Interprofessional Opportunities: Understanding Roles in Collaborative Practice

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Interprofessional practice is a burgeoning movement in the field of health care. In recognition that no single profession can address the complex needs of many of today's young children, it is critical for play therapists to understand and possess interprofessional collaborative practice competencies. In this article, the specific interprofessional competency domain of knowledge of roles and responsibilities is examined as an essential precondition to effective collaboration between registered play therapists, occupational therapists, physical therapists, and speech-language pathologists working together in early-childhood settings. Fictional case examples illustrate how registered play therapists can actively collaborate with early-childhood therapists from other health-care disciplines to mutually learn from and inform one another. Implications for this mutual reciprocity have potential to improve collaboration between and across therapists within an interprofessional team.

Keywords: interprofessional collaboration, play therapy, occupational therapist, physical therapist, speech-language pathologist

The play therapist providing treatment to children in an early-childhood setting soon recognizes that no singular discipline, including their own, can address the multifaceted needs of families and communities. In an effort to address the complex physical, emotional, social, and educational needs of young children, a collaborative interprofessional approach is often recommended (Anderson-Butcher & Aston, 2004; Friend & Cook, 2010).

Understanding interprofessional collaborative practice as it relates to play therapy involves investigating the definitions, supporting evidence, and best practices that inform the field of interprofessional care. The World Health Organization (WHO, 2010) has referred to inter-

professional collaborative practice as when "multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care" (p. 13). Evidence demonstrating that interprofessional collaborative practice improves quality of service and contributes to positive client outcomes is abundant (Bronstein, 2003; Johnson & Freeman, 2014; Priest et al., 2008). Researchers have shown that interprofessional collaboration models are not only effective for both client and provider, but essential for cost-effective care (Levett-Jones, Gilligan, Lapkin & Hoffman, 2012; McClelland & Kleinke, 2013). Specific to community mental health settings, data retrieved from the WHO 2010 report, showed interprofessional practice increased client satisfaction, encouraged engagement in treatment, and reduced duration of treatment and cost of care (WHO, 2010).

Yet to practice collaboratively, specific competencies are needed. A range of competencies associated with positive collaboration can be found in the literature, with those most commonly emphasized being *communication* (Canadian Health Services Research Foundation; CHSRF, 2006; Interprofessional Education

Consortium; IPEC, 2002; University of Toronto, 2008), *understanding other health professionals' roles* (Barr, Koppel, Reeves, Hammick, & Freeth, 2005; Suter et al., 2009; Thistlethwaite, Moran, & WHO, 2010), *understanding the skills of effective team working, group norms, and conflict resolution* (Barr, 1998; IPEC, 2002), and *a willingness to collaborate with mutual trust and respect* (CHSRF, 2006; San Martin-Rodriguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005).

Interprofessional practice within the context of an early-childhood setting may involve specialists such as mental health therapists, physicians, educators, occupational therapists, physical therapists, and speech language pathologists (SLPs). Best practice suggests that creating collaborative relationships among and across professionals provides opportunities for mutual learning, planning, and feedback that lead to rich understandings of young children and families (Hepburn et al., 2007). Although practicing health professionals may collaborate together on behalf of clients, rarely are they learning about each other's roles or from each other (Hammick, Freeth, Koppel, Reeves, & Barr, 2007; Oandasan & Reeves, 2005). With evidentiary support of collaborative practices growing, it is important for play therapists to consider opportunities for interprofessional collaboration.

In this article, we have identified as registered play therapists who focus on the specific competency of understanding professional roles and responsibilities of others. This interprofessional behavior is highlighted by the Interprofessional Education Collaborative Expert Panel (2011) as being one of four core competencies for interprofessional collaborative practice: (a) values and ethics, (b) roles and responsibilities, (c) communication, and (d) teams and teamwork. As play therapists, we assert that the ability to communicate how the play-therapy role compliments others' early-childhood-therapist roles and responsibilities is an essential prerequisite competency to collaboration.

In this article, we examined how developing the competency of knowledge of professional roles and responsibilities of others by those who identify with an early-childhood-therapist role (i.e., registered play therapists, occupational therapists, physical therapists, and SLPs) creates opportunities for effective collaboration.

First we describe four professional early-childhood-therapist roles, balancing the identification of diverse role perspectives with common ground understandings, using play in treatment as a shared area of interest. Next, through case illustrations, we examine how the play therapist might use specific strategies, including informal exchanges, a community-of-practice model, a shared, direct service provision, and formal training experiences to inform and learn from other professionals. Finally, future implications for interprofessional practice and research within play therapy are suggested.

Play in Treatment: Common Ground and Diverse Perspectives

One overlapping area of interest and a point of shared conceptual understanding across early-childhood therapists is the use of play in treatment. Homeyer and Morrison (2008), both prolific play-therapy authors, reminded us that occupational therapists, speech therapists, physical therapists, and many other human-service providers use therapeutic play with toys and games to facilitate treatment goals respective of their disciplines (p. 213). Early-childhood therapists value play as the primary language of children, as a developmentally sensitive approach to assess, plan, and implement goals, and as a motivating treatment approach likely to engage children (Linder & Bixby, 2010; Parham & Fazio, 2008). Similarly, early-childhood therapists use play to help children gain skills in self-regulation, communication, and social skills, however differences exist within treatment focus, materials used, and whether play is viewed as the actual therapy. McMurtry (2013) suggested that when focusing on understanding roles and responsibilities, effort be placed on identifying both diverse role perspectives and the identification of common ground. To illustrate commonalities and differences in how four distinct early-childhood therapists perceive play in treatment, we present brief descriptions.

Occupational Therapy

Occupational therapy services emphasize the use of meaningful everyday activities to promote occupational performance (e.g., education, work, play, leisure, social participation, and activities of daily living, including sleep

and rest) within a variety of contexts (American Occupational Therapy Association, 2015a). With a strong foundation in child development and activity participation, an occupational therapist has specialized knowledge in social–emotional learning and self-regulation, task analysis for sensory, motor, cognitive and social issues, assistive technology, and environmental or activity modifications (American Occupational Therapy Association, 2015c). The occupational therapist might assist a child with body positioning during play activities, provide adaptive equipment that enhances the child's participation and enjoyment of a specific play activity, or look at addressing environmental stimuli that supports the child's sensory processing capabilities. Occupational therapists list play as an occupation or everyday activity of children and Parham and Fazio (2008) provided a view of the functional role of a child to be that of a player (p. 22). Additionally, occupational therapists understand that play serves as the vehicle that cultivates a child's interests, abilities, and cooperation, which in turn leads to mastery of skills (Parham & Fazio, 2008).

Occupational therapists Hébert, Kehayia, Prelock, Wood-Dauphinee, and Snider (2014) also identified the critical role of play in communication. Occupational therapists may help children with social interaction challenges involving communication, including difficulty interpreting social cues and rules and understanding the perspective of others. Some occupational therapists may choose to further specialize in mental health, bringing common-ground understandings even more closely aligned with those of registered play therapists (American Occupational Therapy Association, 2015b).

Physical Therapy

Pediatric physical therapists provide services collaboratively with children and families to promote the child's ability to actively and independently function in the environments of home, school, and community (American Physical Therapy Association, 2015). Physical therapists typically work with children with developmental disabilities and their families by focusing on minimizing the effect of a child's injury or disease on his or her ability to function.

As experts in movement, physical therapists apply clinical reasoning to examination, assessment, diagnosis, and interventions (American Physical Therapy Association, 2015).

Pediatric physical therapists might also use play to increase activity participation, facilitate motor development and function, improve strength and endurance, and to promote learning opportunities (American Physical Therapy Association, 2015). Playful physical activities, such as an obstacle course or a playground, are often used to engage, motivate, and offer a physical challenge for the child while increasing mobility, physical strength, and agility. If the child participates in the activities with other children, treatment goals that focus on improving spatial awareness, self-regulation, and social-skill development may also be incorporated.

Speech-Language Pathology

The work of a speech-language pathologist (SLP) involves prevention, evaluation, diagnosis, and treatment of disorders involving speech, language, social communication, cognitive communication, and swallowing disorders (American Speech-Language-Hearing Association, 2015). A pediatric SLP might use toys and games to engage and motivate children, realizing that language acquisition is a critical tool to gaining mastery over behavior and encouraging expression of emotions (Aro, Eklund, Nurmi, & Poikkeus, 2012; Campos, Frankel, & Camras, 2004). Evidence has suggested that children who engage in quality symbolic pretend play typically use more language (Lewis, Boucher, Lupton, & Watson, 2000). As many children talk or vocalize during play, speech-language pathologists might structure play activities that encourage communication or intentionally elicit specific sounds.

Believing play is young children's natural setting, pediatric SLPs use play in developmental assessments, resulting in increased communication, exploration, attention, and problem solving (Hwa-Froelich, 2004; Meisels & Atkins-Burnett, 2002). One researched-based model of a play-based assessment tool is the Transdisciplinary Play-Based Assessment (TPBA; Linder, 2008). The TBPA examines development in a sequential and holistic way, focusing on the child's strengths and needs

across four developmental domains: emotional–social, communication, cognitive–educational, and sensorimotor. The TBPA typically includes at least three professionals other than the parent (e.g., SLPs, occupational and physical therapists, vision or hearing specialists, nurses, teachers, psychologists, or other mental health providers) and is designed for children between birth and 6 years of age. The TPBA acknowledges parents as key partners in the assessment process and involves them prior to, during, and after the assessment (Linder, 2008). The TPBA recognizes a triad of essential factors that make up a holistic assessment: the expertise of parents, early-childhood therapists from multiple disciplines, and the importance of play as a natural context for children's development (Linder, 2008).

Play Therapy

The Association for Play Therapy (APT) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy, 2015). Registered play therapists are licensed mental health professionals who have obtained additional education, experience, and supervision in the specialty area of play therapy.

Play therapists view play as a child's preferred method of expression and the primary way of building and sustaining relationships (Bennett & Eberts, 2014; Landreth, 2012; Ray & Bratton, 2010; Stewart & Echterling, 2014). Play therapists perceive that children use play to express feelings, thoughts, wishes, and opinions (Gil & Drewes, 2005; Landreth, 2012). Registered play therapists are skilled in offering facilitative responses that communicate sensitivity, understanding, and acceptance of children (Cochran, Nordling, & Cochran, 2010; Ray, 2011; VanFleet, Sywulak, & Caparosa Sniscak, 2010). The way a play therapist listens, observes, and responds often has the potential to deepen, intensify, and facilitate the child's chosen play activity, as well as to encourage interactivity, all skills that could benefit the work of other early-childhood therapists. Examples of how the interactions of registered play therapists may enhance the other fields is explored through specific strategies, skill sharing, and models.

Strategies and Models

In an effort to share role knowledge with other early-childhood therapists who use play, a registered play therapist could share basic skills, such as maintaining structure; setting limits; continual validation of the child's thoughts, feelings, opinions, and encouraging responses; as well as the theoretical rationale behind the skills (Landreth, 2012). Strategies that promote adult responsiveness, such as following the child's lead or mirroring play when asked by the child to join an activity, offer concrete behaviors that can be easily understood and practiced by other therapists and are already skills applied in play-based assessment protocols (Linder, 2008; Parham & Fazio, 2008).

Play therapists have a long history of teaching others the language of therapeutic communication via play. Decades of play-therapy research have shown ample evidence of the benefits of filial therapy and child–parent relationship therapy, whereby therapists train and supervise parents to learn to conduct nondirective play sessions with their own children (Bratton, Landreth, Kellam, & Blackard, 2006; Guerney & Guerney, 1989; VanFleet, 2005). Additionally, researchers have highlighted how educators (Morrison Bennett & Bratton, 2011; Sepulveda, Garza, & Morrison, 2011; Stulmaker, 2013) and paraprofessionals (Demanchick, Peabody, & Johnson, 2009; Jones, 2010; Yoder et al., 2014) can be trained as playful therapeutic agents with support and supervision from play therapists.

Using a variety of formats and adaptations, play therapists can find teachable moments during interprofessional exchanges to educate others about their roles and skill sets. These exchanges could be brief, during conversations, consultations, or interprofessional meetings. Conversely, a play therapist can offer more formalized training over 1 or 2 days or a full range of training modeled after child–parent relationship therapy (Bratton et al., 2006) that includes didactic and experiential role-playing opportunities, with time limited coaching to deepen learning and understanding.

Other knowledge-sharing approaches might take the form of a community-of-practice model. Wenger, McDermott, and Snyder (2002) de-

scribed a community of practice as a group of people who share a common interest, passion, expertise, and practice. Therapists in early-childhood settings share many interests and topics appropriate for a community-of-practice group. Topic examples might include: communication with parents and teachers, reflective practice, or social-emotional competence. This type of community-of-practice model would not only build interprofessional knowledge, but would also create a supportive structure for professional relationship building. With each type early-childhood therapist valuing play to reach treatment goals, this shared interest might serve as an initial catalyst for role sharing and enhanced collaborative practice.

Another model could be an adaptation of filial therapy models, such as the RELATe model (Ray, Muro, & Schumann, 2004) or the child–teacher relationship-training model (Helker & Ray, 2009; Sepulveda et al., 2011). The RELATe model (Ray et al., 2004) is a condensed 7-hr modification of child–parent relationship therapy based on Landreth's (2012) model, spread over two sessions. Child–teacher relationship training (Helker & Ray, 2009; Sepulveda et al., 2011) is a phased intervention that fosters a positive relationship between teachers and students. This model has been successfully researched with teachers and aides in school settings and Head Start programs (Morrison Bennett & Bratton, 2011); however, no studies applying this model with early-childhood therapists were found. Stulmaker (2013) has the only known published study examining the effects of the RELATe model. These identified gaps in the scholarly literature offer future research opportunities for play therapists working interprofessionally with others in the healthcare field. To better illustrate how play therapists might collaborate interprofessionally with other early-childhood therapists, we have suggested hypothetical case examples.

Case Example 1: Sharing Skills

During a team meeting, Sara, the occupational therapist, shared her frustration with recent behavioral changes in 6-year-old Brielle, a child receiving occupational, speech-language, and play-therapy services in the local Head Start program. Sara shared that during the last month, Brielle was increasingly showing resistance to

leaving the session, resulting in tearful transitions. Sara mentioned the behavior change to Brielle's parents, who also shared an increase in transitional difficulties at home. A transitional warning strategy did not seem to help in either the context of home or the occupational therapy setting. Laura, the speech and language pathologist, also described similar difficulties with Brielle, although not at the same level of intensity. Laura provided speech and language services in a small-group format using a variety of games and musical activities that promote language and social-skill development. Laura recalled that Brielle was often the last child to leave the session, lingering to play with the basket of puppets in the corner of the room, which Laura had yet to incorporate into the sessions.

Carol, the play therapist, shared the child-centered, three-step acknowledge–communicate–target (ACT) model of setting limits (Landreth, 2012) and gave rationale for the specific wording sequence. The sequence consists of (a) acknowledging the child's feelings, wishes, and wants; (b) communicating the limit; and (c) targeting acceptable alternatives (Landreth, 2012). Discussion ensued among the therapists regarding the importance of consistent, clear, and concise language.

Carol also shared a fourth step, used when children persist in their behavior(s) even after limits have been set. She shared the careful use of "you choose" language, which lets children know they have a choice and the consequence will be a result of that choice (Landreth, 2012). Discussion ensued about how to set limits that were neither punitive nor rejecting and how limit setting could be approached as a way to respond to children that allowed the child to take responsibility for decision making (Landreth, 2012).

All three therapists agreed to use the limit-setting language across all therapy sessions during the next 2 weeks and to report back during a scheduled team meeting. Carol also agreed to share the language with Brielle's parents and her primary classroom teacher to increase the possibility of generalization across adult–child interactions. As the three therapists talked, Carol suggested that Sara meet with Brielle for a directed, structured, puppet-play session centered on problem solving, limit setting, and as a

way to include the child in behavioral rehearsal outside of the specific therapy sessions.

Case Example 2: Community of Practice

The interprofessional team at a early-childhood center decided to create a community-of-practice forum around the topic of parent communication. Three therapists recognized that they were all feeling frustrated and inadequate about their communication skills with parents. The registered play therapist initially took a leadership role, and suggested that the group follow a journal-club model (Afifi, Davis, Khan, Publicover Trust, & Gee, 2006) as a way to discuss current literature, gain sensitivity, and exchange insights.

The structure of the journal-club model within the community of practice offered accountability, new learning, and provided a forum for social interaction and relationship building. Likewise, as the group met once a month, insight into role knowledge, differences, boundaries, similarities, and commonalities emerged. Each group began with a short reading by parents raising special-needs children. As the group continued to discuss specific journal articles, the physical therapist shared that one of the parents active in the local support group for parents with medically fragile children asked if she could share her personal story with the group.

The community-of-practice group generated other topics of shared interest throughout the year, leading to role clarification, cofacilitation of social-skill groups, and interprofessional presentations at respective discipline-specific conferences. Socially constructed emotional support was increased to offset the feelings of isolation that often result as being the only one in his or her respective role within a school context (Peabody, 2014). The community-of-practice model offered the early-childhood therapists mutually collaborative relationships that positioned them to offer support to each other.

Case Example 3: Coleading a Self-Regulation Group

Nancy, the occupational therapist covering preschool to Grade-2 classrooms, approached Helene, the play therapist, to colead a small group with children identified with attentional-and/or sensory-processing issues. Helene agreed to participate, recognizing the positive opportunity to learn more about the role of occupational therapy in supporting self-regulation and sensory integration. Nancy and Helene colead the nationally recognized, evidence-based Alert Program (Mac Cobb, Fitzgerald, Lanigan-O'Keefe, Irwin, & Mellerick, 2014; Williams & Shellenberger, 2000), which uses the playful metaphor of the child's body as a running engine to teach appropriate strategies for changing or maintaining levels of alertness. Using songs and games related to self-regulation, both therapists incorporated vocabulary and strategies through play-based ways of engaging with the children. Helene appreciated how the Alert Program® could take complex sensory-processing information and make it accessible for nonoccupational therapists, and asked many questions about sensory processing to expand her knowledge and to share with parents.

The two therapists continued to run groups each semester for several years, finding common ground in language, play-based materials, and directive social-skills teaching. This interprofessional experience simultaneously helped their professional relationship grow deeper, as well as increased their understanding of each other's roles, boundaries of practices, overlapping interests, and strengths, all leading to other enhanced collaborative exchanges.

Case Example 4: The RELATe Model

Alex was a shy 4-year-old boy with cerebral palsy that limited his motor and communication abilities. Using a special wheelchair, he was able to join in the play activities of his peers at the preschool in his local public school setting. Alex was especially fond of his two mentors from 11th grade, Tasha and Elijah, who came from the high school twice a week to play with Alex and his peers during recess times. The play therapist, John, had been sharing basic child-centered play-therapy skills sporadically in team meetings, and decided to offer a full day of training, including RELATe (Ray et al., 2004), for the occupational, physical, and speech-language therapists during the next professional staff-development day. The physical therapist, who was the immediate supervisor of the 5th-grade mentors, suggested that Tasha and Elijah

join the training professionals, and parental permission was obtained.

During the RELATe training (Ray et al., 2004), the mentors were especially interested in the skill of encouraging statements and returning responsibility back to the child as a way to both motivate and sustain interest in play activities. Four weeks after the initial training, the group met again to discuss how the skills were or were not being used.

Since they received RELATe training (Ray et al., 2004), Tasha and Elijah had increased their facilitative responses and behavior, specifically attending to Alex's emotions, offering large doses of encouragement and returning responsibility to build his confidence and competence. As a result, Alex was initiating play more often. The three therapists reported that the skills were helpful not just for Alex, but for other students on their caseload. The occupational therapist shared that she was using the skills with her own children, resulting in enhanced relationship and improved behavior.

Implications and Future Research

Given the current focus on interprofessional health care, play therapists who identify as practicing interprofessionally position themselves as collaboratively competent practitioners. If interprofessional competencies are enhanced through particular experiences, it becomes imperative for play therapists to seek and offer reciprocal interprofessional opportunities. Positive, engaged, and mutually reciprocal experiences between early-childhood therapists offer valuable opportunities to learn from and about others' professional roles that ultimately strengthen interprofessional collaboration and bolster efficacious treatment.

We suggest that future researchers explore modified or alternate versions of teacher–child relationship training with occupational, physical, and speech-language therapists, or that they replicate the RELATe model study (Ray et al., 2004) with early-childhood therapists. In addition, future researchers could deconstruct other interprofessional competency domains, examine facets of play-therapist interprofessionalism within different contexts, or examine barriers and enhancers to the implementation of interprofessional education in graduate-level play-therapy curricula.

Conclusion

Collaborative practice depends on continuous learning and refinement of roles and responsibilities of those working together (Interprofessional Education Collaborative Expert Panel, 2011), which includes integrating one's own professional role awareness into the evolution of role awareness of others. In this article, our purpose was to consider the interprofessional competency of knowledge of professional roles of others through the lens of registered play therapists working with other early-childhood therapists (i.e., occupational, physical, and SLPs). We examined definitions, roles, points of common ground, and differences specific to play usage in treatment, strategies, and models of integration across roles. Finally, through case-study examples, we explored how sharing of role knowledge leads to collaboration.

The extent to which interprofessional health care offers new insights in guiding collaborative practice has never been greater (Interprofessional Education Collaborative Expert Panel, 2011). The need for a more integrative interprofessional approach is both timely and compelling, as registered play therapists have much to offer other professionals working therapeutically with children.

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