Adolescents experiencing stress have responded in a variety of ways including substance abuse, criminal activity, and suicide (Curtis, 1987).
The complexity of these issues has affected social service institutions. Complex societal issues have required private and public social service systems to include services on unemployment assistance, youth counseling, parenting education, income maintenance, housing, health care and education to the cadre of services previously offered (Weissbourd, 1992).

Interprofessional practice teams can more efficiently understand and respond to complex social problems by facilitating economic viability, enhancing the quality of services, and sharing responsibility (Kane, 1983). Platt (1994) describes an observed parallel process. When the complexity of social issues increase, the trend of professionals is to become more specialized. Specialists provide expertise in specific component parts of the issues but often lack understanding of the entire system, thus the need for interprofessional teams to collaborate to develop solutions. Interprofessional teams are thought to be more effective because of the comprehensive answers they develop for complex issues (Casto & Julia, 1994a; Kane, 1983).

Legislative Mandates

Legislation has often mandated interprofessional practice. Federal and state laws have been initiated which facilitate, encourage, and/or demand interprofessional practice (e.g. main streaming). Similarly, institutions such as hospitals and schools have developed interprofessional practice initiatives through contractual relationships, collaborative research, and organizational
change initiatives. Institutional initiatives result from financial demands of limited resources and client needs.

Education for Interprofessional Practice

Mandates for interprofessional practice have led to implementation of interprofessional education within social work education (Bright & Das, 1983). Social work education focusing on interprofessional practice has three primary objectives. The first is to provide for basic skills and understanding of an alternative discipline’s knowledge base and operating principles (Weissbourd, 1992). Understanding the contribution of other professions enables social workers, when engaged in interprofessional practice, to recognize the unique contribution of each team member and reduce role overlap and confusion (Kane, 1983).

The second objective is to help social workers develop general skills in working with other professionals on a team (Kane, 1983). Kane (1983) has identified historic patterns of social work participation on teams and has shown a pattern of interaction that primarily reflects the skills of self determination of the group process and secondarily advocating for the client and providing leadership on the team. Interprofessional practice skills such as client advocacy, leadership and active participation, and facilitating greater understanding and respect for the contributions of social work to the interprofessional team (Kane, 1983) to enhance group functioning.
The third objective is to develop positive attitudes toward interprofessional practice. Social work's educational emphasis on practice skills, developed through mentor/supervisory relationships in the field, provides an opportunity for students to develop value orientations toward interprofessional practice. The key element for successful participation on interprofessional teams is related to the socialization of interprofessional practice (Harbough, Casto & Burgess-Ellison, 1987; Waugaman, 1994). Socialization is facilitated by education, practice experiences and role models who encourage interprofessional practice (Waugaman, 1994).

Casto (1994) identifies six requirements of interprofessional education:

1. Interprofessional education should be provided in areas where professional education programs have common or overlapping interests.

2. Interprofessional education should be provided in areas where it would be in the client's or society's best interest to enhance communication and cooperation between the professions.

3. Education for interprofessional practice should enhance the students' knowledge of their profession's area of competence, skills, and knowledge of interprofessional practice.

4. Education for interprofessional practice should be an essential element in all stages of professional education, including the lifelong learning programs of practicing professionals.
5. Education for interprofessional practice should increase awareness
(sensitivity, engagement, cooperation) of member's contribution.

6. Education for interprofessional practice requires the institutional commitment
of funds, personnel, and physical facilities.

**Variables Effecting Success of Interprofessional Practice**

Variables associated with successful interprofessional practice can be
categorized as individual incentives, elements of human interactions, and the
structural context of interprofessional practice.

Characteristics of the individuals that contribute to interprofessional
practice include the self perceived motivations toward interprofessional practice
(Casto, 1994), the perceived rewards in terms of prestige and/or relative status
(Kane, 1983; Casto, 1994), shared credit (Casto, 1994), and increased
effectiveness (Kane, 1983; Segal, 1992).

Human interaction variables associated with successful interprofessional
practice includes influences of the group process on team members and the
institutional context. Team members can reinforce interprofessional practice
through positive communication patterns (Hallett & Stevenson, 1980; Julia &
Thompson, 1994b; Segal, 1992), defining roles (Hallett & Stevenson, 1980;
Kane, 1983), demonstrating the value of all members through respect (Hallett &
Stevenson, 1980; Kane, 1983) and utilizing all team members in facilitating
interprofessional practice (Kane, 1983).
Team membership and process is influenced by purposeful recruitment, (i.e., not arbitrary) (Kane, 1983) and group format (Kane, 1983; Casto, 1994; Bope and Jost, 1994). Effective utilization of team process skills requires leadership possessing a process management approach (Kane, 1983), respect for relationships within the team (Hallett & Stevenson, 1980), and insight to use the generalized and specialized skills of each profession (Kane, 1983). The inclusion of individuals with appropriate professional affiliations and effective group skills can enhance interprofessional practice.

The wider social context has contributed to the success of interprofessional practice through mandates and sanctions of responsibility to the teams. Sanction is particularly valuable for the management of agencies, larger social institutions, professions, and governance bodies. These entities must provide, approve, and support the existence and maintenance of interprofessional teams (Ccasto, 1994). Administrative activity that supports interprofessional practice includes: (a) support from top management (Ccasto, 1994; Nebgen, 1991); (b) semi-permeable boundaries within and between departments of the agency that facilitate communication and collaboration (Kane, 1983); (c) building horizontal affiliations and community participation (Ccasto, 1994); (d) supervision and education of employees that enhances both general and specific interprofessional practice skills (Hallett & Stevenson, 1980; Chavkin & Brown, 1992; Ccasto, 1994); and (e) administrative attitudes that allow flexibility in the time allowed to provide services (Julia & Thompson, 1994b).
Similarly, inter and intra agency practices that provide resources and opportunities for interprofessional practice are vital for program success. Providing resources (i.e., office space, and technology) (Chavkin and Brown, 1992), a neutral base of operations (Casto, 1994), administrative support (Casto, 1994), and shared resources (Casto, 1994) are identified as necessary components of an interprofessional team.

The wider social context also contributes to a viable environment for interprofessional practice. Possession of legal authority, particularly in the decisions regarding services for clients fosters the perception that interprofessional practice teams are necessary and vital social institutions (Nebgen, 1991; Hallett & Stevenson, 1980). Similarly, regulatory and accountability institutions provide sanctions for interprofessional practice by establishing models of care through licensing, liability, and reimbursement criteria (Bope & Jost, 1994).

**Professionalism**

Each interprofessional team must resolve issues of loyalty and identity respective to each profession to establish a common focus with other interprofessional team members (Hallett & Stevenson, 1980; Kane, 1983). A delicate balance of compromise must be reached in both the process and product of interprofessional practice. A balance is necessary between the professional autonomy and compromise in individual professional preferences (Kane, 1983). The process and outcome of interprofessional practice must
reflect shared commitment across professions (Casto, 1994) while simultaneously recognizing different value orientations toward client circumstances (Hallett & Stevenson, 1980).

The challenge of negotiating the balance between professionalism and interprofessional practice is particularly difficult in social work practice. The inherent bias of traditional professions against social work exists based on class and gender discrimination. Social work, considered a profession of middle class women and a 'soft science' does not automatically receive the respect attributed to other professions (Hallett & Stevenson, 1980; Kane, 1983). Ironically, social work shares a set of common skills and a knowledge base with many other professions that are afforded a higher degree of respect. Social workers find it easy to appear to be affiliated with other professions rather than with their own distinct profession (Luntz, 1985). Hallett & Stevenson (1980) describe six professional challenges to social work concerning professionalism in interprofessional teams:

1. To define the nature and roles of social work that are readily recognizable.

2. To recognize and compensate for both the relative newness of the profession and the rapid development of social work practice.

3. To negotiate leadership, power, and authority with interprofessional teams.

4. To establish a standard of training education.

5. To socialize developing professionals through training and development of common values and approaches.
6. To address responsibility and accountability issues toward diverse and multiple constituents.

Factors influencing successful interprofessional practice have been recognized from a variety of practice contexts. For example, in substance abuse prevention programs Interprofessional team members and their collaborative agencies are most successful when there is a shared understanding and agreement on: (a) the model of intervention (Firestone & Drews, 1987; Johnson, 1989); (b) attributive cause or contributing factors to substance abuse (Johnson, 1989); (c) curriculum and program activities (Johnson, 1989); and (d) extent of service needed and capacity (Firestone & Drews, 1987).

Substance Abuse Patterns

Substance abuse in youth is correlated with many negative consequences for the individual and society including; domestic abuse, traffic fatalities, murder, drowning, child abuse, rape, assaults, and suicides. The negative consequences add tremendous costs to society in the form of resources that could be used elsewhere (Johnson, 1989). The negative long term consequence of youth substance abuse problems includes: loss of health, compromised potential in workforce participation, and legal consequences (Walker, 1989).

Risk Factors Associated with Substance Abuse

Current conceptualizations of substance abuse risk in adolescence require an understanding of the multifaceted and interactive relationships between the individual and the environment (Leone, Walter, and Wolford, 1990;

Factors in the immediate environment which increase the risk for substance abuse focus on peer group, family, and community. It is believed that the peer group forms an influencing relationship through reinforcement (Dignan, Block, Steckler, Howard & Cosby, 1986; Downs, 1987) and modeling (Hawkins, et al, 1988) of consumption behavior. Family influences on substance abuse are divided into two major influences: the behaviors modeled by parents or siblings (Hawkins, et al., 1988; Zucker & Fitzgerald, 1991), and family instability, particularly in parental relationships (Hawkins et al., 1988; Zucker & Fitzgerald, 1991; Johnson, Sher & Rolf, 1991). The community in which the substance abuse occurs can be a bounded space (geography) or a relational
collection of social institutions (Johnson et al., 1991a). The community influences individuals through relationships and community organization (Hawkins et al., 1992).

The cultural context of the immediate environment can also interact with the individual and the environment which can lead to substance abuse. Cultural context variables include: minority status (Johnson, et al., 1991a), low socio-economic status families (Hawkins et al., 1988), communities, and federal, state, and county legal measures related to the price, sale and use of alcohol (Johnson, 1989). Advertising alcohol and drugs in multi medias contributes to encouraging or discouraging substance abuse in youth (Johnson, 1989).

Recognition of the factors contributing to an increase in the risk of alcohol or drug addiction in youth has led to an understanding of the need for multiple strategies to address the issue (Sutker & Allain, 1988; Johnson, 1989; Johnson et al., 1991a). The complex issue of alcohol and drug abuse as having multiple interrelated causes originating from the interaction of the individual and environment call for a new paradigm. Professionals respond to the alcohol and drug abuse by facilitating participation at multiple levels including forming coalitions, partnerships and collaborative efforts (Johnson, et al., 1991b; Weissbourd, 1992). Developing a new paradigm requires changes in how the individual is perceived, how the organizational structures can change to meet client needs and recognition of the cultural forces contributing to the problem (Leone, Walter, & Walford, 1990).
Johnson et al. (1991b) have identified several general strategies for substance abuse prevention that include: information, life skills, alternative activities, policy, cultural promotion, and crisis prevention. Effective school programs are beginning to coordinate with other comprehensive approaches to balance the influences of family, social institutions and larger community forces in the individual's life (Botvin, Schinke, & Orlandi, 1989). Johnson (1989) describes components of a comprehensive program to include strategies targeted to: "(a) the individual, (b) the peer group, (c) parents, (d) school-based programs, (e) student assistance programs, (f) teachers, (g) mass media, and (h) policy and legislation" (pp. 38-39).

Four principles of effective service programs have been identified as: prevention, comprehensiveness, continuity, and accountability (Weissbourd, 1992). These principles are relevant to school based programs as well. School programs are significant components of most initiatives and can serve as models for other programs. Components of programs include two items specifically geared to schools (Johnson et al., 1991b):

1. Involvement of the school system is a part of almost every successful program . . . schools work out collaborative arrangements with other community social and health agencies to bring in ancillary services necessary to ensure that children at high risk can stay in school.

2. Effective school-based prevention programs have attributes that may be generalized to other settings . . . programs tailor practices to students'
current levels of maturity, provide an opportunity for active involvement of children in their own learning and decision making, and integrate prevention in every aspect of the curriculum which includes academic and social skills.” (p. 21)

A process of intervention begins with accurately identifying high risk individuals and communities (Gibbs, 1982; Hawkins et al., 1988), and developing intervention plans that include: interpersonal skills training and parental involvement in early childhood education (Hawkins et al., 1988). Intervention programs also depend on: life skills training in schools (i.e., decision making, self image, behavioral skills training, coping, communication, and problem solving)(Hawkins, et al., 1988; Pandina et al., 1990); cognitive interpersonal skills training (Hawkins et al., 1988; Pandina et al., 1990); proactive classroom management, social influences in schools, family, media, community influences, and health clinics and other environmental supports (Hawkins, et al., 1988).

Human Ecological Model

The human ecological model that evolved from the influences of biological sciences, ecology of nature (Micklin & Choldin, 1984; Netting, 1977; Theodorson, 1982) and systems theory (Smith & Reeves, 1989) has been identified as a rich conceptual tool for research design, particularly in social
science research (Boyden, 1979; Sargent, 1974). Diverse disciplines have used the human ecological model as the conceptual foundation for understanding the human experience (Micklin & Choldin, 1984; Netting, 1977; Sargent, 1974) in delinquency (Heitgerd & Bursik, 1987), housing (Raffestin & Lawrence, 1990), employment (Patino, 1986), and substance abuse (Van Hook, 1990).

Two principles comprise a foundation of the human ecological construction of reality. The first principle states that human experience is similar to biological principles of ecology. The biological principle includes the concept of interactive, interdependent, and seemingly causal chain of events relating one entity in the environment to another in a hierarchical and orderly fashion (Micklin & Choldin, 1984, Mlinar & Teune, 1978, Netting, 1977).

Synthesizing the literature on human ecological perspective produces five constructs that characterize the concept of the ecological perspective: (a) social phenomena occur in a space-time universe, (b) social systems are adaptive to the environment, (c) adaptation is an irreversible process of cumulative change, (d) organizing systems and subsystems are generated in the environmental relationship, and (e) adaptation is a collective achievement, a holistic change, not the process of its individual components (Mlinar & Teune, 1978; Micklin & Choldin, 1984).

The second principle of the human ecological perspective states that the primary difference between human ecosystems and natural ecosystems is the ability to control a natural process (i.e., culture) not available to other species.
(Micklin & Choldin, 1984: Netting, 1977). The human ability to anticipate, manipulate, and adjust to environmental changes creates a unique opportunity to mediate the influence of environment in determining the outcome of interactions between the individual and the environment. Therefore, the intrinsic contributions of the individual and the human species become a central focus of the human ecological perspective when examining human conditions and experiences.

The principles of the human ecological model highlight the interaction between human(s) and the environment(s). Bubolz, Eicher, & Sontag (1979) describe the human ecological model with four components (Figure 1). The first component includes elements of the individual. The second component is human behavioral environment which includes human interactions with other individuals, groups, or institutions (e.g., schools, family, and religion). The third component is the human constructed environment that includes elements of the structures and infrastructures created by human effort (e.g. clothing, technology, roads, buildings). The last component is the natural environment that includes elements of the earth and biosphere which are not controlled by humans (e.g. weather, seasons, geography). The interaction of these three environments and the individual determines the final outcome.

as having semi-permeable boundaries which maintain separate yet interactive relationships between entities. Homeostatic and equilibrium balances regulate systems and boundaries of the human ecological model (Micklin & Choldin, 1984; Bubolz, Eicher & Sontag, 1979). The model can be used to measure individual, family, or institutions relative to the respective behavioral, natural and constructed environments (Bubolz, Eicher & Sontag, 1979; Micklin & Choldin, 1984; Mlinar & Teune, 1978).

Figure 1

Human Ecological Model
Summary

Interprofessional practice has been identified as a critical element in substance abuse prevention. The complexity of social issues, including the political, social, and economic nature of social service issues combine to create an atmosphere conducive to interprofessional practice. The complex nature of youth substance abuse prevention further supports the use of interprofessional practice in the Safe and Drug Free Schools Program.

To explore interprofessional practice in the Safe and Drug Free Schools Programs, a systematic and manageable conceptualization of the factors influencing substance abuse is necessary. The human ecological model provides a basis for studying interprofessional practice in the Safe and Drug Free Schools program, the interaction of individuals and the environment.
CHAPTER III

Methodology

Introduction

The Drug Free Schools and Communities Act, and subsequent federal legislation on the Drug Free Schools and Communities Act Amendments of 1989 (Public Law 101-226) provide for federal funding to be available to states on a per pupil basis for drug education and prevention programs. Funding is contingent upon compliance with a variety of requirements including the implementation of an interprofessional practice model. Interprofessional practice is recognized as a significant contributor to community based programs. State and private organizations serve as monitoring bodies which provide economic and professional rewards to programs that meet the requirements (Ohio Department of Education, 1992).

The combination of incentives, curriculum guidelines, and the freedom to develop and implement tailor based programs creates an atmosphere where interprofessional practice exists. As a result, when each school participates in an interprofessional practice program the scope, diversity, and structure of interprofessional practice varies.
This section outlines the methodology used for describing interprofessional practice within districts. The research also described the process of determining which environmental and individual characteristics of the coordinator were associated with the extent of interprofessional practice. The theoretical basis for the design of this study was the Human Ecological Model from systems theory.

**Design of Study**

The study was exploratory, seeking to describe the characteristics of interprofessional practice as it occurs in the Safe and Drug Free Schools Programs in Ohio schools. Standard quantitative research methodologies were used to design and implement the research instrument as a mailed survey (Dolman, 1978; Savant & Dillman, 1994). A single research instrument was used to measure the coordinators' perceptions of interprofessional practice as it occurs in their specific environment. Specific interest focused on the development and implementation of drug free schools programs, and the identification of the environmental and individual characteristics that were associated with the interprofessional activities. In this manner, the study evaluated whether the human ecological model was effective in identifying the environmental and individual characteristics affecting interprofessional practice.
Sampling Design

A census study (inclusion of all individuals within the sample frame) was completed using the 684 coordinators of the Drug Free Schools program as identified by the Ohio Department of Education. The study measured the perception and attitudes of the Safe and Drug Free School Program coordinators regarding the use of interprofessional practice in their role as coordinators in the Safe and Drug Free Schools Program.

Research Questions

What factors influence the interprofessional practice of social workers and educators in the coordination of the Safe and Drug Free Schools program in Ohio?

To answer this question, the following sub-questions were also posed:

To what extent is interprofessional practice occurring (breadth and depth)?

What personal and environmental factors do coordinators identify as hindering or helping interprofessional practice?

Can social workers be distinguished from other professionals in the performance of interprofessional practice?

Can hindrance or enhancement factors as identified by the human ecological model be used to describe categories of interprofessional practice in the Safe and Drug Free Schools initiative?
Operational Definitions of Variables and Instrumentation

According to the human ecological model the status/outcomes of a situation are a function of the interacting environments of the system. In this conceptualization, interprofessional practice is a status or outcome. Interprofessional practice as measured in the current context of time and space, is a function of the environments and their interactions. Interprofessional practice is defined as a construct of individuals and their interaction over time. The interaction was measured within the questionnaire as who is involved and how much time was invested. The influence of Individual and environmental factors on the outcome were also measured. Table 1 outlines the variables and measurement.

Dependent Variables

The dependent variable of interest to this research is the outcome measure of interprofessional practice. As an outcome measure, interprofessional practice was measured as a magnitude of how much and as a process measure of in what way interprofessional practice was occurring. To measure these aspects of interprofessional practice as an outcome, a series of dependent variables were identified.

Extent of interprofessional practice is a construct measured as a composite of the breadth and depth of interprofessional contributions to the decision making and implementation of all the Safe and Drug Free Schools
Program curriculum and programs. Extent of interprofessional practice is defined as a continuous variable generated by combining the breadth and depth of services.

**Breadth of services** was measured as the sum of diverse professions identified as contributing to the Safe and Drug Free Schools Program. This variable was denoted as "Breadth of Services." This measure was generated by adding all the positive responses to questionnaire item 5. (i.e., identification of other professionals who you have had contact with when conducting the Safe and Drug Free Schools Program).

**Depth of services** was measured by totaling the categories of time in contact with each profession identified as contributing to the Safe and Drug Free Schools Program. This variable was denoted as "Depth of Services." This score was generated by summing all the categorical scores of questionnaire item 6. (i.e. Time spent with other professional when participating in the Safe and Drug Free Schools Program).

**Level of commitment** is defined by the coordinator's perception of the commitment of a profession to the Safe and Drug Free Schools. This is measured by a Likert type five point scale ranging from 1=not committed to 5=very strong commitment.

**Hours invested by profession** is defined as the coordinator's hours of contact with representatives from particular professions. This is measured by a Likert type 6 point scale ranging from 1=less than 5 hours to 6=100+ hours.
**Profession involved** is defined by the coordinator’s contact with at least one representative of a particular profession. This is measured by a dichotomous (yes/no) response to the identified profession.

**Team Activity** is defined as the participation of different professions in the Safe and Drug Free Schools program in the format of team activity. This is measured as a Likert type scale of agreement on statements about interprofessional practice as a team.

**Independent Variables**

According to the human ecological model there are four constructs related to the individual and environment which identify component parts that help or hinder interprofessional practice; individual, human behavioral, human constructed, and natural environments. Each of these constructs were measured by a series of questions within the questionnaire.

**The Individual**

The independent variable of the Individual is defined as demographics and a predisposition toward interprofessional practice (Bubolz, Eicher, & Sontag, 1979). This variable was operationally measured by a series of instrument items recognized to be related to the individual's contribution to interprofessional practice. These items included:
Professional identification which was measured in two ways. First, the respondents reported their credentials as a dichotomous (yes / no) response to a list of credentials related to Drug Free Schools initiatives (Item 14). Second, respondents indicated their primary professional affiliation in a categorical item listing professional titles (Item 15).

Personal Attitude was measured through the factor analysis of responses to a Likert-type scale score on thirteen items (Question 16) (Mueller, 1986). The construct included references to perceived rewards, manageability of the tasks, personal commitment to interprofessional practice, and perceived necessity of interprofessional practice for successful programs.

Time invested was a construct of the individual coordinator which describes their experience and investment in the prevention. Time invested was a series of continuous variables. Time invested was operationally measured by years of experience in prevention, years of experience in Safe and Drug Free Schools, years, and percentage of time allocated to components of the Safe and Drug Free Schools program.

Human Behavioral Environment

Human behavioral environment was defined as elements of the Safe and Drug Free School coordinator's human interactions with other individuals, group or institutions (e.g., schools, family, religion) which predispose or facilitate/restrict interprofessional practice within the context of the school district
(Bubolz, Eicher, and Sontag, 1979). The variable was operationally measured as a composite score of perceived environmental resources.

**Environmental support** was a construct measured by the factor analysis of responses to a Likert-type scale score on a fourteen item section of the questionnaire (Questions 20a-20o). The construct included references to resources of time, money and supplies as well as endorsements from other individuals.

**Human Constructed Environment**

The independent variable of the Human Constructed Environment was defined as those structural elements of the environment created by human effort (e.g. clothing, technology, roads/buildings) (Bubolz, Eicher, and Sontag, 1979) that contribute to the coordination of the Safe and Drug Free Schools Program and interprofessional practice. This variable is operationally measured as a composite score and was generated using the constructs and organizational demographics.

**Organizational Demographics** were developed as a two component construct, utilizing information on nature of the community (economic base and number of residents) and nature of the school (size, consortium participation, public/private).

**Natural Environment**

The independent variable of the Natural Environment was defined as elements of environment not controlled by humans (Bubolz, Eicher, and Sontag,
1979) that influence the implementation of interprofessional practice. This variable was operationally measured as a single determinant in the description of the community (rural, urban, suburban, and combined).
Table 1

Definition of Variables

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Operational Definition</th>
<th>Instrument Item</th>
<th>Level of Measurement</th>
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Administration of Data Collection

Instrumentation

A single mailed questionnaire in the form of a booklet was developed according to standard instrument design criteria (Dillman, 1978; Salant & Dillman, 1994). The instrument included measures of the human behavioral, individual variables, human constructed, and natural environment variables as the independent variables. Instrument items were developed by the researcher (Appendix C). Measures of the model variables were not available in application to the Drug Free Schools. The dependent variable of the outcome measure of interprofessional practice was measured as a magnitude of how much and as a process measure of in what way interprofessional practice was occurring.

Data Collection Procedures

Standard data collection procedures for the social sciences were used to collect the data. Criteria established by Dillman (1978) guided the implementation of the data collection process including: (a) cover letter, (b) three stage mailing process, and (c) strategies for handling non-response error.

The Ohio State Department of Education supplied an updated list of Safe and Drug Free School Coordinators, as identified by the school districts for the 1994-1995 school year. A total of 684 coordinators were identified. An initial packet was mailed to each of the 684 identified coordinators on April 17, 1995 that included a questionnaire, return envelope, cover letter and an incentive.
On May 10, 1995 a reminder post card was mailed to each individual who had not returned the initial survey.

On May 19, 1995, a second full packet was mailed to the coordinators who had not yet returned the questionnaire.

Phone calls were made to a random sample of thirty of coordinators who had not responded to the survey during the week of June 5- June 9, encouraging them to return the survey.

Research Questions, Hypotheses and Data Analysis

Research Question 1:

To what extent is interprofessional practice occurring (breadth and depth)?

Hypothesis: Interprofessional practice varies among school districts in Ohio. Some school districts have extensive interprofessional practice activities, whereas some districts have few contacts.

Data Analysis: Interprofessional practice has been defined with component parts of depth and breadth, and a composite score of extent. Determining the occurrence of interprofessional practice and the variation of the occurrence involves the use of descriptive statistics to define the central tendency and dispersion of the scores on these variables. An examination of the frequencies indicated a presence or absence of interprofessional practice variables.
Measures of standard deviation, inter-quartile range, and variance identifies the
degree to which differences occurred between schools in the performance of
interprofessional practice.

**Research Question 2:**

What factors, personal and environmental do coordinators identify as
hindering or helping interprofessional practice?

**Hypothesis 1:** Coordinators will identify elements of their work experience which
are also identified by other coordinators as helping or hindering interprofessional
practice.

**Data Analysis:** Responses to the open ended questions regarding factors which
help (questionnaire item 21) or hinder (questionnaire item 22) interprofessional
practice were compiled into a list for each question. Content analysis of the lists
generated categories of emergent themes. Frequencies of the most common
themes were reported.

**Hypothesis 2:** Elements of the individual coordinator attitude toward
interprofessional practice and demographics correlate with the extent of
interprofessional practice in the Drug Free School Program.
Data Analysis: Factor analysis was also conducted to reduce the number of variables which describe the coordinator’s personal perception of interprofessional practice. Demographic variables and the factors identified were correlated with EXTENT of interprofessional practice.

Hypothesis 3: Elements of the environment correlate with the extent of interprofessional practice in the Drug Free School Program.

Data Analysis: Comparison on means and analysis of variance was used with the variables of community resources including nature of community, community size, and student population. Factor analysis was used with the items which measure perception of community resources. Factors identified were subsequently correlated with EXTENT.

Research Question 3:
Can social workers be distinguished from other professionals in the performance of interprofessional practice?

Hypothesis: Social workers can be distinguished from other professionals in the performance of interprofessional practice. Social workers are more involved than other professions in interprofessional practice.
Data Analysis: Analysis of variance was used to compare the mean score on Extent of Interprofessional Practice for categories of professional identification.

Research Question 4:
Can hindrance or enhancement factors as identified by the human ecological model be used to describe categories of interprofessional practice in the Drug Free Schools initiative?

Hypothesis: Individual and environment variables can be used to differentiate programs by extent of interprofessional practice.

Data Analysis: Logistic regression was conducted using variables of the individual and environments to predict a dichotomous category of extent of interprofessional practice. The dichotomy was generated by differentiating the extent of interprofessional practice as quartiles, and classification of the first and second quartile as low interprofessional practice, and the third and fourth quartiles as high interprofessional practice.

Statistical procedures of multiple regression and discriminant analysis were determined to be inappropriate for exploratory research. Assumptions of these research techniques could not be determined. This exploratory research project could not assume the inclusion of all relevant variables in the derivation
of the multiple regression equation. Discriminant analysis assumptions of equal covariance and a normally distributed population were not met by the data.

**Limitations: Internal Validity**

As the instrument was being developed, evidence of a validation history was not available. Reliability and validity of the instrument was not known. To address this concern, the following process was implemented to address reliability and internal validity issues.

The issues of face and content validity were addressed through the use of an expert panel (Miller, 1994). Face and content validity instruments are included in Appendix A. Panel membership is identified in Appendix B.

Construct validity of the instrument items used to measure the human ecological environments were measured using the comparison of known sources (Miller, 1994). Individuals in the pilot test who were known to be extensively involved in interprofessional practice were compared with individuals known to not be extensively involved. Mean scores on 'extent of interprofessional', practice were higher for those known to be extensively involved (mean = 77) when compared to individuals known to not be extensively involved (mean = 37).

Reliability of the coordinators responses was measured using test-retest reliability measures, except with the open ended questions. A test-retest method was used to estimate reliability and determine a coefficient of stability (Miller, 1994). A pilot test of 5 coordinators' responses to questionnaire items was
compared with their actual responses during the subsequent survey process. The test-retest assessment indicated that 96% agreement existed between the trials.

**Limitations: External Validity**

Threats to external validity caused by sampling error, frame error, and selection error were controlled by the use of the entire population as respondents. The threat of non response error was addressed by the use of standardized survey research techniques with repeated efforts to receive responses from each coordinator. A random sample of 30 of the final group of non-respondents were contacted by phone in the final phase of data collection. Information gathered in the phone contacts were compared between early and late respondents. This review determined no significant differences between respondents and non respondents.

Generalizability to the external populations (i.e., other drug free schools programs or alternative interprofessional practice settings) is a serious concern. Although the entire population of coordinators was measured in this study, the adequacy of the comparability of these results to other programs is not assumed. There has been no attempt to determine the extent to which this population might be a random sample of a larger population, or match significant demographics to warrant consideration of generalizability. The explicit intention of this research was to describe this population and patterns which exist within their interprofessional practice.
CHAPTER IV
FINDINGS AND DATA ANALYSIS

In this chapter, statistical analysis of the responses to survey questions is addressed to test the research hypothesis. Data analysis was completed using SPSS PC Release 6.1. Interpretation of data was based on the texts of Warmbrod (1993, 1994), Hair (1992), Norusis (1990, 1993a, 1993b, 1994), and Stevens (1992).

Data Collection Procedures

A single mailed questionnaire in the form of a booklet was developed according to standard instrument design criteria (Dillman, 1978). The instrument included measures of the human behavioral, human constructed, individual variables, and natural environment variables as the independent variables. The dependent variable of extent of interprofessional practice was measured in terms of breadth and depth of interprofessional practice.

Standard data collection procedures for the social sciences were used to collect the data. Criteria established by Dillman (1978) guided the implementation of the data collection process including: 1) Cover letter design, 2) Three time mailing process, and 3) Strategies for handling non-response.
error. The Ohio State Department of Education supplied a list of Safe and Drug Free School Coordinators, as identified by the school districts for the 1994-1995 school year. A total of 684 coordinators were identified on the list. The initial packet was mailed to each of the 684 identified coordinators on April 17, 1995, and included a questionnaire, return envelope, cover letter and an incentive of a game piece “fortune fish”. On May 10, 1995, a reminder post card was mailed to each individual who had not returned the initial survey (n=402). On May 19, 1995, a second full packet was mailed to those coordinators who had not yet returned the questionnaire (n=354). Phone calls were made to a random sample of thirty of the coordinators who had not responded to the survey during the week of June 5- June 9, 1995.

This collection process resulted in a the return of 494 questionnaires. The remaining questionnaires (n=190) were in three categories: (a) individuals who identified themselves as inappropriate sources of the information (n=14), (b) individuals who were unwilling to complete the survey (n=4), and (c) individuals who were unable to be reached (n=172). Accounting for the misidentified individuals, the response rate of 74% (494/670) was determined.

Demographics

The demographics of communities served by the coordinators are described in terms of the size and sphere of the community served, the nature of the district served, and the nature of the Safe and Drug Free School Program.
The respondents represented all communities in the state of Ohio, as the population of Safe and Drug Free School coordinators was surveyed including at least one coordinator from each school district. The respondents can be characterized by the following demographic details (Table 2).

The majority of respondents served in communities characterized in self report as rural (modal category = 59.7%). This apparent under representation of urban respondents was accounted for by the recognition of the use of “combined community” which included urban with rural or suburban responses.

The modal category of economic base of the respondents is unknown (n=296, 60.2%); the majority of respondents did not indicate the primary economic base. Those individuals who did indicate an economic base, indicated that agriculture was the modal category (n=119, 60.7%).

The modal number of residents was characterized as “less than 10,000" (n=221, 46%). Eighty nine percent of the respondents indicated they served in communities with less than 50,000 residents.

The nature of the district demographics (Table 3) suggests that the typical size of the student population ranged from 1,000 to 2,500 students (mode=41.5%, n=204 ). The majority of respondents were from individual school districts (n=353, 72.8%). The coordinators affiliated with consortiums (n=129, 26.2%) indicated a range of number of schools in affiliation from 2 to 80, with 54% of the cases having 5 or fewer affiliations.
The majority of coordinators indicated that their comprehensive program required additional professionals to implement the program (n=345, 71.3%).

The majority of coordinators indicated that they did contract with other agencies to provide direct services (n=304, 62.6%).
Table 2

**Community Demographics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>286</td>
<td>58.1%</td>
</tr>
<tr>
<td>Urban</td>
<td>37</td>
<td>7.5%</td>
</tr>
<tr>
<td>Suburban</td>
<td>124</td>
<td>25.2%</td>
</tr>
<tr>
<td>Mixed</td>
<td>32</td>
<td>6.5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>13</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Economic Base</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture</td>
<td>119</td>
<td>24.2%</td>
</tr>
<tr>
<td>Industrial</td>
<td>19</td>
<td>3.9%</td>
</tr>
<tr>
<td>Commercial</td>
<td>21</td>
<td>4.3%</td>
</tr>
<tr>
<td>Mixed</td>
<td>37</td>
<td>7.9%</td>
</tr>
<tr>
<td>Unknown</td>
<td>296</td>
<td>60.2%</td>
</tr>
<tr>
<td><strong>Number of Residents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10,000</td>
<td>221</td>
<td>44.9%</td>
</tr>
<tr>
<td>10,000-49,000</td>
<td>198</td>
<td>40.2%</td>
</tr>
<tr>
<td>50,000-99,999</td>
<td>31</td>
<td>6.3%</td>
</tr>
<tr>
<td>100,000-499,999</td>
<td>9</td>
<td>1.8%</td>
</tr>
<tr>
<td>500,000-999,999</td>
<td>2</td>
<td>.4%</td>
</tr>
<tr>
<td>+1,000,000</td>
<td>10</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
Table 3

Demographics of the Safe and Drug Free School Program

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nature of the Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual District</td>
<td>358</td>
<td>72.8%</td>
</tr>
<tr>
<td>Consortium of Districts</td>
<td>129</td>
<td>26.2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Consortium Size</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5</td>
<td>60</td>
<td>54.5%</td>
</tr>
<tr>
<td>6-10</td>
<td>32</td>
<td>29.1%</td>
</tr>
<tr>
<td>11-19</td>
<td>13</td>
<td>.9%</td>
</tr>
<tr>
<td>Unknown</td>
<td>382</td>
<td>77.6%</td>
</tr>
<tr>
<td><strong>Number of Students</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1,000</td>
<td>94</td>
<td>19.1%</td>
</tr>
<tr>
<td>1,000-2,499</td>
<td>204</td>
<td>41.5%</td>
</tr>
<tr>
<td>2,500-4,999</td>
<td>91</td>
<td>18.4%</td>
</tr>
<tr>
<td>5,000-9,999</td>
<td>61</td>
<td>12.4%</td>
</tr>
<tr>
<td>10,000-24,999</td>
<td>18</td>
<td>3.6%</td>
</tr>
<tr>
<td>25,000+</td>
<td>12</td>
<td>2.4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>12</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>School Program</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>381</td>
<td>77.4%</td>
</tr>
<tr>
<td>Private</td>
<td>15</td>
<td>3.0%</td>
</tr>
<tr>
<td>Both</td>
<td>67</td>
<td>13.6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>29</td>
<td>5.9%</td>
</tr>
<tr>
<td><strong>Other Professionals Required?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>139</td>
<td>28.3%</td>
</tr>
<tr>
<td>Yes</td>
<td>345</td>
<td>70.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>8</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Contracts exist?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>182</td>
<td>37.0%</td>
</tr>
<tr>
<td>Yes</td>
<td>304</td>
<td>61.8%</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
<td>1.2%</td>
</tr>
</tbody>
</table>
The research question for this project was: What factors influence the interprofessional practice of social workers and educators in the coordination of the Safe and Drug Free Schools Program in Ohio? In order to answer this question, four sub-questions are addressed in the data analysis. The first sub-question to be addressed is:

Research Question 1
To what extent is interprofessional practice occurring (breadth and depth)?

Hypothesis:
Interprofessional practice varies among school districts Ohio. Some school districts have extensive interprofessional practice activities, whereas some districts have few interprofessional interactions.

Data Analysis:

Interprofessional practice has been defined with component parts of depth and breadth, and a composite score of EXTENT. Determining the occurrence of interprofessional practice and the variation of the occurrence involves the use of descriptive statistics to define the central tendency and dispersion of the scores on these variables. The establishment of mean/median/ mode above zero indicates that each of the variables of interprofessional practice does exist in the population of Safe and Drug Free School coordinators. Measures of standard deviation, inter-quartile range, and variance indicate the degree to which differences occurred between schools in the performance of interprofessional practice.
Professions Participating

Table 4 details each profession identified as participants. Summarizing the details, the following statements can be made.

Professions identified as participating by 50% or more of the coordinators include: Teachers & Teachers Aids (92.6%), Law Enforcement Officials (90.0%), School Administrators (89.4%), Counselors (87.8%), Classroom Teachers (85.4%), Health Care Professionals (83.1%), Substance Abuse Counselors (76.6%), School Support Staff (73.4%), Civic or Government Leaders (62.0%), Psychologist (62.4%), Social Workers (58.7%), Sports Program Directors (55.7%), Social Services Agency Officials (56.9%), Business Persons (55.1%), and Religious Leaders (51.8%).
Table 4

**Professions Involved**

<table>
<thead>
<tr>
<th>Category</th>
<th>Participants</th>
<th>Non Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Health</td>
<td>409</td>
<td>83.1</td>
</tr>
<tr>
<td>Lawyers</td>
<td>134</td>
<td>27.2</td>
</tr>
<tr>
<td>Civic &amp; Gov't Leaders</td>
<td>305</td>
<td>62.0</td>
</tr>
<tr>
<td>Teacher/ Aide</td>
<td>453</td>
<td>92.1</td>
</tr>
<tr>
<td>Business</td>
<td>271</td>
<td>55.1</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>443</td>
<td>90.0</td>
</tr>
<tr>
<td>Paramedic/ Firefighter</td>
<td>136</td>
<td>27.6</td>
</tr>
<tr>
<td>Social Worker</td>
<td>289</td>
<td>58.7</td>
</tr>
<tr>
<td>Psychologist</td>
<td>307</td>
<td>62.4</td>
</tr>
<tr>
<td>Sub. Abuse Counselors</td>
<td>77</td>
<td>76.6</td>
</tr>
<tr>
<td>Homemakers</td>
<td>239</td>
<td>48.6</td>
</tr>
<tr>
<td>Religious Leaders</td>
<td>255</td>
<td>51.8</td>
</tr>
<tr>
<td>School Support Staff</td>
<td>361</td>
<td>73.4</td>
</tr>
<tr>
<td>School Administrator</td>
<td>440</td>
<td>89.4</td>
</tr>
<tr>
<td>Sports Program Dir.</td>
<td>274</td>
<td>55.7</td>
</tr>
<tr>
<td>Youth Prog. Dir.</td>
<td>204</td>
<td>41.5</td>
</tr>
<tr>
<td>Soc. Service Agency</td>
<td>280</td>
<td>56.9</td>
</tr>
<tr>
<td>University Officials</td>
<td>109</td>
<td>22.2</td>
</tr>
<tr>
<td>Counselors</td>
<td>432</td>
<td>87.8</td>
</tr>
<tr>
<td>Consortium Support Staff</td>
<td>142</td>
<td>28.9</td>
</tr>
<tr>
<td>Classroom Teachers</td>
<td>420</td>
<td>85.4</td>
</tr>
<tr>
<td>Media</td>
<td>166</td>
<td>33.7</td>
</tr>
</tbody>
</table>
**Amount of Time Invested**

Amount of time spent with members of each profession are identified by a six point categorical scale: 1= 0 to 5 hours per year, 2= 6 to 10 hours per year, 3= 11-25 hours per year, 4= 25-50 hours per year, 5= 50-100 hours per year, 6= 100 + hours per year. Summary of median category as a measure of centrality, and interquartile range as a measure of dispersion is provided in Table 5.

Summarizing from Table 5 the following statement can be made:

Median categories of 5, 4, and 3 indicate professions identified by the coordinators as on average the most time of direct contact. Professions identified as investing 25-50 hours per year included classroom teachers, teachers and teacher aides. Professions identified as investing 11-25 hours per year include counselors, school administrators, and school support staff. Professions with 6-10 hours per year include law enforcement officers, sports program directors, agency officials, social workers, psychologists, and substance abuse counselors, homemakers, social service agency officials, and consortium support staff.
Table 5

**Time with other Professions**

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Md</th>
<th>Q₁</th>
<th>Q₂</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>421</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lawyers</td>
<td>222</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Civic/Gov't Leaders</td>
<td>335</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Teacher/Aide</td>
<td>442</td>
<td>4</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Business</td>
<td>312</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>428</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Paramedic/ Firefighter</td>
<td>212</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker</td>
<td>327</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Psychologist</td>
<td>329</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Sub. Abuse Counselor</td>
<td>406</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Homemakers</td>
<td>284</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Religious Leaders</td>
<td>291</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>School Support Staff</td>
<td>371</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>School Administrator</td>
<td>439</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Sports Program Dir.</td>
<td>306</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Youth Program Dir.</td>
<td>260</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Soc. Service Agency</td>
<td>311</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Univ. Officials</td>
<td>181</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Counselors</td>
<td>420</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Consortium Support Staff</td>
<td>212</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Classroom Teachers</td>
<td>412</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Media</td>
<td>227</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Perceived Commitment

Perceived commitment of members of each profession were identified on a six point Likert Type scale: 1 = no commitment, 2 = slight commitment, 3 = moderate commitment, 4 = strong commitment, and 5 = very strong commitment. Perceived commitment is reported in Table 6. Summary of median category of perceived commitment as a measure of centrality, and interquartile range as a measure of dispersion are provided. Professions identified by each coordinator as the most committed to the Safe and Drug Free Schools Program are substance abuse counselors (Median = 5). Professions identified by the coordinators as having a strong to very strong commitment to the Safe and Drug Free Schools programs included: Teachers/Teachers Aids (median = 4), Paramedics and Fire Fighters (median = 4), Social Workers (median = 4), Psychologists (median = 4), Religious Leaders (median = 4), School Support Staff (median = 4), School Administrators (median = 4), Sports Program Directors (median = 4), Youth Program Directors (median = 4), Social Service Agency Officials (median = 4) and Counselors (median = 4).
Table 6
Perceived Commitment

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Mdn</th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>441</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Lawyers</td>
<td>307</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Civic/ Gov't Leaders</td>
<td>417</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Teacher / Aide</td>
<td>463</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Business</td>
<td>396</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>456</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Paramedic / Firefighter</td>
<td>335</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Social Worker</td>
<td>390</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Psychologist</td>
<td>401</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Sub. Abuse Counselors</td>
<td>434</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Homemakers</td>
<td>367</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Religious Leaders</td>
<td>392</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>School Support Staff</td>
<td>433</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>School Administrator</td>
<td>457</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Sports Program Dir.</td>
<td>393</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Youth Program Dir.</td>
<td>346</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Soc. Service Agency</td>
<td>383</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Univ. Officials</td>
<td>228</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Counselors</td>
<td>436</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Media / Radio Personalities</td>
<td>303</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
**Extent of Interprofessional Practice**

Extent of interprofessional practice is also characterized by the summative effect of the number of diverse people involved and the amount of time invested in interprofessional practice. The EXTENT statistical variable is a continuous variable and was generated for each respondent by the addition of the total number of professions involved in interprofessional practice (breadth) with the categorical response to the amount of time invested in interprofessional practice (depth).

The total number of professionals involved (Breadth) had a mean of 13.207 professions and a standard deviation of 5.31. The median score was 14 professions with a range of 24 and an interquartile range of 8. The distribution of scores was slightly platykurtic (flat) with a kurtosis value of -.360 and slightly negatively skewed with a skewness of -.462. Figure 2 details this distribution in comparison to a normal distribution.
Figure 2

Distribution of Breadth
The sum of the categorical values of hours involved with other professionals (depth) had a mean of 34.683 and a standard deviation of 21.916. The median depth was 32 with a range of 102 and interquartile range of 28. The distribution was slightly leptokurtic (peaked) with a kurtosis of .182 and slightly positively skewed with a skewness value of .667. Figure 3 details this distribution in comparison to a normal distribution.

Figure 3

Distribution of Depth
The summary variable of EXTENT of interprofessional practice had a mean of 50.287 and standard deviation of 24.337. The median score was 47.000 with a range of 119.00 and interquartile range of 33.000. The distribution was slightly platykurtic (flat) with a kurtosis value of -.088. The distribution is slightly positively skewed from the normal distribution with a skewness value of .576. Figure 4 details this distribution in comparison to a normal distribution.

Figure 4

Distribution of EXTENT
Interprofessional Practice as a Team Activity

Some coordinators reported that interprofessional practice involved small group activities (n=444). These respondents reported variations in the agreement on whether elements of team activity were present in the coordination of the program. Table 7 identifies the central tendencies and dispersion of agreement scores on particular elements of team activities. Use of the criteria of standard deviations of less than one to indicate agreement, and median categories to indicate the category of agreement, the following statements are interpreted.

The coordinators, as a group, tended to agree that: 1) interprofessional teams work well together (median=4), 2) members share their expertise easily with other team members (median =4), and 3) positive relationships exist between team members (median = 4).

Using the interpretation criteria of standard deviations greater than one as indicative of variance in the category of agreement, and criteria of median as the most central statement, the following conclusions are interpreted. The majority of coordinators moderately agreed with the statement that interprofessional practice is a key mode of comprehensive services, although variance in the degree of agreement existed (median = 5). The majority of coordinators tended to agree that there existed positive relationships between team members (median=4). The majority of coordinators tended to disagree that group members were unable to negotiate conflicts (median = 2).
A significant portion (n=50) were unable to respond to some of the measures of team activity. Appendix D describes the comments in the margin of questionnaire items which measured team building concepts. The comments reflect the respondents perspective which questioned the actual team building concepts of interprofessional practice and/or stated that interprofessional collaboration was not synonymous with team work.
Table 7

Interprofessional Practice as a Team Activity

<table>
<thead>
<tr>
<th>Team Activity</th>
<th>M</th>
<th>SD</th>
<th>Mdn*</th>
<th>Q_1</th>
<th>Q_2</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPP is a key mode of providing comprehensive services</td>
<td>4.75</td>
<td>1.12</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Team members work well together</td>
<td>4.48</td>
<td>.99</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Members share their expertise</td>
<td>4.47</td>
<td>.96</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Members conflict over leadership role</td>
<td>2.64</td>
<td>1.17</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Members are unable to negotiate conflicts</td>
<td>2.46</td>
<td>2.21</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Time is set aside to review team process</td>
<td>3.46</td>
<td>1.15</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Professional development exists in team practice</td>
<td>3.45</td>
<td>1.21</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Positive relationships exist between team members</td>
<td>4.46</td>
<td>.95</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>IPP is a rarely chosen mode of practice</td>
<td>3.12</td>
<td>1.32</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

IPP=Interprofessional Practice

* Note, responses were 6 point Likert-type responses. 1=strongly disagree and 6=strongly agree.
Research Question 2

What factors, personal and environmental do coordinators identify as hindering or helping interprofessional practice?

Hypothesis

Coordinators will identify emergent themes of their work experience identified as helping or hindering interprofessional practice.

Elements of the individual coordinator correlate with the EXTENT of interprofessional practice in the Safe and Drug Free School Program.

Elements of the environment will correlate with the EXTENT of interprofessional practice in the Safe and Drug Free School Program.

Data Analysis:

This research question was addressed using three strategies. The first strategy involved the compilation of responses to the open ended questions regarding factors which help or hinder interprofessional practice. Appendix E details the responses to questionnaire item 21 which states: "List conditions/resources which are most essential for interprofessional practice in the coordination of the Safe and Drug Free Schools Program." Appendix F details the responses to questionnaire item 22 which states: "List the barriers to interprofessional practice in the coordination of the Safe and Drug Free Schools Program."

Content analysis of the lists generated categories of emergent themes. Emergent themes were identified by repeated readings of the lists. A list of key
words was generated which identified the nuances of meaning. Common meanings were then reorganized together. Table 8 details the nine most frequent items mentioned in each questionnaire item and the frequency of the observation. Surprisingly, similar emergent themes appeared in both lists. Those resources identified as essential are simultaneously the resources which were identified as barriers when absent.

Open ended questions were designed to address the challenges of the deductive, quantitative measurement techniques used throughout the research. The open ended questions offered the respondents the opportunity to identify factors which helped or hindered interprofessional practice without the constraints of instrument identified options. The categories identified in the open ended responses correspond with the quantitative instrument items, further supporting the appropriateness of the instrument items.
Table 8

**Emergent Themes of Helping and Hindering**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Helping</th>
<th>Hindering*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>201</td>
<td>240</td>
</tr>
<tr>
<td>Money</td>
<td>90</td>
<td>104</td>
</tr>
<tr>
<td>Staff/ Personnel</td>
<td>59</td>
<td>37</td>
</tr>
<tr>
<td>Cooperation</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>Collaboration</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Materials/ Services</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Goals</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Vision/ Leadership</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Facilities</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

* Note: When identifying hindering factors, coordinators reported that lack of these resources hindered interprofessional practice.
Correlations between characteristics of the individual with EXTENT of interprofessional practice indicate significant relationships (Table 9). Previous experience in prevention and years living in the community were not significantly correlated with the EXTENT of interprofessional practice. A moderate positive relationship ($r = .50$) existed between the amount of professional time allocated to the Safe and Drug Free Schools program and EXTENT of interprofessional practice. Those individuals who had more professional time assigned had higher scores in EXTENT of interprofessional practice.
### Table 9

**Individual Variables Correlated With EXTENT**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$r$</th>
<th>$N$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Years Active with DFS</td>
<td>.09</td>
<td>445</td>
<td>.066</td>
</tr>
<tr>
<td>Number of Years Active in Prevention</td>
<td>.05</td>
<td>444</td>
<td>.287</td>
</tr>
<tr>
<td>Number of Years Living in the Community</td>
<td>.06</td>
<td>443</td>
<td>.179</td>
</tr>
<tr>
<td>Percent Time Allocated to DFS</td>
<td>.50</td>
<td>432</td>
<td>.000</td>
</tr>
<tr>
<td>Percent Time in IPP With other Professions</td>
<td>.21</td>
<td>425</td>
<td>.000</td>
</tr>
<tr>
<td>Percent Time Implementing the Curriculum</td>
<td>.22</td>
<td>429</td>
<td>.000</td>
</tr>
</tbody>
</table>
Mean comparisons through one way analysis of variance on variables is used to classify cases independent groups. Analysis of variance of community variables on the EXTENT of interprofessional practice further highlights the relationship. The box plots for the community description groups suggest that differences exist between the means based on nature of community (Figure 5), community size (Figure 6), and student population (Figure 7).

Two assumptions of ANOVA must be tested prior to completing the statistical analysis. The Levene test was used to test the hypothesis that the groups come from populations with the same variance. Levine test for Type of Community (3.15) and Community Size (2.12) were significant at $p < .05$. The situation supported the rejection of the null hypothesis. There exists sufficient evidence to suspect the variances are unequal. The assumption that each group is a random sample from a normal population is tested by observation of Lilliefors test of normalcy and comparing the significance level with the apriori alpha $p < .05$). The test of normalcy on each of the variables has a mixed outcome. Some variables reject the null. Some deviation from normal is expected and acceptable for level of analysis.
Figure 5

Box Plot of Nature of Community
Figure 6

Box Plot of Community Size
Figure 7

Box Plot of Student Population
Table 10 highlights the differences between mean scores on the EXTENT of interprofessional practice for groups defined by demographic characteristics. Patterns can be determined from these scores. Programs characterized as urban (mean = 65.26), suburban (mean = 56.59) and combined communities (56.38) had higher mean scores on interprofessional practice than programs in rural communities (mean = 44.79). Eight percent of the variance in EXTENT can be accounted for by knowing the nature of the community (eta squared = .081). Programs in communities with more residents (100,000 or more) had higher mean scores on EXTENT of interprofessional practice than programs in small communities (less than 100,000). Knowing the size of the community accounts for 10% of the variance in EXTENT (eta squared - .101). Programs which served more students had higher mean scores when compared to all categories of smaller student population size. Twelve percent of the variance in EXTENT can be explained by knowing the student population size.
Table 10

Mean Comparison of Community Demographics

<table>
<thead>
<tr>
<th>Nature of the Community</th>
<th>Mean</th>
<th>Cases</th>
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</thead>
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<tr>
<td>Entire Population</td>
<td>50.29</td>
<td>451</td>
</tr>
<tr>
<td>Rural community</td>
<td>44.79</td>
<td>268</td>
</tr>
<tr>
<td>Urban community</td>
<td>65.26</td>
<td>35</td>
</tr>
<tr>
<td>Suburban community</td>
<td>56.60</td>
<td>119</td>
</tr>
<tr>
<td>Combined community</td>
<td>56.38</td>
<td>29</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Between Groups</td>
<td>3</td>
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<tr>
<td>Within Groups</td>
<td>447</td>
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<tr>
<td>Eta = .28</td>
<td></td>
</tr>
<tr>
<td>Eta Squared = .08</td>
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</table>

<table>
<thead>
<tr>
<th>Community Size</th>
<th>Mean</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire Population</td>
<td>50.35</td>
<td>444</td>
</tr>
<tr>
<td>Less than 10,000</td>
<td>42.39</td>
<td>206</td>
</tr>
<tr>
<td>10,000-49,999</td>
<td>55.74</td>
<td>188</td>
</tr>
<tr>
<td>50,000 - 99,000</td>
<td>61.77</td>
<td>30</td>
</tr>
<tr>
<td>100,000 - 499,999</td>
<td>69.56</td>
<td>9</td>
</tr>
<tr>
<td>500,000 - 999,999</td>
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<td>2</td>
</tr>
<tr>
<td>+1,000,000</td>
<td>58.22</td>
<td>9</td>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Between Groups</td>
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</tr>
<tr>
<td>Within Groups</td>
<td>438</td>
</tr>
<tr>
<td>Eta = .32</td>
<td></td>
</tr>
<tr>
<td>Eta Squared = .10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Population</th>
<th>Mean</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire Population</td>
<td>50.43</td>
<td>454</td>
</tr>
<tr>
<td>Less than 1,000</td>
<td>39.44</td>
<td>89</td>
</tr>
<tr>
<td>1,000 - 2,499</td>
<td>48.10</td>
<td>193</td>
</tr>
<tr>
<td>2,500 - 4,999</td>
<td>52.58</td>
<td>87</td>
</tr>
<tr>
<td>5,000 - 9,999</td>
<td>61.81</td>
<td>57</td>
</tr>
<tr>
<td>10,000 - 24,999</td>
<td>68.88</td>
<td>17</td>
</tr>
<tr>
<td>25,000+</td>
<td>75.73</td>
<td>11</td>
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</table>

<table>
<thead>
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<th>F</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>5</td>
</tr>
<tr>
<td>Within Groups</td>
<td>448</td>
</tr>
<tr>
<td>Eta = .3466</td>
<td></td>
</tr>
<tr>
<td>Eta Squared = .1202</td>
<td></td>
</tr>
</tbody>
</table>

** significance at p < .01
The third strategy involves the refinement of the concepts of helping and hindering factors by using factor analysis to determine underlying concepts of coordinator's attitude and perception of interprofessional practice. The coordinator's perception of resources available provides insight on factors of the environment which contribute to interprofessional practice. The coordinators attitudes toward interprofessional practice provide insight on factors of the individual which contribute to EXTENT of interprofessional practice. Results of factor analysis of questionnaire items identified as measuring coordinator attitude and factor analysis of items related to coordinator perception of resources are correlated to EXTENT of interprofessional practice.

**Perception of Resources**

Factor analysis of the coordinator's perceptions of resources available for interprofessional practice involved an exploratory factor analysis process to reduce the number of variables between questions 20a and 20n.

There are four assumptions of factor analysis 1) correlations among common factors are zero. 2) Correlations among common factors of the unique factors are zero. 3) Correlations among unique factors are zero, and 4) For all factors, the factor scores have a mean =0 and variance = 1. Each of these assumptions is assured throughout the analysis.

The goal of the factor analysis is data reduction by identifying of underlying concepts (factors). Factor analysis generates a factor score which is
a linear combination of common factors and the unique factor. In order to achieve this, there are 3 tests of the assumptions. First, examination of the original correlation matrix (Table 11) assures a minimal relationship (common factors) between the variables. Items 20G and 20L may not be related to other items as they share correlations of less than .3 with all other variables. However, these variables are maintained in the factor analysis. The remaining variables share correlations greater than .3 with at least one other variable, and therefore assure the assumption of underlying relationships between the items measured.
### Table 11

**Original Correlation Matrix of Perception of Community**

<table>
<thead>
<tr>
<th></th>
<th>Willing</th>
<th>Available</th>
<th>RT</th>
<th>RE</th>
<th>Space</th>
<th>NL</th>
<th>IFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willing</td>
<td>1.00</td>
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<td></td>
<td></td>
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<tr>
<td>Available</td>
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<td>1.00</td>
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</tr>
<tr>
<td>RT</td>
<td>.39</td>
<td>.25</td>
<td>1.00</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RE</td>
<td>.25</td>
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<td></td>
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<tr>
<td>Space</td>
<td>-.12</td>
<td>-.05</td>
<td>-.13</td>
<td>-.10</td>
<td>1.00</td>
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<td></td>
</tr>
<tr>
<td>NL</td>
<td>.24</td>
<td>.14</td>
<td>.29</td>
<td>.11</td>
<td>-.28</td>
<td>1.00</td>
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<tr>
<td>IFR</td>
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<td>-.06</td>
<td>.12</td>
<td>.09</td>
<td>.08</td>
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</tr>
<tr>
<td>Tech</td>
<td>-.15</td>
<td>-.09</td>
<td>-.21</td>
<td>-.06</td>
<td>.32</td>
<td>-.21</td>
<td>.18</td>
</tr>
<tr>
<td>CR</td>
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<td>-.01</td>
<td>-.21</td>
<td>-.13</td>
<td>.26</td>
<td>-.20</td>
<td>.05</td>
</tr>
<tr>
<td>OP</td>
<td>.33</td>
<td>.13</td>
<td>.25</td>
<td>.32</td>
<td>-.17</td>
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<td>.001</td>
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<tr>
<td>UI</td>
<td>-.32</td>
<td>-.09</td>
<td>-.20</td>
<td>-.09</td>
<td>.12</td>
<td>-.05</td>
<td>.03</td>
</tr>
<tr>
<td>SD</td>
<td>-.24</td>
<td>-.12</td>
<td>-.12</td>
<td>-.14</td>
<td>.18</td>
<td>-.10</td>
<td>.04</td>
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<tr>
<td>PE</td>
<td>.35</td>
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<td>.32</td>
<td>.18</td>
<td>-.13</td>
<td>.20</td>
<td>.01</td>
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<tr>
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<td>.28</td>
<td>.17</td>
<td>-.05</td>
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<td>.02</td>
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<table>
<thead>
<tr>
<th></th>
<th>Tech</th>
<th>CR</th>
<th>OP</th>
<th>UI</th>
<th>SD</th>
<th>PE</th>
<th>CS</th>
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<tbody>
<tr>
<td>Tech</td>
<td>1.00</td>
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<td>CR</td>
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<td>1.00</td>
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<td>SD</td>
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<td>-.21</td>
<td>.26</td>
<td>1.00</td>
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<tr>
<td>PE</td>
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<td>.31</td>
<td>-.26</td>
<td>-.33</td>
<td>1.00</td>
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<tr>
<td>CS</td>
<td>-.15</td>
<td>-.15</td>
<td>.41</td>
<td>-.30</td>
<td>-.17</td>
<td>.60</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**RT** = Release time is provided.  
**RE** = Effective prevention requires collaboration.  
**NL** = Neutral location.  
**IFR** = Interprofessional team has inadequate financial resources.  
**Tech** = Infrastructure technology inadequate.  
**CR** = Curriculum restricts interprofessional practice.  
**OP** = Program offers opportunities for interprofessional practice.  
**UI** = Community representatives are uninterested in programs.  
**SD** = Supervisors discourage interprofessional practice.  
**PE** = Other school personnel encourage interprofessional practice.  
**CS** = Outside community is supportive of interprofessional practice.
Tests of the assumptions of factor analysis included measures of sphericity and sampling adequacy. Bartlett's Test of Sphericity (1071.05 significant at p < .01) assures that the correlation matrix is not an identity matrix (i.e. the test rejects the null hypothesis that the correlation matrix is an identity matrix) and assures the assumption that the sample is from a multivariate normal population. The Kaiser-Meyer Olkin measure of sampling adequacy (MSA) compares the correlation coefficients to the partial correlation coefficients. KMO (.78049) indicates adequate sampling size as it is above .5.

Examination of the anti-image correlation matrix (Table 12) provides two pieces of information. First, the measure sampling adequacy (MSA) is printed on the diagonal. Reasonable large (+.7) MSA's are indicative of a good sample size, and only item 20g does not meet this criteria. The partial correlation coefficients are also reported in the anti-image correlation matrix and reflect the correlations between unique factors which should be zero. All the partial correlation coefficients are below .3 (except 20 m and 20n) which indicates the factors are not correlated.
Table 12

Anti-Image Correlation Matrix of Perception of Community

<table>
<thead>
<tr>
<th></th>
<th>Willing</th>
<th>Available</th>
<th>RT</th>
<th>RE</th>
<th>Space</th>
<th>NL</th>
<th>IFR</th>
</tr>
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<tbody>
<tr>
<td>Willing</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<td>Available</td>
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<tr>
<td>RE</td>
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</tr>
</tbody>
</table>

Measures of Sampling Adequacy (MSA) are printed on the diagonal

RT = Release time is provided.
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PE = Other school personnel encourage interprofessional practice.
CS = Outside community is supportive of interprofessional practice.
The decision to maintain four factors is based on several standards. The first standard is the apriori eigen value minimum of 1 and the cumulative percent of variance explained of 53% (Table 13). Communality is the squared multiple correlation coefficient (SMC) between each variable in the observed variable set and the linear relationship of all variables in the variable set. The communality is a measure of the adequacy of the model in explaining the variance in particular items. The communality is the proportion of variance in the variable explained by the common factors. For this model, at least 40% of common variance was explained and therefore the model was determined to be useful. The scree plot (Figure 8) substantiates this decision by demonstrating the leveling off of variance explained with the fifth factor.
Figure 8

Factor Scree Plot of Perception of Community
Table 13

Initial Statistics of Factor Analysis on Perception of Community

<table>
<thead>
<tr>
<th>Variable</th>
<th>Communality</th>
<th>Factor</th>
<th>Eigenvalue</th>
<th>Pct of Var</th>
<th>Cum Pct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willing</td>
<td>1.00</td>
<td>* 1</td>
<td>3.63</td>
<td>25.9</td>
<td>25.9</td>
</tr>
<tr>
<td>Available</td>
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<td>* 2</td>
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<td>36.3</td>
</tr>
<tr>
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<td>* 3</td>
<td>1.21</td>
<td>8.7</td>
<td>45.0</td>
</tr>
<tr>
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<td>1.00</td>
<td>* 4</td>
<td>1.13</td>
<td>8.0</td>
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</tr>
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<td>71.4</td>
</tr>
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<td>5.2</td>
<td>76.7</td>
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<tr>
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<td>81.5</td>
</tr>
<tr>
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<td>4.6</td>
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<tr>
<td>UI</td>
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<td>* 14</td>
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</tr>
</tbody>
</table>

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PE = Other school personnel encourage interprofessional practice.
CS = Outside community is supportive of interprofessional practice.
Factor loadings for the four factors are reported in Table 14. These factor loadings are correlation coefficients between the item and the factor score. According to Stevens (1992, p. 383) factor loadings of .258 (2 x .129) are considered significant for a sample size of 400. Bold correlations are identified as loading on the respective factor.
### Table 14

**Factor Matrix of Perception of Community**

<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
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<td>.06</td>
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<td>-.17</td>
<td>.60</td>
</tr>
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<td>-.59</td>
<td>.17</td>
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<td>-.06</td>
<td>-.003</td>
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<td>.42</td>
<td>.25</td>
<td>.15</td>
</tr>
<tr>
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<td>UI</td>
<td>-.50</td>
<td>-.01</td>
<td>-.09</td>
<td>.47</td>
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<tr>
<td>SD</td>
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<td>.07</td>
<td>.42</td>
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<td>-.13</td>
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</table>

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CS = Outside community is supportive of interprofessional practice.
Conceptual relationships are difficult to identify among the unrotated factors. There appears to be no identifiable underlying relationship between items loading together on the same factor. In order to more clearly observe the relationships between items and the factors, the statistical procedure of varimax and oblim rotations were completed. The Oblim rotation did not converge within 25 interactions and was eliminated from consideration.

Varimax rotation was completed in 7 iterations and the rotated factor matrix is reported in Table 15. The varimax rotation is an orthogonal rotation which maintains the quality of the original factors of uncorrelated relationship between the factors. The varimax rotation process does not affect the model's goodness of fit, communalities and percent of total variance explained, although the percent of variance explained by each factor is altered. The varimax rotation facilitates a more obvious loading pattern by facilitating the high loading on one factor and limiting the loading on other factors. In this manner, a clearer picture of the relationship between items can be observed. Factor loadings of each variable are noted in the Rotated Factor matrix (Table 16). Those values above .5 have been underlined to note loadings on a factor.
<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
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<td>.03</td>
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<td>.36</td>
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<td>-.10</td>
<td>.22</td>
<td>.73</td>
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<tr>
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<td>-.13</td>
<td>.66</td>
<td>.19</td>
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<td>.61</td>
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<td>.39</td>
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<td>.19</td>
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<td>CS</td>
<td>.59</td>
<td>.48</td>
<td>.07</td>
<td>.22</td>
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</table>

RT = Release time is provided.  
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Table 16

Rotated Factor Statistics on Perception of Community

<table>
<thead>
<tr>
<th>Variable</th>
<th>Communality</th>
<th>Factor</th>
<th>Eigenvalue</th>
<th>Pct of Var</th>
<th>Cum Pct</th>
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<td></td>
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<td>*</td>
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<td></td>
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<tr>
<td>PE</td>
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<td></td>
<td></td>
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<tr>
<td>CS</td>
<td>.64</td>
<td>*</td>
<td></td>
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</tr>
</tbody>
</table>

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The covariance matrix describes the relationship between scores on each rotated factor and the remaining factors (Table 17). The scores of zero on each of these covariances suggests that relationship between the discrete factors remains insignificant.

Table 17

Covariance Matrix for Estimated Regression Factor Scores on Perception of Community

<table>
<thead>
<tr>
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<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
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<td></td>
</tr>
<tr>
<td>Factor 2</td>
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<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 3</td>
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<td>0.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Based on the conceptual connections on the factor loadings, names are given to the factors.

**Factor 1 Name: Community Support**

<table>
<thead>
<tr>
<th>Variable Concept</th>
<th>Loading Direction</th>
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</thead>
<tbody>
<tr>
<td>Community representatives uninterested (20k)</td>
<td>(-)</td>
</tr>
<tr>
<td>Supervisors discourage interprofessional practice (20l)</td>
<td>(-)</td>
</tr>
<tr>
<td>Other school personnel encourage (20w)</td>
<td>(+)</td>
</tr>
<tr>
<td>Community is supportive (20n)</td>
<td>(+)</td>
</tr>
</tbody>
</table>

**Factor 2 Name: Availability of Personnel**

<table>
<thead>
<tr>
<th>Variable Concept</th>
<th>Loading Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community resources willing to participate (20a)</td>
<td>(+)</td>
</tr>
<tr>
<td>Enough agencies exist (20b)</td>
<td>(+)</td>
</tr>
<tr>
<td>Professionals given release time (20c)</td>
<td>(+)</td>
</tr>
</tbody>
</table>

**Factor 3 Name: Implementation Resources**

<table>
<thead>
<tr>
<th>Variable Concept</th>
<th>Loading Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space (20e)</td>
<td>(+)</td>
</tr>
<tr>
<td>Adequate Technology (20H)</td>
<td>(+)</td>
</tr>
<tr>
<td>Curriculum restricts opportunities (20 I)</td>
<td>(+)</td>
</tr>
</tbody>
</table>
Factor 4 Name: Need for Investment Resources

<table>
<thead>
<tr>
<th>Variable Concept</th>
<th>Loading Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness requires collaboration (20D)</td>
<td>(+)</td>
</tr>
<tr>
<td>Financial resources are inadequate (20G)</td>
<td>(+)</td>
</tr>
</tbody>
</table>

The factor score coefficient matrix is the coefficient for the variable on each factor which is used to determine the individual score for the respondent on the particular factor (Table 18). This calculated score was added to the data base. The correlation between the calculated score on each factor and EXTENT of interprofessional practice was used to determine a relationship between the variables (Table 19). The following relationships were determined to be relevant. Availability of personnel from the community had a low correlation with EXTENT of interprofessional practice ($r = .11$). Coordinators which indicated that community resources were available for interprofessional practice also had greater scores on EXTENT of interprofessional practice. The recognition of the need for investment resources had a low correlation with EXTENT of interprofessional practice ($r = .20$). Coordinators who indicated a value of interprofessional practice and need for financing also had higher scores on EXTENT of interprofessional practice.
Table 18

Factor Score Coefficient Matrix on Perception of Community

<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
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<tr>
<td>Willing</td>
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<td>.26</td>
<td>.11</td>
<td>.09</td>
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<tr>
<td>Available</td>
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<td>.10</td>
<td>-.24</td>
</tr>
<tr>
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<td>-.09</td>
<td>.38</td>
<td>-.04</td>
<td>-.06</td>
</tr>
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<td>-.08</td>
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<td>.43</td>
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RT = Release time is provided.
RE = Effective prevention requires collaboration.
NL = Neutral location.
IFR = Interprofessional team has inadequate financial resources
Tech = Infrastructure technology inadequate.
CR = Curriculum restricts interprofessional practice.
OP = Program offers opportunities for interprofessional practice.
UI = Community representatives are uninterested in programs
SD = Supervisors discourage interprofessional practice.
PE = Other school personnel encourage interprofessional practice.
CS = Outside community is supportive of interprofessional practice.
Table 19

Correlations Between EXTENT and Factors of Community

<table>
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<th>Community Factor</th>
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<th>N</th>
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Coordinator Attitude

Factor analysis of the coordinator's attitude toward interprofessional practice involved an exploratory factor analysis process to reduce the number of variables between questions 16a-16m.

There are four assumptions of factor analysis 1) correlations among common factors are zero, 2) Correlations among common factors of the unique factors are zero, 3) Correlations among unique factors are zero, and 4) For all factors, the factor scores have a mean = 0 and variance = 1. Each of these assumptions is assured throughout the analysis.

The goal of the factor analysis is data reduction by identification of underlying concepts (factors). Factor analysis generates a factor score which is
a linear combination of common factors and the unique factor. In order to achieve this, there are 3 tests of the assumptions. First, examination of the original correlation matrix (Table 20) suggests that items 16 h and 16 m are not correlated with any of the other variables in a substantial pattern to warrant their inclusion in the model. These items are removed from the factor analysis and analyzed in relationship to the EXTENT of interprofessional practice in another format. The remaining variables share correlations greater than .3 with at least one other variable, and therefore assure the assumption of underlying relationships between the items measured (Table 21).
Table 20

Original Correlation Matrix of Personal Attitude

<table>
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<tr>
<th></th>
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</tbody>
</table>

IP = Interprofessional Practice  
PE= Previous Experience  
NIP= IP not important for prevention.  
UID = IP unimportant for successful DFS  
PR = Personal Rewards  
RP =Rewarding for my profession  
CIP=Committed to IP  
UM =Coordination of IP is unmanageable  
Train = Training or instruction in IP  
GP =Generally pessimistic toward IP  
CD =Committed to IP in coordination of DFS  
Avoid = Would avoid working with other professions  
EMP = Prevention requires expertise of many professions  
CBP = Prevention should be a community based program.
**Table 21**

**Correlation Matrix of Personal Attitude**

<table>
<thead>
<tr>
<th></th>
<th>PE</th>
<th>NIP</th>
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<th>PR</th>
<th>RP</th>
<th>CIP</th>
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PE = Previous Experience  
NIP = IP not important for prevention.  
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UM = Coordination of IP is unmanageable  
GP = Generally pessimistic toward IP  
CD = Committed to IP in coordination of DFS  
Avoid = Would avoid working with other professions  
EMP = Prevention requires expertise of many professions
Tests of the assumptions of factor analysis included Bartlett's Test of Sphericity (1850.40, significant at \( p < .01 \)). This score assures that the correlation matrix is not an identity matrix (i.e. the test rejects the null that the correlation matrix is an identity matrix) and assures the assumption that the sample is from a multivariate normal population. The Kaiser-Meyer Olkin measure of sampling adequacy (MSA) compares the correlation coefficients to the partial correlation coefficients. KMO (.85) indicates adequate sampling size as it is above .5.

Examination of the anti-image correlation matrix (Table 22) provides two pieces of information. First, the measure sampling adequacy (MSA) is printed on the diagonal. Reasonably large (+.7) MSA's are indicative of a good sample size. The partial correlation coefficients are also reported in the anti-image correlation matrix and reflect the correlations between unique factors which should be zero. All the partial correlation coefficients are below .3 (except 16e and 16f) which indicates the factors are not correlated.
Table 22

Anti-Image Correlation Matrix of Personal Attitude

<table>
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Measures of Sampling Adequacy (MSA) are printed on the diagonal.

IP = Interprofessional Practice
PE = Previous Experience
NIP = IP not important for prevention.
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EMP = Prevention requires expertise of many professions
Two factors were identified by principal component analysis (Table 23). The decision to maintain two factors is based on several criteria. The apriori eigen value minimum of 1 and the cumulative percent of variance explained of 52.5% is adequate. The scree plot (Figure 9) substantiates this decision by demonstrating the leveling off of variance explained with the third factor.

Figure 9
Factor Scree Plot on Personal Attitude
Table 23

Factor Matrix of Personal Attitude

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</table>

IP = Interprofessional Practice
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Avoid = Would avoid working with other professions
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Communality is the squared multiple correlation coefficient (SMC) between each variable in the observed variable set and the linear relationship of all variables in the variable set (Warmbrod, 1994). Communality is a measure of the adequacy of the model in explaining the variance in particular items. The communality score is the decimal representation of the percentage of common variation of each variable with the use of four factors. For this model at least 30% of common variance was explained and therefore the model was determined to be useful.

Factor loadings for the two factors are also reported in Table 23. These factor loadings are correlation coefficients between the item and the factor score. According to Stevens (1992, p. 383) factor loadings of .258 (2 x .129) are considered significant for a sample size of 400. Bolded correlations are identified as loading on the respective factor. Only one factor loads significantly on factor 2 and therefore conceptual relationships are difficult to identify among the unrotated factors. In order to more clearly observe the relationships between items and the factors, the statistical procedure of varimax and oblim rotations were completed.

The Oblim and Varimax rotations were examined for consideration, with similar results in the loadings of items onto factors. Varimax rotation was chosen for inclusion. This decision was made to maintain the uncorrelated relationships between factors of the orthogonal rotation. The oblique rotation of OBLIM could include a correlation between the factors.
Varimax rotation was completed in 3 iterations and the rotated factor matrix is reported in Table 24. The varimax rotation is a more obvious loading pattern by facilitating the high loading on one factor and limiting the loading on other factors. In this manner, a clearer picture of the relationship between items can be observed.
Table 24

Varimax Rotated Factor Matrix of Personal Attitude

<table>
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<th>Factor 1</th>
<th>Factor 2</th>
</tr>
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<tr>
<td>PE</td>
<td>.33</td>
<td>-.44</td>
</tr>
<tr>
<td>NIP</td>
<td>-.14</td>
<td>.77</td>
</tr>
<tr>
<td>UID</td>
<td>-.01</td>
<td>.76</td>
</tr>
<tr>
<td>PR</td>
<td>.84</td>
<td>-.02</td>
</tr>
<tr>
<td>RP</td>
<td>.87</td>
<td>-.20</td>
</tr>
<tr>
<td>CIP</td>
<td>.79</td>
<td>-.36</td>
</tr>
<tr>
<td>UM</td>
<td>-.29</td>
<td>.37</td>
</tr>
<tr>
<td>GP</td>
<td>-.29</td>
<td>.56</td>
</tr>
<tr>
<td>CD</td>
<td>.68</td>
<td>-.42</td>
</tr>
<tr>
<td>Avoid</td>
<td>-.16</td>
<td>.61</td>
</tr>
<tr>
<td>EMP</td>
<td>.33</td>
<td>-.51</td>
</tr>
</tbody>
</table>

IP = Interprofessional Practice
PE = Previous Experience
NIP = IP not important for prevention.
UID = IP unimportant for successful DFS
PR = Personal Rewards
RP = Rewarding for my profession
CIP = Committed to IP
UM = Coordination of IP is unmanageable
GP = Generally pessimistic toward IP
CD = Committed to IP in coordination of DFS
Avoid = Would avoid working with other professions
EMP = Prevention requires expertise of many professions

The covariance matrix describes the relationship between scores on each rotated factor and the remaining factors. The scores of zero on each of these covariances suggest that the relationship between the factors remains insignificant (Table 25).
Table 25

Covariance Matrix for Estimated Regression Factor Scores On Personal Attitude

<table>
<thead>
<tr>
<th></th>
<th>FACTOR 1</th>
<th>FACTOR 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACTOR 1</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>FACTOR 2</td>
<td>0.0000</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Based on the conceptual connections on the factor loadings, the following names are given to the factors:

**Factor 1 Name: Personal Investment**

<table>
<thead>
<tr>
<th>Variable Concept</th>
<th>Loading Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.P. is personally rewarding (16D)</td>
<td>(+)</td>
</tr>
<tr>
<td>I.P. is professionally rewarding (16E)</td>
<td>(+)</td>
</tr>
<tr>
<td>I am committed to I.P. (16F)</td>
<td>(+)</td>
</tr>
<tr>
<td>I am committed to I.P. in DFS (16J)</td>
<td>(+)</td>
</tr>
</tbody>
</table>
**Factor 2 Name: Negative Value of Interprofessional Practice**

<table>
<thead>
<tr>
<th>Variable Concept</th>
<th>Loading Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous experience (16a)</td>
<td>(-)</td>
</tr>
<tr>
<td>I.P. not important for prevention (16b)</td>
<td>(+)</td>
</tr>
<tr>
<td>I.P. not important for successful DFS (16c)</td>
<td>(+)</td>
</tr>
<tr>
<td>I.P. is an unmanageable task (16g)</td>
<td>(+)</td>
</tr>
<tr>
<td>Generally pessimistic about I.P. (16i)</td>
<td>(-)</td>
</tr>
<tr>
<td>Avoid working with others (16K)</td>
<td>(+)</td>
</tr>
<tr>
<td>DFS requires expertise of many (16L)</td>
<td>(-)</td>
</tr>
</tbody>
</table>

The factor score coefficient matrix (Table 26) is the coefficient for the variable on each factor which is used to determine the individual score for the respondent on the particular factor. This calculated score was added to the data base. The calculated score was used to determine a relationship between score for each factor and the EXTENT of interprofessional practice (Table 27). The following relationships were determined to be relevant. Factors of personal investment ($r= .21$) and negative value ($r= -.18$) correlated with EXTENT of interprofessional practice. Those individuals who had high scores on personal investment in interprofessional had high scores on interprofessional practice. A low inverse relationship existed between negative value and EXTENT of interprofessional practice. Coordinators who perceived a negative value for interprofessional practice had low scores on EXTENT of interprofessional practice.
Tables 26

**Factor Score Coefficient Matrix for Personal Attitude Items**

<table>
<thead>
<tr>
<th>Category</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Experience</td>
<td>.04</td>
<td>-.13</td>
</tr>
<tr>
<td>IP is not important for successful prevention</td>
<td>.10</td>
<td>.35</td>
</tr>
<tr>
<td>IP is unimportant for successful DFS</td>
<td>.20</td>
<td>.38</td>
</tr>
<tr>
<td>IP provides personal rewards</td>
<td>.39</td>
<td>.21</td>
</tr>
<tr>
<td>IP provides professional rewards</td>
<td>.36</td>
<td>.13</td>
</tr>
<tr>
<td>Committed to IP</td>
<td>.28</td>
<td>.03</td>
</tr>
<tr>
<td>Coordination is unmanageable</td>
<td>-.04</td>
<td>.11</td>
</tr>
<tr>
<td>Generally pessimistic about IP</td>
<td>.01</td>
<td>.20</td>
</tr>
<tr>
<td>Committed to IP in DFS</td>
<td>.21</td>
<td>-.03</td>
</tr>
<tr>
<td>Avoid working with other professions</td>
<td>.08</td>
<td>.23</td>
</tr>
<tr>
<td>SAP requires expertise of many professions</td>
<td>.02</td>
<td>-.17</td>
</tr>
</tbody>
</table>

IP = Interprofessional Practice
DFS = Drug Free Schools
Table 27

Correlations Between EXTENT AND Factors of Individual

<table>
<thead>
<tr>
<th>Individual Factor</th>
<th>r</th>
<th>N</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Investment</td>
<td>.21</td>
<td>432</td>
<td>.000</td>
</tr>
<tr>
<td>Negative Value</td>
<td>-.18</td>
<td>432</td>
<td>.000</td>
</tr>
</tbody>
</table>

Research Question 3

Can social workers be distinguished from other professionals in the performance of interprofessional practice?

Hypothesis

Social workers can be distinguished from other professionals in the performance of interprofessional practice. Social workers are more involved than other professions in interprofessional practice.

Data Analysis

The contingency table between primary professional affiliation and quartile ranks of EXTENT of interprofessional practice (Table 28) demonstrate an association between profession and quartiles of EXTENT. There is a small relationship between the variables (Cramer's V = .14). Social workers were
predominantly represented (64.7%) in the fourth quartile of EXTENT of interprofessional practice, when compared to other professions; teachers (23.7%), counselors (27.4%), psychologists (46.2%), nurses (20.0%) and others (23%). Social workers as a group represented 9% of all individuals in the fourth quartile, yet only represented 4% (17/459) of the population.

Although the population of social work respondents was small, comparisons to similarly sized profession populations is appropriate. Although there were only seventeen identified social workers, they represent responses of the entire population. The disproportionate representation is assumed to be a result of conditions in the environment which make social workers less frequently hired as coordinators, rather than a sampling or statistical bias.
Table 28
Crosstabs of EXTENT by Coordinator Profession

<table>
<thead>
<tr>
<th>Coordinator Profession</th>
<th>EXTENT Quartiles</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Count</td>
<td>Row PCT</td>
<td>Col Pct</td>
</tr>
<tr>
<td>Teacher</td>
<td>24</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>17.8%</td>
<td>31.1%</td>
</tr>
<tr>
<td></td>
<td>26.1%</td>
<td>33.1%</td>
</tr>
<tr>
<td>Counselor</td>
<td>27</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>20.0%</td>
<td>26.7%</td>
</tr>
<tr>
<td></td>
<td>29.3%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>23.1%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>3.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>5.0%</td>
<td>45.0%</td>
</tr>
<tr>
<td></td>
<td>1.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5.9%</td>
<td>11.8%</td>
</tr>
<tr>
<td></td>
<td>1.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Other</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>25.9%</td>
<td>27.3%</td>
</tr>
<tr>
<td></td>
<td>39.1%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Column Total</td>
<td>92</td>
<td>127</td>
</tr>
<tr>
<td>Total</td>
<td>20.0%</td>
<td>27.7%</td>
</tr>
</tbody>
</table>

Cramers V = .14*

**Significance at p < .05**
Social workers can also be distinguished from other professions with an analysis of variance. Mean scores on EXTENT of interprofessional practice varied among professions (Table 29). Social workers had a substantially higher mean score (more than 10 points) on EXTENT of interprofessional practice when compared with all other professions. Four percent of the variance in EXTENT could be accounted for by knowing the profession of the coordinator (eta squared = .04). Similarly, social workers mean score on number of hours spent working with other professions (Table 30) was significantly higher than all other professional groups. Three percent of the variance in Depth could be accounted for by knowing the profession of the coordinator (eta squared = .03). Social workers' mean score on Breadth involved was statistically significant and higher than all other groups (Table 31). Although, practically mean scores on Breadth was consistent across professions. Two percent of the variance in Breadth could be accounted for by knowing the profession of the coordinator (eta squared = .02).
Table 29

Mean Comparison of EXTENT of Interprofessional Practice

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>49.04</td>
<td>135</td>
</tr>
<tr>
<td>Counselor</td>
<td>51.38</td>
<td>135</td>
</tr>
<tr>
<td>Psychologist</td>
<td>60.23</td>
<td>13</td>
</tr>
<tr>
<td>Nurse</td>
<td>51.45</td>
<td>20</td>
</tr>
<tr>
<td>Social worker</td>
<td>70.94</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>47.41</td>
<td>139</td>
</tr>
<tr>
<td>Within Groups Total</td>
<td>50.47</td>
<td>459</td>
</tr>
</tbody>
</table>

Between Groups

<table>
<thead>
<tr>
<th>df</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3.50**</td>
</tr>
</tbody>
</table>

Within Groups

| Eta = .19 | Eta Squared = .04 |

** significance p < .01
Table 30

**Mean Comparison of Depth**

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>33.45</td>
<td>144</td>
</tr>
<tr>
<td>Counselor</td>
<td>35.77</td>
<td>141</td>
</tr>
<tr>
<td>Psychologist</td>
<td>45.85</td>
<td>13</td>
</tr>
<tr>
<td>Nurse</td>
<td>37.30</td>
<td>20</td>
</tr>
<tr>
<td>Social worker</td>
<td>49.68</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>32.46</td>
<td>148</td>
</tr>
<tr>
<td><strong>Entire Population</strong></td>
<td><strong>34.95</strong></td>
<td><strong>485</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>5</td>
</tr>
<tr>
<td>Within Groups</td>
<td>479</td>
</tr>
</tbody>
</table>

**Eta = .18  Eta Squared = .03**

* significance at $p<.05$
Table 31

**Mean Comparison of Breadth**

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>12.65</td>
<td>144</td>
</tr>
<tr>
<td>Counselor</td>
<td>14.26</td>
<td>141</td>
</tr>
<tr>
<td>Psychologist</td>
<td>14.38</td>
<td>13</td>
</tr>
<tr>
<td>Nurse</td>
<td>14.15</td>
<td>20</td>
</tr>
<tr>
<td>Social worker</td>
<td>14.42</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>12.51</td>
<td>148</td>
</tr>
<tr>
<td><strong>Entire Population</strong></td>
<td><strong>13.25</strong></td>
<td><strong>485</strong></td>
</tr>
</tbody>
</table>

\[
\text{df} \quad F
\]

- Between Groups 5 2.43*
- Within Groups 479

\[
\text{Eta} = .16 \quad \text{Eta Squared} = .02
\]

*significance at p<.05

**Research Question 4**

Can hindrance or enhancement factors as identified by the human ecological model be used to describe categories of interprofessional practice in the Drug Free Schools initiative?

**Hypothesis**

Individual and environment variables can be used to differentiate programs within EXTENT.
Data Analysis:

Logistic regression was conducted using variables of the individual and environments to predict a dichotomous category of interprofessional practice. Logistic regression allows for several independent variables to predict the probabilities of the outcome of a single dichotomous dependent variable. Logistic regression was chosen to compensate for violations of the assumptions of normal distribution of the independent variables and the unequal population covariance that characterize logistic regression. Discriminant analysis was eliminated as an option as the assumptions were not met by the data.

The dependent variable was generated by creating a dichotomy of the EXTENT of interprofessional practice. The dichotomy was defined as low interprofessional practice (scores below the 50th percentile) and high interprofessional practice (scores above the 50th percentile) based on scores of EXTENT.

Independent variables were selected according to previous identification of the variable's relationship with EXTENT of interprofessional practice. The potential predictors of the dichotomous variable included: 1) Percentage of professional time allocated to DFS; 2) Percentage of time coordinating with individuals from other professions; 3) Community size; 4) Student population size; 5) Attitude of personal investment, 6) Attitude of negative value, 7) Perception of availability of community personnel; 8) and Perception of the need for investment resources.
Forward stepwise entry of the variables in the logistic regression equation was used. In this manner, the variable that makes the largest contribution to separating the dichotomous variable is included first. The Wald statistic with the significance level set at alpha ≤ .05 was used to discontinue entry.

A total of 329 cases were used in the analysis, 163 of the 492 respondents had missing data on one or more of the independent variables.

Table 32 details the initial status of the logistic regression model. The model with the constant only, predicts group membership with an overall accuracy of 53.5% simply by predicting that all cases will be in the high interprofessional practice category.

Table 32

Classification Table for Dichotomy of Interprofessional Practice

<table>
<thead>
<tr>
<th>Predicted</th>
<th>Percent Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed</td>
<td>Low</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
</tr>
<tr>
<td>High</td>
<td>0</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
</tr>
</tbody>
</table>

Variables in the Equation

<table>
<thead>
<tr>
<th>B</th>
<th>SE</th>
<th>WALD</th>
<th>df</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>.14</td>
<td>.11</td>
<td>1.61</td>
<td>1</td>
<td>.21</td>
</tr>
</tbody>
</table>
Table 33 details the addition of percentage of time allocated to DFS to the model. This model increases the accuracy of predicting low interprofessional practice to 82.35% and decreases the accuracy of predicting high interprofessional practice to 59.66% when compared with predicting that all to have high interprofessional practice. Knowledge of the amount of time allocated, increased the model's accuracy to 70.21% overall.

Table 33

Step One Entry of Logistic Regression

Variable(s) Entered on Step Number 1
Percentage of time allocated to DFS

<table>
<thead>
<tr>
<th>Predicted</th>
<th>Low IP</th>
<th>High IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Correct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low IP</td>
<td>126</td>
<td>27</td>
</tr>
<tr>
<td>High IP</td>
<td>71</td>
<td>105</td>
</tr>
<tr>
<td>Overall</td>
<td>82.35%</td>
<td>59.66%</td>
</tr>
</tbody>
</table>

Variables in the Equation

<table>
<thead>
<tr>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>df</th>
<th>R</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>.04</td>
<td>.01</td>
<td>37.02**</td>
<td>1</td>
<td>.28</td>
</tr>
<tr>
<td>Constant</td>
<td>-.67</td>
<td>.16</td>
<td>18.06**</td>
<td>1</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**significance at p<.01
AT = Amount of Time Allocated to the Drug Free Schools
IP = Interprofessional Practice
Table 34 details the addition of community size which increases the accuracy of predicting low interprofessional practice to 85.62%, decreases the accuracy of predicting high interprofessional practice to 57.82%, and increases accuracy to 70.82% overall.

Table 34

Step Two Entry of Logistic Regression

Variable(s) Entered on Step Number 2
Community Size

<table>
<thead>
<tr>
<th>Predicted</th>
<th>Low IP</th>
<th>High IP</th>
<th>Percent Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low IP</td>
<td>131</td>
<td>22</td>
<td>85.62%</td>
</tr>
<tr>
<td>High IP</td>
<td>74</td>
<td>102</td>
<td>57.82%</td>
</tr>
</tbody>
</table>

Overall 70.82%

Variables in the Equation

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>df</th>
<th>R</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>.04</td>
<td>.01</td>
<td>31.69**</td>
<td>1</td>
<td>.26</td>
<td>1.04</td>
</tr>
<tr>
<td>Total Community</td>
<td>1.80</td>
<td>5</td>
<td>.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10,000</td>
<td>-7.14</td>
<td>13.43</td>
<td>.28</td>
<td>1</td>
<td>.60</td>
<td>.0008</td>
</tr>
<tr>
<td>10,000-49,999</td>
<td>-6.84</td>
<td>13.43</td>
<td>.25</td>
<td>1</td>
<td>.61</td>
<td>.0011</td>
</tr>
<tr>
<td>50,000-99,999</td>
<td>-6.76</td>
<td>13.44</td>
<td>.25</td>
<td>1</td>
<td>.61</td>
<td>.0012</td>
</tr>
<tr>
<td>100,000-499,999</td>
<td>-7.07</td>
<td>13.50</td>
<td>.27</td>
<td>1</td>
<td>.60</td>
<td>.0008</td>
</tr>
<tr>
<td>500,000-999,999</td>
<td>-17.21</td>
<td>39.05</td>
<td>.19</td>
<td>1</td>
<td>.66</td>
<td>.0000</td>
</tr>
<tr>
<td>Constant</td>
<td>-1.23</td>
<td>6.52</td>
<td>.04</td>
<td>1</td>
<td>.85</td>
<td></td>
</tr>
</tbody>
</table>

**significant at p<.01

AT = Amount of Time Allocated to the Drug Free Schools
IP = Interprofessional Practice
Table 35 details the addition of coordinator perception of resources being available in the community. Accuracy of predicting low interprofessional practice is decreased to 79.08% and accuracy of predicting high interprofessional practice is increased to 63.07% and overall accuracy is maintained at 70.52% when compared to the previous step entry.

Table 35

**Step Three Entry of Logistic Regression**

<table>
<thead>
<tr>
<th>Variable(s) Entered on Step Number 3</th>
<th>Perceived Resources Available in the Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predicted</td>
<td>Observed</td>
</tr>
<tr>
<td>Low IP</td>
<td>High IP</td>
</tr>
<tr>
<td>Low IP</td>
<td>121</td>
</tr>
<tr>
<td>High IP</td>
<td>65</td>
</tr>
</tbody>
</table>

Overall 70.52%

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>df</th>
<th>R</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>.04</td>
<td>.01</td>
<td>31.26**</td>
<td>1</td>
<td>.25</td>
<td>1.04</td>
</tr>
<tr>
<td>Total Community</td>
<td>1.79</td>
<td>5</td>
<td></td>
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</tr>
<tr>
<td>&lt;10,000</td>
<td>-7.21</td>
<td>13.24</td>
<td>.30</td>
<td>1</td>
<td>.59</td>
<td>.00</td>
</tr>
<tr>
<td>10,000-49,999</td>
<td>-6.94</td>
<td>13.24</td>
<td>.27</td>
<td>1</td>
<td>.60</td>
<td>.00</td>
</tr>
<tr>
<td>50,000-99,999</td>
<td>-6.76</td>
<td>13.25</td>
<td>.26</td>
<td>1</td>
<td>.61</td>
<td>.00</td>
</tr>
<tr>
<td>100,000-499,999</td>
<td>-7.21</td>
<td>13.31</td>
<td>.29</td>
<td>1</td>
<td>.59</td>
<td>.00</td>
</tr>
<tr>
<td>500,000-999,999</td>
<td>-17.41</td>
<td>38.98</td>
<td>.20</td>
<td>1</td>
<td>.66</td>
<td>.00</td>
</tr>
<tr>
<td>PRC</td>
<td>.37</td>
<td>.13</td>
<td>7.88**</td>
<td>1</td>
<td>.11</td>
<td>1.45</td>
</tr>
<tr>
<td>Constant</td>
<td>-1.22</td>
<td>6.51</td>
<td></td>
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</tr>
</tbody>
</table>

**significant at p<.01
PRC = Perceived Resources in the Community
AT = Amount of Time Allocated to the Drug Free Schools
IP = Interprofessional Practice
Table 36 details the deletion of community size from the model. Low interprofessional practice is predicted with 79.74% accuracy, high interprofessional practice is predicted with 61.93% accuracy. This action decreases the overall accuracy to 70.21% (reduction of less than 1%, Chi Square Improvement = -15.41) yet demonstrates a more parsimonious model. The model is appropriate for the data (Goodness of Fit, Chi square=71.42, $\alpha=.00$).

Table 36

**Step Four Entry of Logistic Regression**

<table>
<thead>
<tr>
<th>Variable Removed on Step Number 4</th>
<th>Community Size</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Predicted</th>
<th>Low IP</th>
<th>High IP</th>
<th>Percent Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low IP</td>
<td>122</td>
<td>31</td>
<td>79.74%</td>
</tr>
<tr>
<td>High IP</td>
<td>67</td>
<td>109</td>
<td>61.93%</td>
</tr>
</tbody>
</table>

**Overall** 70.21%

**Variables in the Equation**

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>df</th>
<th>R</th>
<th>Exp(B)</th>
<th>Chi-Square</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>.04</td>
<td>.01</td>
<td>36.54**</td>
<td>1</td>
<td>.28</td>
<td>1.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRC</td>
<td>.35</td>
<td>.13</td>
<td>7.46**</td>
<td>1</td>
<td>.11</td>
<td>1.42</td>
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</tr>
<tr>
<td>Constant</td>
<td>-.66</td>
<td>.16</td>
<td>16.86**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chi-Square 71.42** 2

Improvement -15.41** 5

**significance at $p<.01$**

IP = Interprofessional Practice
AT = Amount of Time Allocated to the Drug Free Schools
PRC = Perceived Resources in the Community
Interpretation of the Model

Testing the hypothesis that the logistic regression coefficient is zero is measured by the Wald statistic (TABLE 36). Comparison of the significance of the Wald statistic significance level with the a priori alpha < .05 rejects the null for the constant (Wald=16.85, sig.=.000), time allocated to DFS (Wald = 35.53 sig.=000), and perceived resources in the environment (Wald=7.46, sig=.000).

Interpreting the logistic regression coefficients in Table 36, the logistic regression coefficients (B) indicate the change in log odds associated with one unit change in the independent variable. These logarithms are transformed to EXP(B) for interpretation. Interpreting an EXP(B), one unit change in the percent of time allocated to DFS leads to an increase in the odds of high interprofessional practice at a factor equal to 1.04 (EXP(B)=1.04) when all other variables are held constant. Similarly, one unit increase in perceived availability of community personnel leads to an increase in the odds of high interprofessional practice at a factor equal to 1.42 (EXP(B)=1.42).

Contribution of the individual variables to the model is assessed by the magnitude of the partial correlation coefficients of the variable (Table 36). The direction of the contribution coincides with the sign of the logistic regression coefficient (B). For this model, percent of time allocated to DFS has a small positive contribution (r=.28). Perceived availability of community personnel has a positive contribution to the model (r=.11).
Goodness of Fit of the model to the data was measured by the Model Chi Square with significance of Chi Square compared to apriori alpha = .05. The model chi square is 71.47 (sig.=.0000) and indicates rejection of the null hypothesis that the logistic regression for the terms is 0. Improvement is negative for this model (chi-square = -15.41, sig.=.0000) as the previous step had an additional variable included. The loss of 1% of increased accuracy in predicting high interprofessional practice is compensated for in the increased simplicity of the model.

Further assessment of the goodness of fit involves analysis of the classification table (Table 36) which indicates 79.74% of the cases were correctly classified as low interprofessional practice, and 61.93% of the cases were correctly classified as high interprofessional practice. The model was accurate in classifying 70% of the cases overall.

Analysis of the histogram of observed and estimated probabilities (Figure 10) suggests that the majority of misclassified cases clustered near the probability of occurring as 50/50. The two groups formed clusters on opposite ends of the histogram: cases observed high interprofessional practice clustered near 1 and cases observing low interprofessional practice cluster near .25.
Figure 10

Distribution of Observed and Predicted Probabilities

Therefore, two variables are significant in predicting the probability of a case being classified as High Interprofessional Practice: The amount of time the coordinator is involved in the DFS program and the perception of the coordinator that there exists personnel resources in the community for interprofessional practice. These items are consistent with elements of the human ecological model, representing the individual and environment respectively. Therefore, the logistic regression equation of:

\[ P(\text{High}) = -0.6565 + 0.3494 \times \text{Perceived Resources} + 0.0360 \times \text{Time allocated} \]

is accepted as a tool for predicting the probability of cases as high or low interprofessional practice.
CHAPTER V
DISCUSSION AND IMPLICATIONS

The use of standard quantitative research methods of data collection and analysis has enabled the recognition of factors which influence the interprofessional practice of coordinators of the Safe and Drug Free Schools program in Ohio. Extent of interprofessional practice was measured and factors which influence this outcome was documented. Reflection on these measures has led to four primary conclusions regarding the interprofessional practice of social workers and educators in the Safe and Drug Free Schools programs.

The first conclusion is that interprofessional practice exists in the coordination of the Safe and Drug Free Schools, and varies among districts. The research demonstrates that interprofessional practice does occur in the coordination of the Safe and Drug Free Schools programs. Mean values above 0 on measures of numbers of professionals involved (mean = 13.207), hours invested (mean = 34.68), and extent of interprofessional practice (mean = 50.287) demonstrate that interprofessional practice does occur.

The research demonstrates that interprofessional practice varied among programs. Standard deviations larger than one and range values larger than 5
indicate that programs varied in the number of people involved (standard deviation = 5.31), the amount of time others were involved (standard deviation = 34.68), and the extent of interprofessional practice that occurred (standard deviation = 24.34).

Furthermore, the manifestation of interprofessional practice as a small group activity also varied among programs. Variance from the conceptual definition of interprofessional practice as a small group activity was demonstrated. Some coordinators indicated that small group activities did not exist in the interprofessional practice of their program.

Variance was also demonstrated within programs by dimensions of small group activities. Standard deviation scores greater than one and interquartile ranges which spanned agreement and disagreement categories indicated great variance in the role of teams in interprofessional practice.

There exist two important implications of these findings to social work. First, evidence of interprofessional practice existing in substance abuse prevention in the schools allows for two opportunities for social workers to participate. Social workers interested in prevention can be employed by the schools as the coordinator and social workers employed in outside agencies can participate by working collaboratively with prevention programs in the schools.

Second, although different professions are involved in all programs of the Drug Free Schools, the extent and format of the collaboration also varies. The report of some schools having interprofessional teams whereas others do not
suggests that there exists either different needs for interprofessional practice, or team formation is an evolving process of the program. Regardless of the reason for the diverse representation of collaboration, the situation supports social work curriculum inclusion of interprofessional practice. Interprofessional practice curriculum opportunities for the social worker to gain skills in interaction with diverse people in diverse setting. In this manner, a social worker would be prepared to work in interprofessional practice as a team member or as an individual. Social workers with an interest in prevention of adolescent substance abuse will have opportunities to interact professionally, either as a school social worker or as a community based social worker. Social work education which teach the skills necessary for interprofessional practice will prepare social workers for their future employment situations.

The second conclusion recognizes the performance of social workers as distinct from other professionals. Measures of participation and perceived commitment distinguish social workers from other professions in the extent of interprofessional practice.

Social workers who were coordinators participated in interprofessional practice to a greater extent than other professions. As a group, social workers were involved with more professions and spent more time with individuals from other professions than all other coordinators. This phenomenon could have resulted from the previous education and experiences of social workers.
Social work education emphasizes the conceptualization of the individual in interaction with the environment. This conceptualization is more complex than singular foci of other perspectives. The emphasis in conceptualization may assist social workers in recognizing the necessity and potential of interprofessional practice.

Similarly, social work education's focus on skills may differentiate professionals from others. Social workers have specific training in working with others to solve problems. Social work practice/generalist practice in group skills may distinguish social workers as more successful in encouraging the participation of others.

Social workers might also be different because they are performing in an alien environment. Social workers in the host environment of schools (the domain of educators) may have to be more readily involved in interprofessional practice to survive. Education based professions may be more comfortable and successful in the school domain by practicing within their profession rather than interprofessionally.

Comparison of social workers with other professions was challenged by the small number of representatives from each profession. This challenge was addressed by comparison of like-sized groups and representation of the population of coordinators. Small sample size represented the nature of the population rather than sampling or statistical error.
The third conclusion is that the extent of interprofessional practice is influenced by factors which help and or hinder interprofessional practice. The use of the Human Ecological Model facilitates the recognition of the factors and describes the interaction of the factors. Elements of the individual coordinator and the environment interact to describe the extent of interprofessional practice. Emergent themes of factors which help or hinder interprofessional practice were identified by coordinators. The emergent themes can be separated into the categories of individual and environment (human constructed and human behavioral) characteristics. Human constructed environment factors included facilities, materials and money. Human behavioral factors included goals, vision, collaboration and cooperation. The individual is characterized in interaction with the environment factors of time and staff/personnel. The individual is also present in the demonstration of collaboration and cooperation. The individual is important as an available resource and the manner of implementation of interprofessional practice.

These themes were supported by quantitative data analysis measures of individual and community variables. Individual variables which contributes to interprofessional practice include: more professional time spent in coordination of the Safe and Drug Free Schools, attitude of personal investment, and the attitude which valued interprofessional practice.

Similarly, the environment was also identified as contributing to the extent of interprofessional practice. Environmental factors of natural
environment indicated that rural environments scored lower on extent of interprofessional practice. Human constructed environment as measured by community size and student population also influenced interprofessional practice. Larger communities tended to score higher on Extent of interprofessional practice.

Human behavioral environment, as measured by the coordinator's perception of the community indicates that perception of availability of personnel and the perception of need for investment of resources correlate with extent of interprofessional practice. Coordinators who perceive resources in the community score higher on extent of interprofessional practice. Coordinators who perceive a need for investment of resources score higher on interprofessional practice.

In summary, the factors which coordinators identified as helping interprofessional practice include: time, personnel, and finances. Each of these factors also corresponds to what hinders interprofessional practice.

The implication of these identified factors to social work influences education, practice and policy. Social work curricula which facilitate maximization of these resources contribute to 'helping' interprofessional practice. Educators must include knowledge and skill building in recognizing these resources in the social work curriculum.

In the practice arena, social workers who have skills in time management, recognition of community personnel resources, and increased funding, will be
able to maximize resources in the community. Social workers with these skills will be more likely to develop programs characterized as high interprofessional involvement.

These identified factors also contribute to the social work agenda of policy formulation. Understanding the role of interprofessional practice in strengthening social programs is the first step in policy advocacy. It appears that policy in the Safe and Drug Free Schools programs already reflects this concept (i.e. there exists legislation to facilitate interprofessional practice). The current role is to advocate for additional component parts which contribute to successful interprofessional practice. Social workers, as a profession, can advocate for adequate funding and provisions for extended community involvement in the Safe and Drug Free Schools program. Special attention is necessary for small programs and rural communities where community resources are not as prevalent.

Social workers in administrative capacities have a unique role of advocating for policy within their organization as well. Social workers who are able to bridge "turf" issues and encourage employees to interact with other agency entities will contribute to interprofessional practice.

The final conclusion determined that the Human Ecological Model was useful in identifying components of the individual in interaction with the environment. The individual variable of amount of time allocated to the Safe and Drug Free Schools program combined with the human behavioral environment of
perceived community resources led to a model which was effective in
determining the probability of high or low interprofessional practice in 70% of the
cases. The interactive model was more successful than either variable alone in
successfully identifying those participants with high scores on EXTENT of
interprofessional practice.

This research reinforces the social work conceptualization of the
individual in the social environment as an interactive force in determining
whether interprofessional practice occurs. Prediction of extent of
interprofessional practice requires knowledge of the individual and knowledge of
the environment to maximize accuracy.

**Further Research**

There are six major categories of further research. First, research is
necessary in further refining the notion of extent of interprofessional practice.
The measures of depth and breadth of this study are simplistic compared to the
actual performance of interprofessional practice. Further research to identify
other potential measurements of extent of interprofessional practice would
contribute to understanding how interprofessional practice exists and varies in
the provision of services.

Second, further research is necessary to understand the pattern of
interprofessional practice as it evolves over time. This research project explored
a cross section of programs, with each program at various stages of
development and priority. Information from longitudinal research would facilitate an understanding of the differences in programs, particularly if there exists a pattern of change in the manifestation of interprofessional practice over time.

Third, research is necessary to observe interprofessional practice in other settings of substance abuse prevention and other social issues. Substance abuse prevention in the schools may be a unique setting for prevention. Inherent constraints and assets may influence interprofessional practice. Further research would enrich the understanding of how interprofessional practice enhances prevention and other service issues.

Fourth, further research is necessary to articulate why social workers are different from other professions in interprofessional practice. Research is necessary to explore the underlying knowledge, skill and affect differences of social workers which influence interprofessional practice. Social worker educators will benefit from this knowledge in the construction of curricula and experiences which enhance interprofessional skills.

Fifth, further research is necessary to address generalizability issues. The small number of respondents from key professional areas restricts generalizability to other professional populations. Similarly the context of Ohio is not representative of other geographic areas. Exploring interprofessional practice in other contexts and with more diverse and representative samples of professions is necessary for generalizability. A cross state comparison would be
helpful, particularly comparing states with mandated school social work positions with Ohio (without mandated school social workers).

The final area of need for further research is in the documentation of the link between interprofessional practice and successful prevention. Inherent in the challenge of this research is the measurement of successful prevention, which is limited in the literature. However, the research link is necessary. Funding and resources have been invested in interprofessional practice as a component of prevention based predominantly on conceptualizations of the issue of prevention as an interprofessional topics. Evidence is necessary which documents the link between interprofessional practice and successful prevention to substantiate continued funding.
REFERENCES


APPENDIX A

PILOT TEST PANEL RESPONSES
How much time was required to complete the questionnaire?

About 15 minutes
35-40 minutes
30 minutes
30 minutes

Was this length of time too long?

No
No, not too long
Probably

Were there moments in completing the questionnaire in which you became fatigued or confused? If so, please indicate where.

Question 6, it would be difficult to arrive at the number of hours
There was a need to review other materials to completely answer questions
No, very easy to complete- some thought required to determine hours spent

Did the cover letter provide adequate explanation of the research? What additional information should be provided in the cover letter?

Adequate
Yes, no additional information needed
Yes
Yes-none

Are the questions and options for answering appropriate for the Safe and Drug Free Schools programs in Ohio? Should there be alternative or additional questions or responses?

The questions are appropriate
Yes, no
See comments in the booklet
. Need some additional focus on intervention/counseling activities to be comprehensive
How can the questions be improved to express the key ideas of how coordinators may be involved in interprofessional practice?

None come to mind
No suggestions
Do not forget their staff contacts especially on question #5 if you want the full picture of contacts made
"Is there a collaborative/partnership in your area?"

How could the definitions of interprofessional practice, extent of interprofessional practice, coordinator characteristics, and environmental context be strengthened?

It appears adequate
It's simple and understandable as is
May want to move definition from cover page to right before question #5 so people won't miss it
They are fine and understandable as is

How can the questionnaire be improved to adequately identify and measure what helps and/or hinders interprofessional practice in the Safe and Drug Free Schools?

It is fine
No suggestions, it is really difficult to indicate how much time one spends with other professionals
Need a "do not know" option on question #7
Determine what other/adjunct duties of the coordinator impede or prevent emphasis on SDFS
It's fine, I don't think you can prime the pump too directly without affecting results

In what ways could the language (readability and vocabulary) be altered to be appropriate to coordinators' experiences?

I did not find any need to change the language
No suggestions
See booklet, Social worker was not defined- too vague & not connected to an agency, very hard to answer
?
See Text
Discuss your reactions to the organization, layout, and appearance of the instrument. List any recommendations you would offer to enhance the appearance.

Excellent, very readable/useable
It appears fine
Easy to respond to. Color of paper is nice. Book format doesn’t make it seem so long
Easy to read and follow
Nicely done, very readable and professional looking

Please comment on any additional topic which you identify as relevant to the face and content validity of the instrument.

It seems to overall be a fine instrument. Except for question #6, it was completed without difficulty
See booklet, Be aware of different situations of consortium coordinators and single school district coordinators
This is not a quick and easy survey. One has to do a fair amount of thinking. It will be more interesting to those involved in interprofessional practice.
I was impressed with the scope of the survey and am interested in the findings

None
APPENDIX B

PILOT TEST PANEL
Pilot Test Panel

Jane Dunckelman
Coordinator
Dayton Public Schools
2013 West 3rd St
Dayton, OH 45417

Mary Greenlee
Coordinator
52 Starling St
Columbus, OH 43215

Janet Groome
Coordinator
Student Services
35th and Gurnsey
Belaire, OH 43906

Mike Magnusson
Consultant
Ohio Department of Education
655 S Front St, Room 719
Columbus OH 43215-4183

Pat Sudlow
Coordinator
Glenwood Middle School
1715 North Main
Findley, OH 45840

Alan Woods
Coordinator
114 West South Boundary St
Perrysburg, OH 43551-1754

R. Michael Casto
Director
Interprofessional Commission
161 Mershon Building
1501 Neil Ave
Columbus OH 43201
APPENDIX C
INSTRUMENT
Interprofessional Practice

A group of two or more individuals from differing professional affiliations who work together to plan, implement, and/or evaluate services to meet a common goal. In addition to collaboration, a team atmosphere of a shared set of values is developed in terms of professional practice and desired outcomes.

A survey of the Ohio Coordinators of the Safe and Drug Free Schools Initiatives

by
Kathleen Woehrle
Doctoral Candidate

Elizabeth Segal, Ph.D.
Ohio State University

Mike Magnusson
Ohio Department of Education
Purpose

This survey was developed to assess the opinions of the coordinators of the Safe and Drug Free Schools regarding interprofessional practice. The researchers would like to know what helps and what hinders you in your interprofessional practice. The survey will assist educators and school support personnel in facilitating interprofessional practice.

A summary of the study will be published in the OPERC Newsletter!

Interprofessional practice for this study is defined as:

A group of two or more individuals from differing professional affiliations who work together to plan, implement, and/or evaluate services to meet a common goal. In addition to collaboration, a team atmosphere of a shared set of values is developed in terms of professional practice and desired outcomes.
Demographics  The following items help me to understand the general description of the community you serve.

1) Which of the following characteristics best describes the community in which you coordinate drug free schools programs?
   (Please mark each that apply.)
   A) _____ rural  _____ urban  _____ suburban
   B) _____ agricultural  _____ industrial  _____ commercial

   C) Number of residents in the geographic area served by your Safe and Drug Free Schools Program.
      _____ less than 10,000
      _____ 10,000-49,999
      _____ 50,000-99,999
      _____ 100,000-499,999
      _____ 500,000-999,999
      _____ +1,000,000

2) Which of the following characteristics best describe the drug free schools program which you coordinate?
   A) _____ Individual district
      _____ Consortium of districts
      (If yes, How many districts are members of the consortium? _____)
   B) Number of students served by school district
      _____ less than 1,000
      _____ 1,000-2,499
      _____ 2500-4,999
      _____ 5,000-9,999
      _____ 10,000-24,999
      _____ 25,000 +
   C) _____ public school(s)
      _____ private school(s)
      _____ both public and private schools

3) Does your program require additional professionals to implement the comprehensive program?
   _____ No _____ Yes

4) Does your district(s) contract with other agencies to provide direct services?
   _____ No _____ Yes
**Extent of Interprofessional Practice** The following items help me to understand how much interprofessional practice occurs in the drug free schools program in your school district(s).

5) In the last nine months have you, in your capacity as coordinator, had contact with any of the professionals listed below? These professionals might serve in the capacity of advisory board members, program volunteers, funding agents, even presenters. For each profession you have worked with please mark on the respective line.

<table>
<thead>
<tr>
<th>Professions</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health professionals</td>
<td></td>
</tr>
<tr>
<td>Lawyers</td>
<td></td>
</tr>
<tr>
<td>Civic or government leaders</td>
<td></td>
</tr>
<tr>
<td>Teachers, teacher aides</td>
<td></td>
</tr>
<tr>
<td>Business persons</td>
<td></td>
</tr>
<tr>
<td>Law enforcement officers</td>
<td></td>
</tr>
<tr>
<td>Paramedics, firefighters</td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Counselors</td>
<td></td>
</tr>
<tr>
<td>Homemakers</td>
<td></td>
</tr>
<tr>
<td>Religious leaders</td>
<td></td>
</tr>
<tr>
<td>School support staff</td>
<td></td>
</tr>
<tr>
<td>School administrators</td>
<td></td>
</tr>
<tr>
<td>Sports program directors</td>
<td></td>
</tr>
<tr>
<td>Youth program directors</td>
<td></td>
</tr>
<tr>
<td>Social service agency officials</td>
<td></td>
</tr>
<tr>
<td>University officials and faculty</td>
<td></td>
</tr>
<tr>
<td>Media or radio personalities</td>
<td></td>
</tr>
<tr>
<td>Counselors</td>
<td></td>
</tr>
<tr>
<td>Consortium support staff</td>
<td></td>
</tr>
<tr>
<td>Classroom teachers</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
6) Please indicate how much time you spend each year with professionals from the following groups in your role as coordinator of the Drug Free School Program.

1 = 0 to 5 hours per year  
2 = 6 to 10 hours per year  
3 = 11 to 25 hours per year  
4 = 25 to 50 hours per year  
5 = 50 to 100 hours per year  
6 = more than 100 hours per year

<table>
<thead>
<tr>
<th>Professions</th>
<th>Category of hours</th>
</tr>
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<tbody>
<tr>
<td>Health care professionals</td>
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<tr>
<td>Lawyers</td>
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<tr>
<td>Civic or government leaders</td>
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<td>Teachers, teacher aides</td>
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<tr>
<td>Business persons</td>
<td></td>
</tr>
<tr>
<td>Law enforcement officers</td>
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</tr>
<tr>
<td>Paramedics, firefighters</td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td></td>
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<tr>
<td>Psychologists</td>
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<td>Substance Abuse Counselors</td>
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<td>Homemakers</td>
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<td>Religious leaders</td>
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<tr>
<td>Sports program directors</td>
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<td>Youth program directors</td>
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<tr>
<td>Classroom teachers</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
7) How committed do you think each of the following groups are to the Drug Free Schools program in your area?

N/A = Not Applicable
1= no commitment
2= slight commitment
3= moderate commitment
4= strong commitment
5= very strong commitment

<table>
<thead>
<tr>
<th>Professions</th>
<th>Level of commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care professionals</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Lawyers</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Civic or government leaders</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Teachers, teacher aides</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Business persons</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Law enforcement officers</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Paramedics, firefighters</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Social Workers</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Psychologists</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Substance Abuse Counselors</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Homemakers</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Religious leaders</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>School support staff</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>School administrators</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Sports program directors</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Youth program directors</td>
<td>N/A 1 2 3 4 5</td>
</tr>
<tr>
<td>Social service agency officials</td>
<td>N/A 1 2 3 4 5</td>
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<tr>
<td>University officials &amp; Faculty</td>
<td>N/A 1 2 3 4 5</td>
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<tr>
<td>Media or radio personalities</td>
<td>N/A 1 2 3 4 5</td>
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<tr>
<td>Counselors</td>
<td>N/A 1 2 3 4 5</td>
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<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Other</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
**Coordinator Characteristics**. The following items help me understand the coordinator's experiences with and attitudes toward interprofessional practice.

8) How many years have you been active with the Drug Free Schools program?

9) How many years have you been active in substance abuse prevention?

10) How many years have you lived/been involved in the community where you are the coordinator?

11) What percentage of your professional time is allocated to the drug free schools program?

12) Considering the time you spend with the Drug Free Schools program, what percentage of your time is spent coordinating with individuals from other professions?

13) What percentage of your time as coordinator involves the direct implementation of the prevention curriculum and programs?
14) Which of the following credentials do you have? Please indicate all that apply.

- Teaching certification
- Counseling certification
- School psychology certification
- School nurse certification
- Certified drug counselor
- Certified chemical dependency counselor
- Certified alcoholism counselor
- Ohio certified prevention consultant
- Ohio certified prevention specialist
- Licensed professional counselor
- Licensed social worker
- Licensed school psychologist
- School administrator certification
- Other (please identify ________________)

15) Which profession would you identify as your primary affiliation? (Check one)

- Teacher
- Counselor
- Psychologist
- Nurse
- Social worker
- Other, (please identify _____________)

16) Please indicate your level of agreement with each of the statements below. The scale is:

1 = strongly disagree
2 = moderately disagree
3 = tend to disagree
4 = tend to agree
5 = moderately agree
6 = strongly agree

I had previous experience in interprofessional practice. 1 2 3 4 5 6

Interprofessional practice is not important for successful substance abuse prevention. 1 2 3 4 5 6
16) CONTINUED

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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</thead>
<tbody>
<tr>
<td>Interprofessional practice is unimportant for successful drug free schools.</td>
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<tr>
<td>Interprofessional practice provides personal rewards.</td>
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<td>Interprofessional practice is rewarding for my profession.</td>
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<tr>
<td>I am committed to interprofessional practice.</td>
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<tr>
<td>Coordinating interprofessional efforts is an unmanageable task.</td>
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<tr>
<td>I have received specific training and/or instruction in working with individuals in other professions.</td>
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<tr>
<td>I am generally pessimistic toward interprofessional practice.</td>
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<tr>
<td>I am committed to interprofessional practice in the coordination of the drug free schools programs.</td>
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<tr>
<td>I would avoid working with individuals from other professions if it was not required.</td>
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<tr>
<td>Substance abuse prevention requires the expertise of many professions.</td>
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<tr>
<td>Substance abuse prevention should be a community based program.</td>
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</tbody>
</table>
The environmental context. The following items will help me understand your point of view on how professional environment contributes to interprofessional practice. This includes two elements; how individuals work together and how resources are invested by the community for this effort.

17) Which curriculum does your program use in the drug free schools program in your school district? (Mark all that apply)

- BABES (Beginning Alcohol/Addictions Basic Education Studies)
- Children Are People
- DARE (Drug Abuse Resistance Education)
- Discover: Skills for Life
- Here’s Looking at You 2000
- Learning to Live Drug Free
- Project Charlie (Chemical Abuse Resolution Lies in Education)
- Quest (Skills for Growing, Skills for Adolescence, Skills for Action)
- Tribes
- TWYSAA (Talking With Your Students About Alcohol)
- Other, (please identify) ________

18) Which of the following individuals are involved in the instruction of the curriculum? Please indicate all that apply.

- Drug Free School Coordinator
- Health Educator
- Guidance counselor
- School psychologist
- School nurse
- Social Worker
- School Administrator
- Agency/community prevention specialist
- Community volunteer
- Community health professional
- Law enforcement officer
- DARE curriculum instructor
- Peer facilitators/listener
- Parents
- Classroom teachers
- Drug Free Schools Support Staff
- Other, please identify ________
19) Which of the following activities does your school district provide in addition to the curriculum? (please indicate all that apply)

___ Parent education and support
___ Parent outreach
___ Employee Assistance Programs
___ Teacher training
___ Sponsor drug free activities
___ Community service for youth
___ Community support networks
___ Student Assistance Programs
___ Community collaboration
___ Referrals to outside agencies
___ Health Fairs
___ Field Trips
___ Recovery support for students
___ Conflict resolution/Peer mediation training
___ Other, please identify __________
___ Other, please identify __________
20) Please indicate your level of agreement with each of the statements below. The scale is:

1 = strongly disagree
2 = moderately disagree
3 = tend to disagree
4 = tend to agree
5 = moderately agree
6 = strongly agree

Resources
Community based resources are willing to participate in the interprofessional practice teams. 1 2 3 4 5 6

There are enough agencies nearby to provide adequate substance abuse prevention services to the community. 1 2 3 4 5 6

Professionals on the interprofessional team are given release time to participate in the Safe and Drug Free Schools initiatives. 1 2 3 4 5 6

Effective substance abuse prevention requires the collaboration of diverse professionals. 1 2 3 4 5 6

The interprofessional team(s) does not have adequate space to meet. 1 2 3 4 5 6

The interprofessional team(s) has a neutral location in which to meet. 1 2 3 4 5 6

The interprofessional team(s) has inadequate financial resources to implement their efforts. 1 2 3 4 5 6

The infrastructure does not provide adequate technology (i.e. photocopier, telephone, computers) to the interprofessional team. 1 2 3 4 5 6

The prevention curriculum restricts opportunities for interprofessional practice. 1 2 3 4 5 6

The drug free schools program provides opportunities for interprofessional practice. 1 2 3 4 5 6

Community representatives from other professions are uninterested in the drug free schools programs. 1 2 3 4 5 6
20) CONTINUED

Supervisors in the school district discourage interprofessional practice.

Other school personnel are encouraging of interprofessional practice.

The outside community is supportive of interprofessional practice.

**Interprofessional practice as a team activity:**

Interprofessional practice is a key mode of providing comprehensive services to the students in drug free schools.

The interprofessional team(s) works well together, despite their professional differences.

Interprofessional team members share their expertise easily with other team members.

Interprofessional team members conflict over leadership roles.

Interprofessional team members are unable to negotiate conflict effectively.

The interprofessional team sets aside time to review team process and issues.

The interprofessional team provides itself opportunities for professional development in team practice.

The interprofessional practice team members have positive relationships with other team members.

Interprofessional practice is rarely chosen as a mode of practice for operating for the team members of our drug free schools initiatives.
21) List conditions/resources which are most essential for interprofessional practice in the coordination of the Safe and Drug Free Schools program.

1) 
2) 
3) 
4) 
5) 

22) List barriers to interprofessional practice in the coordination of the Safe and Drug Free Schools program.

1) 
2) 
3) 
4) 
5) 

23) In what ways will interprofessional practice contribute to the future of the Safe and Drug Free Schools Program in your area?
Thank you for completing the questionnaire!!!

Your contribution of time and expertise is greatly appreciated. A summary of the study will be published in the OPERC Newsletter. If you would like an additional copy of the summary, please indicate "yes" below:

______ Yes, I would like a copy of the summary from this study.

______ No, I would not like a copy of the summary.

If you have further questions or comments regarding this survey, please contact Kathleen Woehrle at 614-292-6288 or fax #614-292-6940.
Post note: Numbering the survey is important. The number allows the researchers to identify which school districts have responded. Responses to the survey will be kept confidential so that no one external to the research can associate the respondent with their response.

Survey Number __________
APPENDIX D

RESPONSE TO OPEN ENDED QUESTION 20
Responses to Question 20

I have a difficult time convincing school Administration that it's important to

Since I am not involved in an interprofessional team, I don't feel I can answer

I'm not certain I can speak to the notion of "team activity" we don't have one
Enough agencies but not enough funding to run them.

We do not have an active team involved in our programs


**Question 21:**

List conditions/resources which are most essential for interprofessional practice in the coordination of the Safe and Drug Free Schools program.

**Responses separated by respondent, no particular order:**

Significant amount of time designated to that program that does not conflict, ability of space in other locations, well defined goals and objectives, commitment of all staff to goals and objectives, willingness to change and to demand change

Communication among team members and back to community, funding for training, release time for teaching professionals and other professionals

Training in team practices, identification of people in various committees with expertise, time to work together, more personnel in schools (which are cutting back instead), easy access to funds

Commitment to youth, experience with youth

Continued funding of drug free programs, community commitment to drug free/safe schools

Personal and professional commitment, strong leadership, financial resources, organizational support, mutually agreed upon goals

Cooperative sharing individuals, time allotted to spend on DFS, education of committee and community, affordable/available treatment

Interprofessional education

Time, commitment

Availability of resources in community, time to coordinate activities

Money for projects and materials, A person to head up coordination of program

Cooperative personnel

Need more release time

Reduce turf issues, Establish lead agency/individual community-wide, shared resources.
Financial resources, dedicated teachers, family/community support, planning time

Shared time, shared location, common funding, leadership

Specific time set aside to accomplish goals. Interruptions and other duties cause conflict, finances, parent/community commitment, DARE program has been very positive

Attitude of importance by administration, time set aside specifically for this purpose, access to support services - secretarial, electronic, computerized

Priority of importance by all involved, release time, financing

Support personnel in schools, administration support, money for programs, support from other programs

Centralized meeting place, centralized communication

Time, money, staff, materials, consultants

Time

People in charge of making the contacts and grooming them, time, people to do the job, money, facilities/resources

Enough time

Need one person/committee who has a passion to initiate the effort; respect for one another, define vision mission, needs goals, objectives, methods, evaluation for the community

Time, money

Funding, community awareness

Local funding, support from federal government, support of school administration, support of staff, support of parents

Time frames, release time for students, sports, attitudes, personal agendas
Student assistant coordination, open communication availability, board support and approval, funding and time

Drug free school funding, assumption of responsibility, clear measures of success

Administration (supr. principals, etc.) support, S.T.A.R.S.-Chattanooga, Tenn. 1-800-477-8277 <the best.

Time, commitment, agenda, local resources/agencies tied to rural community, quantity of members (team)

Brings varied educational, experiential and clinical styles together; interprofessional practice is similar to a community in its diversity, strengths becomes focus when alliances are formed-can get more accomplished; there is "not a single right way" to have a comprehensive SIDFS program without a true "team" approach

Collaboration (time), communication, communique (brochure) of available local agencies, space for activities

Time, time, time, money, money

Reasons for collaboration, time for team-building, willingness to share resources, willingness to share "turf", a collaborative "mission" developed

Willing professionals, time, financial resources, need for

Relationship between coordinator. & agency, willingness of agency to be in schools

Money, meetings, staff size, leadership

County agencies/resources, help from students, student motivation

Government agencies, School administration

Staff from local agencies, adequate space, common goals, participation from all community sectors, money

Incentives/encouragement to collaborate-agencies, human services, community, Responsibility sharing - leadership, Collaboration/partnership organizational structure, ID & training of community constituencies, Adequate funding
Release time, places for meetings, concerned & involved team members, well trained professional, funding

Substance agencies, court, law, parents, administrators

Successful, collaboration of school, home and community; Communication

Regular meetings, agencies willing to participate in the program; adequate financial resources.

Money; time.

Appropriate funding.

Coordinator; strong community team.

Administrative support and staff support.

Keep roles on team clear; keep job descriptions clear and keep reviewing the processing.

Ability to plug into existing network rather than create one and funding to support collaborators time.

Cooperation from staff/support staff; cooperation from administration staff and commitment from students.

Leadership; vehicle to bring folks together; need for $$ as a common goal; awareness by other professionals of the need for this idea and commitment by all combined.

Shared goals.

A coordinator who has time and is committed to drug-free education, and is able to leave regular duties for it. administration's support, Community support with time, people, and money. Professionals available to small schools for a reasonable fee.

Cooperation; caring attitude.

Money; released time from duties; training teachers; cooperation from business arena and parental involvement.
Making time for meeting; getting people together the 1st time.

Time; communication networks and organization infrastructuring.

Quality time for planning, etc; collaboration.

D.A.R.E.

Common planning time; expectations that agencies will participate and concern for goals, not turf.

Positive attitude, open handed; human resources from variety of professionals and adequate time to work together.

Money needed and more time.

Establish meetings; administrative support; staff support.

Administration must back it with more than just words; community must be in support and teachers all staff must be trained and students (are appropriate) need to be allowed to input in program.

Time; validation; time, release; budget and support.

Communications; released time and more financial resources

Adequate staff.

Money to bring in individuals who can help; communication between professionals; bank of resources (and side agencies/professionals and commitment of entire staff or at least one element.

Support (time and money) of school administrators; willingness to learn from each other and faculties to meet.

Diversity of members; inter-agency representation; parents a must; team mission statement and commitment and short and long term goals defined and prioritized by team.

Good communication and similar goals.

Time and funding sources.
Communication network; opportunity for professionals to meet, plan and organize; access to students - staff; knowledge of existing agencies/personnel so that school professionals can go to and make recommendation to parents.

Money; time; space and people.

School professional ownership; interprofessional work between ADD agency schools; professional development; school administrator buy-in; outcome measurers and adequate surveys such as student vision.

School administrative support; making the time (seeing the need); money; making it a priority.

Monthly meetings; communication; flexibility and leadership, action plans.

Time/schedules; location/expense (if at a location where services are there are interruptions); communication; support staff; financial support.

Don't feel qualified to answer those. I am a S.A.D.D. advisor in a local high school.

Time-most DFS coordinators have several other job responsibilities, commitment/support of supt., emphasis on building interprofessional relationships, community involvement in the education of our youth

Common goal, adequate time

Cooperation, respect

Ongoing education, communication

That it is a team effort and not one agency, individual or group by itself will be able to get the job done that is needed.

Release time, agency commitment

Comfort level among professionals, coordination/coordinator to set dates, mtg. places, etc., working and efficient subcommittees, organization

Willingness to walk for a community goal

Cooperative members, organized programs, common goals
Set goals and agree on what needs to be accomplished!

Time, money

Money, time, support from administration training, money

Everyone working for the same goal, activities students enjoy and relate to.

Newspapers/media coverage, hospitals, churches, business cooperation

Communication/collaboration, commitment, time

"Collaborating"- not out to make self/our program look better, each taking an active part-not just relying on one person, same mission.

Focus on common problem, central agency to bring profession's together, good problem solving model, good time management when meeting

Time, $, willingness to give up "territorial rights"

Recognized leader that is full time, paid position in every school district; planned meetings, goals, supported direction; money for participation and resources; commitment from school, community, nation, state, local officials, all teachers and administration

Reports, agendas, etc; forms for co-ordination

Knowledge of chemical dependency and the current drug problem among teens, a commitment to our youth, responsible people each willing to take a part

Release time, funds, materials, good resource guide, parent involvement

Time and commitment

Time, money

Money, time

People, money

Cooperative people, financial resources
Cooperation of administration, strong leader to organize, sharing of information about kids, idea of direction of group, sense of commitment to community

Need for service, global view by agencies, team approach by political officials, caring attitude by participants

Support from administration, time (release time for teachers)

Finances, staff training

A full time coordinator (or at least one who can contribute 100% of contractual time, a working knowledge of the support sources in the community, no "turf" issues

Accessibility for handicapped, therapeutic environments, speakers, workshops

$, time

State-federal funding, citizen's drug free network (CDFN), gateway outreach program, coordination of school & local programs

I feel my advisory board has been an invaluable resource because they represent many walks of life and different communities

Time, $

Time, money/to fund positions, support of administrators

Ongoing communication, mission statement, specific goal w/objective

Enthusiasm for prevention, Knowledge about new violence/use of chemicals affects community, Time and place routinely set to share ideas/problem solve

Finances, time/schedules, openness, collaboration

Time set aside to meet and discuss ideas, Effective curriculum, Competent teachers and professionals, Caring and dedicated adults, Money for materials and stuff

$, common goals and purpose

$, positive attitudes, cooperation, acceptance, commitment
Organized/able to document, leadership ability, compassion/education, persistence, willingness to collaborate

Common goals, shared resources, expertise

Release time, interested staff, knowledgeable staff

Respect for/belief in viability of prevention work necessary to implement program, Priority to prevention-assistance with developing objectives and assessment tools

Time, money

Time, money, genuine concern

Making DFS #1 priority, full time person to run DFS program

Time, money, common goals

Staff, facilities, budget

Willingness to work together for common goals

Time, resources - (financial), willingness to do it, inservice

Common understanding of problem and common acceptance of effective responses

State support, local effort, county leadership

Time in busy schedules to meet, sense of useful purpose, concern for young people

Ideas for programs, interested non-school persons, meeting time

Time-availability of teachers and other professionals for interaction, $ for substitute teachers and materials, shared vision of goals, priorities, shared vision of goals, priorities, administrative support (policy, procedures, sanction, enforcement), parental involvement

Money, cooperation

School, business, criminal justice, parents, city
Willing participants, qualified participants, timing can be difficult

Cooperation of administration, dropping turf barriers, having a job for everyone, support of local boards, money to implement

Money

Schools really need assistance with developing interprofessional practices, time and staff prohibit the development of interprofessional practices as most, drug free coordinates are also in charge of a hundred other things

Team training, regular mailings, decision making component in meetings who can change policy in a group, good communication

Time, availability of personnel, willingness of administration and supervisors

Availability of profession expertise, facility, materials support, administrator support:

Flexibility for scheduling, acceptance of historical perspective, acknowledge of expertise

Time, cooperation, willingness, money, unity

Empowerment & charge from community, empowerment & charge from local BOE, "Big Picture" view of previous. goals targeted, financial support, business commitment on local/regional level

Opportunity for all to meet at one time, cooperative planning

Most professions have full time jobs already, time to coordinate the team, common time to meet

Community where there is good communication

Time, willingness to participate, community attitude

Board policy, needs assessment

Direct service by triad, experienced professionals

Community awareness
Willingness of professionals to work together, time

Administrators to make drug free schools prevention and priorities, involvement of parents in decision making, administration to set a priority for prevention, students need to be involved more

Time, financial resources, common goal/mission, someone to get it started, coordinated, requirement for funding both school, districts and agencies

Full time coordinator, impartial individual

Supportive administrators in our schools, adequate funding, support from teaching staff

Community based (sch./village/church), coordinator in charge of entire program, family and peer pressure based programs

A individual or organization who assumes responsibility to make it happen, adequate funding

A willingness to be a part of a group interested in helping and working with young people

Cooperation between staff, student, adm. business, health dept., etc., United front to present facts to students

Time, availability, places to meet, coordinating schedules, communication skills

Coordinating by county office, money available, office to use, space at a school to use

Continuation of Safe and Drug Free School Grant

Time, money, cooperation, support, commitment

Stable funding

Time, money, space

$, communication accessibility, support

Financial resources are limited each year, time is a problem, materials, good communication
People who are paid for their effort/work, people who can work full time in DFS programs, or people who are part time but wholly in DFS

Time allocation, meeting schedules

Networking time, support at administrative levels, staff training/training with community prof.

Need time to meet, need a common agenda

Time, administrative commitment, staff training, parent training & awareness, student curriculum

Knowledge of the availability and function of various agencies, time allocated for collaboration of efforts

Financial, release time, substitutes

Professionals within the district that can make themselves available, released time for school personnel to be able to meet, an area which is outside of the school setting in which to meet, community support for such a collaboration

Working towards a united effort. Establishing common goals. Developing a comprehensive community program.

Time, cooperative attitude

Money (available for programs, space for meetings, time scheduling meetings, books, videos prof. journals, etc., members have common goals and good interpersonal skills

Available time, money, coordination of effort

Time, finances, commitment, resources, expertise

Cooperation of agencies, involvement of administrators, commitment

Open communication, no guilt/blame

A wide variety of professionals involved, meeting place

Time to operate, funds, resources, place, lots of help
Time, school/community support, volunteers, interest

Cooperative student participants, available resource personnel, support of parents

Having a stated goal, available money for after school activities, commitment on member's part

Support of superintendent, support of school board, full-time program coordination, funding, enthusiastic people

Funding, time to meet and work together

Leadership, commitment, common sense of purpose/goals, financial means to reach goals, time/scheduling allowance

Cooperation, flexibility, consistency, communication, client/student centered

Not enough people employed in our school system to handle the load, More financial support needed, Loss of our specific coordinator has hurt our effectiveness, continued commitment and patience with efforts.

Court cooperation, networking w/social service agencies, school staff participation

Leadership (paid), central location, money

Cooperation b/w involved parties, time, monies

Communication, local funds, community support, cooperation, time

Participates, central meeting places that are neutral

Time, money

Community support, an effective prevention program by ADAMhs board, skilled professionals, skilled professionals with time to do the job adequately.

Time away from desk, meeting place, money, people to meet, community involvement

Adequate funding, available personnel, time for coordination, energy and commitment
Time of participants, finances, understanding of what is to be done, by all.

Adequate funding

Common goals, commitment to collaborative network

Commitment from the top (board presidents, superintendents, city managers, etc.), sense of power to be able to make decisions, committed individuals to serve

Time, money

PTO, police, administration, teachers, specials

Vision, commitment, common interest in addressing the problem

Money, administration support, community support/awareness, wide community collaboration, help of law enforcement

I have received no training/instruction in "organized" interprofessional team practice

Sharing of monetary resources, strong leader to start the process

Collaboration of diverse professionals, support of outside community

Understanding - generally-of problem as it exists-knowledge, ownership - problem belongs to entire community, financial support, constant need for educating team about extent of problem and opportunities, creativity-multi disciplinary team of professionals must be able to break new ground-try new things

Development of team concept, extensive planning, grants money, training of staff

Appropriate training of all members, communication between members, full commitment of all members, clear definition of goals.

Cooperative attitude, flexibility, goals, financial resources, training
Good relationship with people, cooperative attitude, sharing of resources, child centered priorities, open communication

That we come together on a consistent basis to discuss what we are doing, agencies offer free services of all sorts of schools and communities, yearly updated directory of contact people-who and what in services

Well informed members, a variety of agencies represented

Time, $, Interest

Oral agreements, knowledge of what others do, trust

Time commitment/comp time etc., dedication to program, communication among participants, a coordinator for entire program.

Knowledge of available resources in community, encouragement/support of interprofessional concept.

Willingness of people to volunteer time, continuation of local drug and alcohol prevention. Agency, continuation of Drug Free Schools Grant, willingness of school staff to be involved, keeping someone on staff to coordinate activities

More time, more money

All involved professionals should have input regarding use of money, shared information of effective prevention programs, community involvement

Common time to meet, commitment to the program goals, willingness to do "leg work" to carry out subgoals, financial resources, technology resources

Support of top administrators, personnel who support program, cooperative networking

Cooperation, time, money, pride in community, trust

Communication, dedication, desire

Often becomes/remains the school responsibility for coordination of community-based interventions.

Dedicated participants
Time, money, commitment by school administrators, commitment by other professionals

Communication, shared experience, administrative support

Time, money

Realization that substance use is a community problem and not just a school problem, appreciation and respect for expertise from each profession, mechanics and coordination of the interprofessional team

Opening communications, willing spirit to collaborate, scheduling activities at approve times, commitment to projects, evaluation component

Funding, readily available material

Time, knowledge of other agencies, assistance available

Coordination, time-plant/implement, increased personnel/student ratio

Administrative support, policy, money, time

A measurable objective, school-law -court-service, people working together, a well thought out program

Explaining expectations, timing, asking and including others

Agreement on goals and objectives, willingness to work toward interprofessional objective over personal agenda, adequate funding to implement program activities, a broad based program to meet the needs of all age

Trust in the abilities of other members, Support from administrators of involved agencies, Coordinator willing to work with various agencies

Time to meet, larger resource pool needed

Release time for school officials to attend interprofessional meetings

Active participation, better time management, more effective coordination of paperwork, good leadership-organized, planned motivating, moving to action on behalf of students

Red ribbon week, DARE program, MADD/SADD chapters, local law
These people all need to know that they're listened to by administration, etc.

Funding

Funding, stability of funding, cooperative school administration, community agency level of training and commitment

Sharing information, dedication of members, training

Availability of resources, close (distance) services, common site for service-providers-better coordination, etc.

Communication, time allocation by employers team member, true commitment by full community

Coordination/cooperation of programs, agreements of what problem, agreement of solution to the problem

Money to promote drug free programs and activities, concerned/educated staff to drug alcohol problems, open communication between staff and administrators, parents & community interest & support, full-time or even part-time coordinator

Time to network, ability to develop interest of outsiders and parents

Working with local fire department and highway patrol on anti-drunk driving, working with drug counselors in the classroom, DARE

Administrative support, release time from reg. job duties, funding, understanding of mission/requirements of various professions, optimism and commitment to prevention/intervention. Openness to new strategies.

All team members need released times that coincide on a regular basis, all people must have a vested interest in our students, there must be compensation for time with this alone. I can't do my regular job and this justice.

Discussion with other schools about their program

Support, monetary and otherwise from Children's Services, Juvenile Court, Tri County Mental Health and Counseling as well as the school district. Hocking county is blessed with great interprofessional working relationships.

Scheduling is critical. Knowing when and how to utilize your professionals
Increase access to services, decrease in agency competition, facilities for service within schools, agencies more open to school indecision in services, increases community commitment & involvement

Time, $, interest

Drug/alcohol agencies, hospitals, staff and administrators that believe in the program, strong program

Time: demands on professionals, limit time to meet to discuss individual cases; identifying key people to be involved on the team

Community links

Office, room space for groups/office, administration backing

Alcoholism Council takes leadership in organizing a Butler County Core Team, Our DARE officers have worked out very well.

Time to meet, respect for all members of the team, leadership, willingness to make a commitment, financial support

Facilitating the team, access to resources, coordination, education, finances

Financial resources, personnel, time, facilities and technology

Professionals who would donate their time and services, time to meet

Open communication, cooperation

Adequate resources, a substance abuse policy, a substance abuse strategic plan, opportunity for meetings of professionals, interest of professions

Open communication, time/space for meeting

Coordinator/director, programs and training, community support and commitment

Time, $ 

Availability of personnel during work hours, leadership from local community
Finding a time suitable to all to meet, setting goals and objectives for the group to accomplish, developing policy for the community re safe D.F.S., clarifying roles/communicating, money

Telephone directory of agencies available and who to contact

Willingness, organization, specific plan, impact, outcome, coordination

Time, specific needs, interest, coordination, leadership

Opportunities for networking, opportunities for communication, conferences

Cooperation, money

Commitment, space, seriousness of abuse of A/D (norms), energy-time to be creative, support of for each other

Time allocation, money, communication

Supportive attitude, cooperative spirit, formulation of working councils

Sincere concern for students not for just protecting turf., More resources geared at helping families.

$, direction from superiors, seen as a priority by superiors, understanding of problem by superiors, community values

Coordinating time when team members can meet, community support, parental commitments, money to fund programs, resources to meet comprehensive programs

Community based, programs comprehensive in nature, factual information regarding the community, i.e., (surveys)

Time

Time, communication

Cooperation

A leader-with clerical availability, good balance on team, shedding of personal agendas
Qualified instructor that relates well to students

Time, money

Willing to work together, time for regular meetings, research to back up interprofessional practice.

Time, financial resources, interested personnel

time resources

Community leaders, police department, drug agencies, social workers, parents

Community interest and support, financial assistance for programs, school leadership and coordination of programs, time commitment of volunteers

Money, one person coordinating, good policy, interested trained CORE teams, time

Time to meet together, willingness to work together

Time

Commitment of personnel involved, adequate time for personnel to meet together, adequate financial resources

Time to work together, money to pay professionals

Finances, less expensive materials available, exciting programs for teenagers

Time, expansive team

Time, location

Time, available, interested, professionals

Respect for the contributions, perspectives, and expertise that each team member can make. Shared ownership of the problem and creating solutions. Stronger priority for local, state and fed. funding. On-going training and commitment to becoming knowledgeable. Commitment to meeting times, objectives and projects.

School-community commitment, outside agency help, feedback on referrals
Money

People, youth/family center

A variety of professionals

Time to collaborate, common missions, open mindedness, commitment to the projects, fair and accurate evaluation of DFS programs

Time to meet for coordination and collaboration, resources are available when needed, watching that the $ used is spent on worthwhile and beneficial programs.

Substance abuse agency, DFS funding

Traditional families & communication, school administrators willing to punish those breaking rules

Huron County Health Dept., Huron County Collaborative 90's, space, time to meet, open minds

Coordinator, human resources, administrative support, released time for team meetings

Condition-recognize, problem, acceptance of student asst. model, leadership

Meetings, videos, presenters

Time, money

Time, understanding of the field of prevention, awareness of effective programs, money

Number of professional organizations that serve a community, amount of funds available for drug-free programming

Continuity, stability, enthusiasm, trust/communication

Convenient time, people to serve

Leadership, finances, time, space, community acceptance

Funds to coordinate such programs, people/personnel to run these programs
Coordination of communication

Meeting time acceptable to all, education aimed at how interprofessional team members can contribute, support from administration in school

Time, attendance to meetings

Communication, time, support of administrators, clear focus, commitment to need for Drug Prevention Activities

More staff, more time, more staff, more staff, more staff

Leadership to involve everyone, adequate resources including funds, time to meet and collaborate

Released time, If we had the above we would have more members to help. Only two people really run this program. The rest of us just refer or consult.

Time
APPENDIX F

RESPONSE TO OPEN ENDED QUESTION 22
**Question 22:** List barriers to interprofessional practice in the coordination of the Safe and Drug Free Schools Program.

Comments separated by respondent and are included in random order.

Time; lack of infra-structuring.

People don’t recognize the need; changing leadership at various positions; not knowing how to apply resources and for greatest impact.

Lack of funding; community awareness and released time to plan, attend meetings, etc.

Teachers free time; money and inservice.

Problems related to rural areas - few professionals; Isolated schools doing their own programs - lack of coordination among schools and community; lack of money to pay professionals (TWYSAA cost $1100 for 50 students). Sheriff says no money for DARE officer and neither he nor commissioners can get it (cities have it).

Time limitations and coordinating schedules.

Time - many of us are not full time coordinator and lack of awareness by other professionals.

Lack of time and sometimes no motivation from staff.

Many teams are intervention/TX based rather than prevention.

Turf issues; different theoretical backgrounds; different priorities.

Lack of administrative support and lack of staff support.

Finances and faculty.

Appropriate funding.

Money; time.

Conflicts in time/work schedules.
Money (lack of funds); district in loan fund. No money; except grant money for implementing "Drug Free Schools" programs.

Lack of support especially from school administration, viewing comm. constituencies as "closed" systems (esp. schools), turf issues, lack of organization or shared responsibility among interprofessional teams - seems as if one person or group has to take most responsibility

Time.

Time.

Lack of time; turf issues; different perspectives, mental health views are different from alcohol treatment views.; lack of motivation from all agencies. This becomes a lower priority when thrown into the mix of responsibilities.

Lack of time; lack of involvement from educational community and not serious enough attitude.

Everyone is already on "overload"; not enough to do lots.

Time and money resources.

Lip service no meat; not enough time; looks good on paper, but practical application hard to do; need more than just band-aid approach and commitment by total "community" to work on their issues of youth.

Time; administrative support; communication and lack of communal goal.

Availability of professionals; commitment lacking and other interests.

Limited Staff

Lack of funds; lack of communication; lack of ready resources (and side agencies); burn out from frustration - with handling of funds. I am very discouraged. All funds have been cut. I've begun some exciting things which will die if I don't have financial resources.

Time; money; pre-conceived hang-ups and too many seem to be too old to be willing to make necessary changes - fear of unknown.
"Turf" issues; lack of funding for programming; lack of initiative to accept responsibilities; inconsistent team attendance at meetings and lack of time (#1 issue).

Schedule conflict and priorities.

Funds for programs.

Lack of communication and knowledge of different organizations; lack of coordination of agencies and teams of responsibilities/roles.

People; time; space and money.

Parental investment; business investment; DARE institution and PR; track of funds and shifting focus from politicians.

Denial of the problems existence by school, parents, students, and community; seeing it as a priority and coordinating schedules.

Schedules, time franchises and funding.

Time/Schedules/money; location/expense (see above); some professional people such as MD's consent to attend - then do not; expense of newsletters etc. and support staff (e.g. secretaries)

Open communication between agencies

Facilities, Finances

Time, willing professionals, financial resources

Time, time, time, money, money

Time, physical gathering together, funding, resources

Not enough funding, the lack of commitment in follow through, time restrictions, communication coordination

Finances, engaging more sectors to participate, denial about substance abuse problems.

Money
Lack of time

Time, money, scheduling

Time-off from work, etc., money available, turnover in staff

Commitment and consistency in the operation of an established program by community members, turf, team members other duties and commitments, social values/marijuana and alcohol are becoming more acceptable. In a rural area it is more difficult to coordinate services.

Lack of funding, "turf issues"

Turf, funding based on "turf"/services creaks competition

Someone to coordinate efforts

Lack of access to professional tools

Administrative ignorance, staff ignorance

Time for collaboration

Time - decisions take too long, lack of commitment, attendance at meetings events, low levels of expertise, no agreed upon goals

Lack of communication, inadequate funding

Geographic constraints, inadequate planning

Time- most DFS coordinators have several other job responsibilities, priority by supt., board, administration.; money, realization that alcohol is a drug, community concern

Lack of communication, denial of problems, inconsistent approaches between agencies, law enforcement schools, etc.

Time, money

Release time, $, availability of social service agencies (distance)

Time and schedule factors
Time support from administrators, time, no money, time
Lack of time, lack of money, lack of commitment
Scheduling, failure to always share info, failure to ask for assistance
Time, $, willingness to be less territorial
Time
Time constraints, over commitment/too many things
Not enough time
Time
Finding a convenient time for meetings
Time when we can get together for meetings
Finding mutually agreeable time to meet.
Space for assemblies, time with all the added testing requirements and curriculum changes, 1 person has too many responsibilities in addition to this
Funding cuts, burn-out, lack of concern/understanding on behalf of parents/community
Employees resistance to non-use of tobacco and alcohol
Dollars
Government bureaucrats, massive paper work, uncertain funding
Limited resources, one person in charge of program
Time, turf
Flexibility of curriculum calendar
Time for coordination
Agency heads wanting to work together, chemistry is not there for working together.

Time, connecting resources networking, lack of personnel, schools isolated-community spread out, one person who has time to coordinate DFS on full time basis

Lack of available funding, public mind set that a problem really does not exist, society's acceptance f substance abuse as an ok thing, i.e., teen age drinking, smokeless tobacco, etc.

Lack of concern, lack of time, lack of financial resources

Talking clearly about goals, territorial issues - philosophical approaches, meeting time vs. delivery of services

Lack of common time, lack of common location, lack of leadership, unwillingness or legal barriers to communicate, uncertain funding and considerable time and effort getting funding and accounting for it!, (No one agency or group is able to focus exclusively on the problem.)

Differing goals and philosophies

Lack of interagency coordination, lack of people to do all the work required, lack of money, differing ideas on what prevention means

Time, all agencies seem understaffed and have heavy work loads

Professionals on the committee have various job duties-not always time for DFS, DFS

Program not top priority of employees-e.g., person makes commitment but "boss" gives other assignments, more affordable treatment centers, at state/national level conflicting campaigns and seasons-Red Ribbon, SADD Awareness, None for 21-Prom Promise

Responsibilities in your own profession/school district

Time, money, unwillingness to cooperate, who runs the program? team?

Not enough programs-inconsistencies among districts, decisions made only by grant writer, professionals involved in additional programs and committees
Finding the time to meet, managing strong leadership personalities, changing staff

Politics of school system, liability

Rural area, lack of funds, everyone is too busy with their own agenda, lack of coordination.

Time/schedule constraints, turf issues, lack of collaborative agreements

Distance, time to talk limited, busy schedules, territorial issues.

Lack of funds, do not include schools, need equipment (computer on line, etc.)

Lack of equal commitment from all members.

Time to meet, other duties Drug-free school coordinators have

Time, it has-DFS-has made the program no ones responsibility

Protection of turf, protection of money, community understanding, full local school support

Time, money, interest

Funding from state

Time, lack of cooperative effort, political isolation

Time away from desk, meeting place, money, people to meet, community involvement

Time constraints

Time, money

Competing for same funds; duplication of services, not cooperating; Lack of qualified people in positions who do not have the knowledge of social work practice or the benefits of interprofessional practiced.

Time for all personnel to meet, commitment "wanes" on some people's part, time to coordinate and communicate with one another.
Community attitude, tax law enforcement, lack of priority for school system

Time constraints, availability of members— at the same time; requires much coordination and cooperation—which may limit its use.

Attitudes

Having time off from their jobs to work on projects, remembering to attend meetings, not knowing what will work with kids, no funds

Time restraints, scheduling conflicts

Time, finances

Lack of follow through, administration not buying in

Lack of finances, lack of release time, lack of substitutes

The above are also barriers in our district, the lack of recognition that there is a problem also is a barrier

Time!—being a classroom teacher, have limited time, schedules—release time, personal "territories", everyone having the same agenda

DFS is not primary reason most involved are hired by their employers, funding needs; any amount available can be spent

Time allocation, meeting schedules

Time restraint, shortage of qualified interpreters

Lack of parental, community support

Having to have nonprofessional groups

Outside agencies having no frame of reference for the school setting

People who do not follow through with their responsibilities, competition with each other

It is sometimes hard to get everyone involved together.

Time to meet, money to effectively put together a program
Most agencies certainly school districts are going a hundred different directions at the same time, no one to take the lead, then coordinate, not required for funding, can't count on funding DFSG funding cut 46% in our district for 94-95 school year-may be "0" in 95-96, turnover in both agency and school district personnel assigned to DFSG projects

Not enough time

Time restraints, location, limited personnel within area-the personnel with the exception of the school will actively participate in the city but rebuff local area even though these people are their customers too, immunity attitude (in denial)

Communication, the status quo, administration-change

Opportunity for all to meet at one time, cooperative planning, when time not available for group meeting

Lack of funding dollars to implement program, lack of continuity in programming

Time, commitment, money

Money, affordable training, good models & education of concept, commitment

Mixed goals, confidentiality laws, burn out, lack of community support, lack of funding

Lack of money

Not enough time, not enough people to help during 8:00 A.M.-10 P.M. hrs., conflicts over best prevention program for community-different ideas, should different faces, money and youth activities in evening

Lack of community resources for some kids, disinterest in welfare of kids by business community, sense of futility kids who abuse

Lack of common time for planning, program activities, inadequate financial support, lack of understanding of the institutional "culture" of the schools by other professionals, lack of willingness to share credit/resources, institutional inflexibility

Territory-not my job-on this is my job only

Lack of time
Time, expertise, lack of awareness

Lack of time to meet, unable to know who to contact within community

Time-to do anything, time to get people together, willingness of court to work with schools, parent's denial, administrators refusing to intervene

Time, money

Lack of money, lack of cooperation

Meeting times, getting volunteers, finances, community involvement

Time, money, territorial-ism

Money, time, facility, personnel availability and numbers, commitment by society

Lack of cooperation, lack of finances

Lack of "big picture" view, reinventing the wheel, lack of research base, dwindling funds

Time and schedules of professionals

Lack of money, lack of time

Time constraints, other duties for those of us for whom this is only a part of our assignment, often an "add on"

School system needs to sell

We need to work together if we are to make an impact on our students and parents.

Working just in the schools

Time, money

Time restraints

Other agenda's

Time
Time, money, space

Time, denial-community, levy votes-job security is always unknown

Communication, time to meet, turnover of workers, need names of workers, not title

Lack of parent/community participation, denial/enabling, lack of community ownership

Time, confidentiality guidelines for educational agencies vs. public agencies

Time, money

Turf issues, budget & funding concerns, denial, time limited

Scheduling, lack of follow up

Time, commitment, belief there is a need, willingness to participate

Lack of money (available for programs, space for meetings, time scheduling meetings, books, videos prof. journals, etc., members have common goals and good interpersonal skills

Lack of superintendent/board support, lack of time, lack of secretarial help, funding, turf issues

Guarding your own "territory", inflexibility, lack of communication, not putting kids first, rules, policies and paper work

Funds, time, lack of understanding, organization, training (lack of)

Paid leadership, central location, money, turf issues

Lack of communication, funds from state and grants, lack of community support, time, $ local funds

Time/scheduling conflicts - lack of time, lack of agreement or goals/priorities, personal/professional conflicts between members, financial constraints in some areas

Time, treatment programs only available if you have a lot of money or excellent insurance, agencies funded by the ADAMhs board are ineffective
Time, finances, understanding of program

Turf issues

Schedules, other curriculum priority (attitude), fear of students

Lack of funding, minimum number of personnel, inadequate time allotments

Geographic - rural area. Nearest city with other professionals is 8-10 miles away, funding-decreased money=increased difficulties of coordinating interprofessional practice.

Time-so many team members re already so involved in so many activities, $ to purchase program materials, training for teachers (substitutes), a community that always looks to the schools to provide the "fix", persons who come onto the school team, but have no real concept of school operations, but do have some idealistic picture of how things should work.

Lack of professional training in inter professional

Lack of financial resources, lack of commitment from top leadership, time

Everyone is busy, finding common meeting time

Conflict of team members, need time to review progress

Most members must volunteer time, everyone is very busy, cost: need funds to pay for coordinator, comp time, etc.

Time, money

Everybody jockeys for limited $, don't know who does what-especially agencies, government keeps re-inventing the wheel by taking away from one place/giving it to someone else

Ego's who protect turf, limited vision of problem, lack of community support, denial of problem by parents, denial of problem by schools

Much of agency involvement is solely based on grant $. If grants are not available, agency personnel aren't either.

Money
Lack of $, commitment of school staff, lack of involvement of administrators, inadequate communication system @ school. In small school systems with few $ there is danger of not having a coordinator because in this situation someone has to squeeze these duties in among an already packed list of duties.

Lack of communication, experience, administrative support

School finances, closed minded teachers and school personnel, overburdened teachers, denial that problem exists

Time

No interest, not enough time

Financial support

Time, money

Time management, overload in work/responsibilities, population size

Multiple locations, different goals/objectives, funding concerns, respect for even others roles

Busy schedules, distances

Reliance on ineffective methods education, e.g. . . .

Time/work schedules, finances/funding

Time, willingness to get involved

Time when all can meet together, looking at the small picture instead of the good of all.

Time and location of meetings, different expectations as to what is important!

Finances, time constraints

Adequate funds, adequate time to meet and plan activities, coordination of multi interested agencies and organizations

Lack of staff, lack of facilities, lack of budget
Time, money, expertise

Inability of team members to coordinate meetings with their busy schedules

None that I've found.

Money, time, bureaucracy

Time to do job and get together to coordinate efforts/strategy

Time-my position is teacher, I teach 6 classes and have 1 period 43 min. a day for Drug Coordination

Time

Territorial-ism, system differences, denial, differing theories/beliefs regarding prevention/chemical dependency, time limitations - release time, high turn over rate professionally (in drugs/alcohol)

Scheduling conflicts

Availability of time

Competition to provide services, duplication of services, lack of communication between professionals, other professionals discount school personnel expertise and involvement

Denial of problems in the community, communication between diverse interests, time and interest, main concern is not so much the professionals-getting parents, business community, etc., involved is next to impossible, lack of policy and specific goals.

Time, size of school district, ours has 14 blds and they are geographically spread

Time schedules and demands of team members

Finances

Inadequate funding, inadequate personnel, inadequate time, inadequate facilities and technology

Lack of interest, lack of opportunity, lack of finances
Fear of loss of control of a program, personal egos

Time, $

Coordinating the time for everyone to attend, some people may not want to get on board

Limited time, apathy by those served

Time, money, space

Time/schedule conflicts

Lack of time

Turf protection, money, denial, time!

Availability of personnel, money (to hire subs. or secure additional personnel), time, lack of defined goals and objectives (agreed upon), resistance to change

Time, communication

Schedule conflicts

Lack of commitment, lack of focus of committee, lack of release $ for core leaders and teaching staff, lack of time for in-serving staff due to union contracts

Funding, major turf issues, administration against outside involvement

Rivalries between groups/individuals, lack of funding, regular meeting dates

Time

Denial of use, parent denial when problem exists, non-interest of parents in education. for this area, time, pay for activity advisors

Turfmanship, state/federal regulations (confidentiality, billing systems, time factor

Time for meetings, limited classroom time for drug education activities, distance from office of agencies
Community resistance; lack of parental involvement; A working with "blinders" on attitudes, Territorial-ality

No time, no money, no cooperation, no communication

Time

Cuts in funding, time, space

Meeting times, costs to agencies, degrees of difference in exposure

Too many other job responsibilities

Apathy by organizations, administration which doesn't care, large amount of people switching jobs

Availability for staff time for training, time and coordination to teach DARE - GREAT-QUEST...

Turf issues, money, people

Time

Time to meet

Not enough time people busy, cuts in funding, changes in administration, lack of awareness of the magnetics of the drug problem

It seems overwhelming, not detailed plan, no leader, attitude of here today, gone tomorrow, denial of the problem from every direction

Scheduling time for meetings

Each member out to make self look good, each wanting to "own" their own program, everyone not being on same wave-length, burnout

Amount of time, money needed

Lack of personnel, time, training, funds

Money, time

Volunteers, time to meet, support of administration. and staff
Coming to grips with the seriousness of the problem.

Time for people to meet.

Parent apathy, commercial promotion of alcohol and drugs, distance/travel time, lack of positive role model, lack of time for implementation of programs due to other mandates, involves regular academic time

Don't feel qualified to answer those. I am a S.A.D.D. advisor in a local high school.

Conflicting agendas, insufficient team building and collaboration

Lack of communication, Lack of leadership, Lack of unified services approach, Lack of time for "teaming"

Time, money, concern/caring

Time, interest, scheduling

Funding, time conflicts

$, time, lack of sufficient personnel

Larger resource pool, better parental participation

Lack of common meeting times, "Turf protection" by some administrators, Confidentiality and "Sunshine Laws"

Time, work overload, paperwork, money at the top (administrative spent for trip, banquets, meetings, etc.

Lack of funds, time in school curriculum, too many other pressing issues, lack of understanding as to how bad and deep the problem is.

Funding, time

Distance, multiple sites for service, time for coordination, etc.

Lack of funding, lack of a full or part-time coordinator

Time
None

Some agencies are more worried about getting a chunk of our grant $ than about saving our students, our agency has very young, inexperienced counselors who aren't familiar with school policies, attitudes, etc. We need more choices!!

There aren't many in our county!

Staff time (meetings, inservice), coordinator time-to build more effective programs, etc for our district, more money to work with

Rural area, lack of funds, everyone is too busy with their own agenda, lack of coordination

Schools locality. Rural schools do not usually have as much community support-have to go to closest city-where city school systems get first priority

Overloading of cases, time limitations, lack of education base

Lack of time to meet, differing focuses and goals, lack of community involvement and support, lack of time to coordinate activities, lack of coordination of efforts.

Time, money, problem referring students out without being responsible for payment of services

Money, time, lack of community support, lack of direction

Time/personnel to coordinate, lack of role specificity, $ available to

Time, interest, coordination, leadership, space

Time, location, worthwhile, effectiveness

Territorially, funding, competition for funds (same dollars)

Lack of volunteers-commitment, $ of alcohol-Liquor Industry, lack of communication between business schools, athletic-prof-programs, civic leaders

Too many other meetings, not enough dedication, not enough parent support

Getting others to be involved

Time money, commonality in approach
Finding coordinating time is difficult and to many busy schedules, available resources are limited in rural community, a significant number of parents are either too busy or do not see the importance of ATOD prevention.

S, denial, lack of support of superiors, community support, lack of community understanding of problem

Random programming, reactive rather than proactive planning

Egos

Money, time, commitment, parents

Time

"Release" time for planning for school personnel, money for training in teamwork, priorities for team training in relation to priorities for training in prob. areas.

Busy schedules, financial resources

Funding

Time to implement, lack of sense of urgency

Time, $, commitment

Loss of positions/people, lack of administrative support, unwillingness to participate, turf issues

Territory boundaries (policy), money

Everyone is busy

"Turf" issues, lack of time for coordinators not hired specifically for that position

Financial, time, other job responsibilities

Time, money

Attitude

Lack of support from community, money
No $  
Lack of time, inadequate resources  
Convenient time, people to serve, common objective  
Not enough time  
Time money  
Time money  
Lack of community leadership, lack of community involvement, no location other than schools for program/activities  
Time commitment  
Lack of time, lack of funds, loss of drug free money  
Teachers not willingly releasing students, as a volunteer, commitment time limited, not reimbursed  
Time-people are just busy! Scheduling  
Money is somewhat limited for purchasing videos, other materials  
Cooperation of individual school personnel and administration, lack of interest in safe and drug free schools program, lack of identification and referral to agencies by schools and for police  
Time set aside to plan and develop, financial resources  
Time, suitable meeting time for professionals, compatible philosophies  
Small district and town, limited resources available in community  
Turf issues, ideologies, time, $  
Time commitments, some funding  
Time constraints, follow-up programs, involving everyone  
Lack of money, lack of time, disagreement about what works.
Financial resources/local and funded, people

No time to really do the program, too many other jobs and duties required of staff.

Scheduling, communications

Fear, Egos, misunderstandings, funds, lack of time to process team issues

Time, coordination of agencies and curriculum

$, networking

Time

Lack of money, lack of personnel

Neutral space, narrow viewpoints, reluctance to change, lack of ownership of the problem

Number of professional organizations that serve a community, amount of funds available for drug-free programming

Time, need more time and staff to attend meetings

Finances, time, public perception, goals, leadership

No time to meet, financial resources, cut backs in programs

No single person to coordinate, lack of funds, lack of time

Lack of communication, organizational time, shared goals, recognition of issue importance, other more pressing priorities

Time, money

Time - difficult to get everyone together

Denial that the problem should be given priority. Legislation that protects confidentiality therefore inhibiting service coordination. Politics. Competition for grant funding. Focus on credentials interfering with problem solving. The one Upmanship. Our field knows what's best.