Journal of Music Therapy, XXXIX (4), 2002, 305–321

Collaboration and Consultation: A Survey of Board Certified Music Therapists

Dena Register, MM, MT-BC
The Florida State University

The purpose of this study was to examine the consultation and collaboration practices of board certified music therapists (MT-BC) in order to establish a baseline of service provision for this profession. Board certified music therapists who are members of the American Music Therapy Association (n = 2039) were asked to complete a survey regarding collaboration and consultation in their professional practice. Specific areas of investigation included (a) population(s) with whom the MT-BC works and site of service delivery, (b) self-identification as a collaborator and/or a consultant (c) populations with whom the MT-BC collaborates, and (d) frequency, methods, purpose, locations, and personnel for whom they provide consultative services. Responses (n = 873, 42.8%) from each of the 8 regions designated by the American Music Therapy Association (AMTA) indicated a significantly higher report of collaboration versus consultation among music therapists. Implications for music therapy education and need for further research are discussed.

Consultation and collaboration are key to growth and development of many professions. Collaboration is the process of working jointly with others in an intellectual endeavor to bring about change, and it implies shared responsibility. This collaborative process is comprised of decision making, problem solving, conflict management, and interpersonal communication among the group members.

Rubin (1998) views collaboration as a 12-step process. First the collaborative team must define the goal or vision, identify targeted outcomes, and recruit stakeholders for the team. Clearly defining the issue(s) to be addressed, selecting leaders, and formalizing their roles allow the team as a whole to make an action plan. It is also imperative for the team to prioritize targeted changes beginning with the least sensitive issues, and to effectively implement the

action plan. Professionalism and rapport among the collaborators allows all parties to celebrate success with internal recognition in order to strengthen the team. Data collection and systematic assessment help team members adjust and reinforce client- or patient-centered care. Finally, revisiting and modifying goals and objectives when necessary enable all parties to reap the benefits of comprehensive services. Additionally, the result of bringing various disciplines together "promotes an increased range and number of possible solutions" (Welch, 1998).

There are many factors that affect collaboration, and relevant literature supporting positive outcomes from it. Life history, cultural and systemic influences, training and experience, conceptual and pragmatic barriers, varying attitudes and experiences affect the collaborative process. Educational reform offers many examples of positive outcomes and growth as a result of collaborative efforts.

Smith (2001) found teachers to be excited, focused, more willing to take risks, more accepting of challenges, felt supported, and were encouraged by the collaborative process. Teachers agreed to participate in collaboration based partly on their prior experiences. These teachers cited such reasons as boredom and isolation as a catalyst for trying something new and breaking old habits and routines. Each of these teachers stated that collaboration was an ideal way for teachers to work together, was a way to end the isolation that they felt in their teaching, and offered opportunities to give and receive support in taking on new challenges. As a result, students were able to provide increased support to one another and stated that they recognized these qualities in the collaborative efforts of the teachers.

According to Gregory (1995), a collaborative relationship provides many benefits for higher education personnel, students, and K–12 schools. Publication of research, creation of resource materials, economic savings, better field experiences for students, student recruitment, and sharing of limited resources impact each of the parties involved in the collaboration. Faculty members who participate on a collaborative team report a greater awareness of the realities of teaching in a public education system. Additionally, the sharing of ideas increased their enthusiasm and motivation.

Landrum's (2001) experimental program, which used co-planning, co-teaching and cluster grouping of students at various aca-

demic levels and their teachers, resulted in a number of positive outcomes. Enhanced student academic performance, enhanced teacher competencies, and inclusion of various learning types and styles across cognitive levels evidenced the efficacy of a consultation and collaboration model in gifted student education. Results indicated potential "spill over" effects to the total school program.

These "spill over" effects indicate that collaboration among diverse groups optimizes development. This idea translates directly to the relationship between parents and caregivers. In many clinical settings professionals are accountable not only to the client but also to the other members of the family system. Collaboration with those family members and caregivers empowers them to take part in and be accountable for the growth of the client (Porter & McKenzie, 2000).

Collaboration can be compounded by a myriad of challenges. The research literature cites additional training in order to empower and support personnel to engage in collaborative activities as the most prevalent need. More specifically, training prior to entering a collaborative relationship may better prepare team members to accommodate the changing needs of the team as well as the clients. There is wide use of interdisciplinary teams (IDT) within a variety of working systems, however, establishing partnerships outside of the immediate agency or school (i.e., with the community) is a challenge. Professional development that includes conflict resolution and empowerment techniques are desired by collaborative team members in order for them to feel as though they can effect greater change (Foley, 2001).

Additionally, Kastan (2000) discusses the difficulties faced in interorganizational collaboration. The culture of the organization and roles of collaborative members prior to implementing program development goals may affect the overall outcome and/or the efforts of the team. Success of the collaborative effort may be hindered due to the individual perceptions and bureaucratic agendas of team members. Awareness of preconceptions upon entering the collaborative relationship will allow parties to accept and ultimately complement one another's roles. Also, careful consideration of where alliances lie and what "roadblocks" one might face in an organization can be key components to the overall outcome.

Collaboration in the area of fine and performing arts has be-

come a necessity. Pooling resources in order to advocate for arts education has become a popular and effective means for keeping and creating arts-based education and programs. Robinson (1998) discussed a number of ways in which a community collaborated in order to expand the range of music education in their community. This included addressing pre-K initiatives in music, intergenerational music experiences, outreach programs for culturally and economically diverse populations, and inclusion of the arts in the classroom. Collaborative models have also been created in order to help music education students create lesson plans. This process gave the students extra support and facilitated creative yet focused plans (McCoy, 2000).

Integrated service delivery in the classroom caused music professionals to turn to collaboration as a means of learning to provide services to children with special needs in the music classroom. In-service training and attending individualized education plan (IEP) meetings were necessary to help understand the needs of special learners and the benefits of mainstreaming in a music classroom. Collaborative efforts also included hands-on support of special education staff as well as curriculum modification (Hock, Hasazi, & Patten, 1990).

Stankiewicz (2001) wrote about the development of the Arts Education Task Force of the County Arts Council in order to revitalize and reinstate arts education programs. Based on educational theory and national policy initiatives, the task force designed its own theoretical path to meet the needs of its community, and the challenges they faced. Members agreed on priorities and developed advocacy skills. Through the process of expanding and reorganizing group efforts, committees were formed to focus on specific desired outcomes. Success of these efforts were contributed to the agreement of common goals, communication, and trust among collaborative parties, a core of active participants, an understanding of the system in which they were operating, shared leadership among many parties, development of a long range, inclusive plan, and persistence.

Dreeszen, Aprill, and Deasy (1999) pinpointed collaborative partnerships between the schools and arts community as an effective strategy for improving schools, improving the quality of arts learning, improving overall academic performance of students, developing effective curricula, involving parents and families in stu-

dent learning, providing quality professional development, meeting the needs of special populations, developing or implementing plans and policies, and extending school influence to improve communities. All partners shared goals that enhanced student outcomes and shared leadership responsibilities. A shared sense of ownership in the collaborative program prevailed and effective partnerships were created. The authors illustrated that not only are partnerships flexible and survive setbacks, but the collaborative process engages multiple community sectors and disciplines.

Consultation allows for the dissemination of information to an individual or group in order to educate and advise on a given topic or methodology. Kampwirth (1999) describes consultation as a collaborative process in which a trained consultant assists one or more "consultees" in efforts to make decisions and carry out plans that will be in the best interest of their clients or patients. The goal of most consultation is to improve the functioning of the client while enhancing the functioning of the consultee. However, collaboration and consultation are not interchangeable.

Palsha and Wesley (1998) explored the relationship of on-site consultation and collaboration in early childhood programs. Results indicated improvement in the physical environment, service delivery, and teacher comfort and satisfaction. Having access to a professional consultant helped ease the stress of implementing extensive change.

Both collaboration and consultation play pivotal roles in the growth and understanding of music therapy as it relates to a variety of other disciplines. As music therapy has become more widely recognized as a viable treatment, it has become increasingly more important to act as a consultant to other professions in order to clearly define the principles of the therapeutic use of music. It is also important to recognize the lack of uniformity due to the varying ideology within the discipline of music therapy.

Jellison and Gainer (1995) briefly discuss the role that collaboration played in the process of mainstreaming a special education student. The cooperative efforts of the music educator, music therapist, and classroom teacher contributed to the successful transition of the student. Currently there are no published works that specifically investigate the nature of collaboration among music therapists. However, collaboration is mentioned throughout the music therapy literature, though it is not the focal point of any study. References to

consultation are sparse despite the fact that it plays a vital role in educating other professionals about music therapy.

Methods of consultation vary and may include diverse communication media. Books, publications, lectures, interactive presentations, on-site services, observation, and written/oral feedback are widely cited methods of consultation. Specific benefits for music therapists include clearer performance expectations and focus, creation of more monetary resources, diversification of revenue, serving a wide variety of clients, and flexibility and independence (Reuer, 1996).

The consultant also acts as a liaison between other professions and their own, making relevant transfers between multiple fields. Educating music therapists on the potential benefits of collaboration and consultation is imperative in order to fully explore the employment potential of music therapists. Music therapists are trained to utilize music as a tool for addressing a wide-variety of issues. The inclusive nature of our education and the populations we serve speak directly to the issue of collaborating with and consulting to other professionals in order to provide holistic services to clients or patients and their families.

Consultation paired with collaboration can be an augmentative service that enhances the overall service delivery to clients, patients, or students and provides more comprehensive intervention or treatment (Sandler, 1997). This also provides continuity of service and a greater understanding of holistic intervention as no issue is completely isolated. Transfer of learning among professionals and individuals receiving interventions results in a multitude of benefits for all parties, particularly the clients or patients receiving services.

Research regarding the consultation and collaboration practices of professional music therapists is virtually exiguous. This survey was designed to examine the extent and nature of consultation and collaboration of board certified music therapists (MT-BC) in order to establish a baseline of service provision by this profession. Specific areas of investigation include (a) population(s) with whom the MT-BC works and the site of service delivery, (b) self-identification as a collaborator and/or a consultant, (c) populations with whom the MT-BC collaborates, and (d) frequency, methods, purpose, locations, and personnel for whom they provide consultative services are provided. Music therapists were allowed to self-define

collaboration and consultation in order to determine current perceptions and actions within the profession and set a baseline to compare future findings.

Method

A one-page, 13-question survey regarding collaboration and consultation among professional music therapists was designed by the researcher and revised and edited by a committee of two practicing music therapists and two university professors. The explanation at the top indicated that the survey was part of a research project and provided an e-mail address to which the respondent could direct questions. Completion of the survey assumed consent.

A multiple-choice format was used in order to limit the amount of time it would take for an individual to complete the survey. Population and work setting categories were patterned after those used by AMTA on the annual survey of music therapists. Several questions contained the choice "other" in order to provide a respondent opportunities to add a response if they felt an appropriate answer was not adequately reflected in the choices given.

Demographic information surveyed included the number of years the individual had been working as a music therapist, populations with whom they worked, and where they delivered services. Participants were asked if they "collaborate with other team members regarding treatment of clients" and if so, what professions they collaborate with for treatment purposes. When asked if they ever act as a consultant, a "no" response completed the survey. Respondents who indicated they acted as music therapy consultants were asked to identify other professions they provided services to and whether they worked with large or small groups and/or individuals. Other questions addressed frequency, payment, location, goals, and type of consultation.

Surveys were mailed to all board certified music therapists (MT-BC) ($N = 2039$) who were members of the American Music Therapy Association (AMTA) as of July 2001. Members indicate whether or not they are board-certified when they join AMTA and those names are verified quarterly with Certification Board of Music Therapy. Potential respondents were identified in 46 states and the District of Columbia. Surveys were numbered in order to provide a method for identifying and contacting those individuals who did not respond in case of an uncharacteristically low return rate. A

self-addressed envelope was enclosed but return postage was not provided. Returned surveys were entered into a database by postmark in order to sort data by state and region. Response categories were assigned nominal level values for statistical analyses. Responses to open-ended questions were transcribed and grouped by like categories.

Results

A total of 873 music therapists from eight AMTA designated regions returned the survey for a response rate of 42.8%. Sixty respondents indicated that they were no longer employed as a music therapist therefore those surveys were not considered in the final data analysis. Results discussed in the remainder of this article reflect 793 responses from MT-BCs working in 40 states and the District of Columbia at the time of data collection. Four responses were received via e-mail and were unable to be grouped by state and region. When the number of surveys distributed exceeds 2000 a return of 400 responses gives a valid representation of the sample in question (Leedy & Ormrod, 2001). Response rates for each region ranged from 35% to 50%, with a mean percentage of 39.8%. Rates are reflected in Table 1 by region and state and percentage of return within each region. Return rate ratios by region are listed in Table 2. The sample is reflective of the region as return percentages are proportionate to the total number of surveys mailed per region.

Question 1 asked the respondent to state number of years worked as a music therapist in one of four categories: 0–3 years, 4–6 years, 7–9 years and 10+ years. Results indicate that over half (52.9%) of all surveys returned were completed by music therapists who had worked for 10 or more years. Of the remaining respondents, 17.2% had worked for 0–3 years, 19.1% had worked for 4–6 years, and 10.2% had worked for 7–9 years. Four individuals did not complete this question.

Question 2 asked music therapists to select all populations with whom they work. Categories for this question were fairly broad and many respondents selected "other" and identified a population not encompassed in one the options listed. In some cases, the researcher counted the written answer in one of the preprinted categories. For example, if the "other" category was selected, and the respondent wrote in "cancer patients" the researcher categorized

TABLE 1

Rate of Survey Return

Region	State	Sent	Returned	Collaborate	Consult
Great Lakes	IL*	85	25	21	8
	IN*	43	17	13	7
	MI*	95	31	30	11
	MN*	65	32	28	13
	OH*	100	32	30	17
	WI*	93	45	41	18
Mid-Atlantic	DE*	11	4	4	1
	DC	1	2	2	1
	MD*	50	19	17	9
	NJ*	65	18	17	6
	NY	210	76	74	27
	PA*	175	64	45	21
	VA*	62	17	15	9
	WV	4	2	2	1
Mid-Western	CO*	41	16	13	5
	IA*	31	8	8	3
	KS	51	11	10	4
	MO*	55	55	47	27
	NE	9	6	6	2
	SD	2	2	2	2
	WY	2	0	0	0
	ND	2	0	0	0
	MT	1	0	0	0
	NV	2	0	0	0
New England	CT*	41	16	16	7
	MA*	67	24	21	10
	NH	4	1	1	0
	RI	2	3	3	2
	VT	4	2	2	2
	ME	2	0	0	0
South-Central	LA	27	11	10	4
	MS	8	3	2	2
	AR	1	0	0	0
Southeastern	AL	14	7	4	4
	FL*	69	29	23	15
	GA*	46	13	12	6
	KY*	8	3	3	2
	NC*	44	19	16	9
	SC*	20	3	3	3
	TN	22	7	6	4
Southwestern	NM	11	5	5	3
	OK*	16	8	6	4
	TX*	136	54	49	38
Western	AZ*	33	19	14	10
	CA*	195	78	68	31
	ID	3	2	2	0
	UT	11	4	4	2
TOTAL:		2039	793	695	350

*Indicates additional surveys were returned from MT-BCs not currently working.

TABLE 2
Return Rate Ratio by Region

Region	% Return regionally	% Return nationally
Mid-Atlantic	35	26
Great Lakes	38	23
Western	43	13
Mid-Western	50	12
Southeastern	36	10
Southwestern	41	8
New England	38	6
South-Central	38	2

that under the "medical/surgical" designation. Based on the various responses additionally identified in the "other" category, the following categories were added: substance abuse, special education, AIDS/HIV, well-baby, child, adult and/or geriatric, college students, and forensics. Most respondents work with clients that are developmentally disabled or with the elderly. Results are listed in Table 3.

Table 4 indicates locations where respondents deliver music therapy services. As with Question 2, categories were added as a result of responses written in the "other" designation. Additions include day treatment facilities, live-in or residential facilities, therapist's home, and state/community agencies. Thus, sites are consistent with the types of patients reflected in Table 3 for the top two client groups. Based on the responses received, it appears that many psychiatric patients are not seen in mental health facilities.

Of the 793 individuals responding, 695 (87.5%) indicated they collaborate with other team members or professionals regarding the treatment of their clients or patients. Table 5 outlines the various professionals with whom music therapists collaborate. Most frequent collaborations are with parents/caregivers and other family members, medical personnel, and related therapies such as speech and occupational therapy (PT, OT).

Only 44% of respondents ($n = 350$) indicated they act as a music therapy consultant. Of those respondents, 62% worked for 10 or more years, 11% worked for 0–3 years, 16% worked for 4–6 years, and 10% worked 7–9 years. Only one respondent in this category did not indicate the duration of years worked as a music therapist. Table 1 reflects the number of consulting music therapists by region and state.

TABLE 3
Populations with Whom Respondents Work

Population	%
Developmentally disabled	51.8
Elderly & Alzheimer's	41.1
Mental health	35.3
*Other	29.5
Neurological disorders	26.1
Medical/surgical	14.5
Hospice	12.2

* Substance abuse, special education, AIDS/HIV, well baby, child, adult, geriatrics, college students, forensic mental health, offenders.

Responses indicate that most music therapy consultants administer services in education-related settings and with the parents, caregivers or other family members of music therapy clients. Table 6 contains a summary of the other disciplines with whom respondents consult. Subheadings added via the "other" category include home health aides, social workers, recreation and activity personnel, art therapists, mental health professionals, clergy, and corporate personnel. Music therapists view themselves as consulting with educators and parents and collaborating with parents, medical personnel, and related therapies (PT, OT).

The primary methods of delivery for consultation include workshops/seminars/in-services (72.6%) and one-to-one meetings (67.7%). Other delivery methods include publications and literature (10.3%) and observation/feedback (7.7%). Most consultative services are delivered in small group or individual (75.4%) settings.

TABLE 4
Locations of Service Delivery

Location	%
School/educational facility	38.8
Geriatric facility	30.4
*Other	24.6
Patient/client home	21.4
Medical facility	17.6
Psychiatric facility	16.5
Private MT agency	10.5

* Day treatment facility, live-in facility, therapist home/private practice, state/community agency.

TABLE 5
Professions with Whom MT-BC Collaborate

Profession	%
Parent/caregiver/other family	55.8
Occupation therapist	47.2
Medical personnel	46.1
Speech therapist	44.6
Educators	41.4
Physical therapist	40.3
Client	40.1
*Other	33.8
Other music therapists	31.2
Administration	30.6

* Social worker, creative arts therapies (drama, dance, art), scientists, behavior specialists, activity/recreation professionals, mental health professional, clergy.

Only 25.4% of consultants indicated that they provide consultation to large groups.

Those who provide consultative services report that they do so frequently, usually on a weekly (21.1%) or monthly basis (21.1%). Others provide service irregularly on an as-needed basis (21.4%). Payment for services is often included in the cost of therapeutic intervention (57.7%) or charged per hour and/or per service (83.4%). Average cost per hour for consulting range from $40 to $58 according to the 2001 AMTA Sourcebook. Most consultants provide service in their local area (84%) or in their home state (38%).

When asked to classify goals and objectives of consultative work under widely-used subject headings, 84% of respondents cited education. Other frequently-cited subject areas included communication (47.1%), socialization (35.7%), and mental health (36.6%) goals and objectives (see Table 7).

Analyses of survey responses focused on whether differences in collaboration and consultation were related to the region of the country, number of years worked, or population of clients with whom MT-BC worked. A chi square test comparing collaboration and consultation of respondents to the regions in which they live and populations they served yielded no statistically significant difference ($\chi^2 = 46.06$, $df = 40$, $p > .05$). However, respondents who have worked 10 or more years consulted more than their peers who have worked less than 10 years ($\chi^2 = 23.92$, $df = 5$, $p \leq .001$).

TABLE 6
Professions with Whom MT-BC Consult

Profession	%
Educators	62.0
Parent/caregiver/other family	59.7
Administration	40.6
Other music therapists	38.6
Medical personnel	36.3
Speech therapist	36.3
Occupational therapist	33.4
Client	32.0
Physical therapists	29.1
*Other	23.7

* Home health aides, social worker, activity/recreation professionals, mental health professional, clergy.

Discussion

One of the many challenges of conducting research via survey is creating a concise, yet thorough instrument that participants will take the time to complete and return. Typically, return rates do not exceed 20 to 25%. The overall return rate and distribution of percentages across regions reflected in Tables 1 and 2 serve as a solid baseline allowing for the discussion the current state of collaboration and consultation among practicing music therapists.

The "unsolicited respondent feedback," which is inherent in survey research, was discussed by Plouffe (1999). The "unique insight" offered when respondents provide their perceptions gives individuals the opportunity to voice their opinions while raising issues previously unidentified by the researcher. Over half of all respondents'

TABLE 7
Goals of Consultative Work

Goal by general subject area	%
Educational	84.0
Communication	47.1
Mental health	36.6
Socialization	35.7
Geriatric	25.1
Medical/surgical	18.9
Employee relations/productivity	18.9

comments were not related to the subject matter addressed in the survey. Indirectly related information included positive support and encouragement, disapproval for not enclosing a stamped return envelope and disclosure of personal information (i.e., reasons for no longer being employed as a music therapist).

Several respondents indicated that they were no longer working as a music therapist, however, they still utilize music therapy in their work (ministry, psychology). In contrast, a few respondents indicated that they were working in music-related fields (professional musician, organist, Kindermusik teacher, music educator) but did not indicate that they worked as a music therapist. Another interesting response included a respondent's notation of professions that she frequently collaborated with versus those she "worked with on occasion." This unsolicited feedback should be taken in to consideration when developing future surveys.

Results of this survey indicated that half of the respondents worked with clients that have a developmental disability, 41.1% worked with the elderly and Alzheimer's patients and 35.3% worked with clients with mental health issues. Additionally, more than 1/3 of the respondents indicated that they work in either a geriatric or an educational facility. These percentages are measurably higher than those reflected in the AMTA Source book (2001) for these client groups. The number of individuals surveyed by AMTA is more than twice that reflected in this study, but that sample is not limited to MT-BCs. The difference reflected in these findings may be the result of a variation in accountability from one facility to another. In other words, board certification may be required by more geriatric and educational facilities in comparison to other sites that employ music therapists.

The majority of respondents (87.5%) indicated that they collaborate with others regarding treatment of clients. Over half of those individuals collaborate with the parent(s) and/or caregivers of clients which provide lasting benefits for all parties (Porter & McKenzie, 2000). Further investigation regarding the effects of collaboration and its impact on the individual with whom music therapists collaborate may provide insight into experiences and relationships facilitating the growth of music therapy as a more widely recognized method of treatment.

Less than half (44.1%) of MT-BCs that responded indicated they

act as a consultant; of respondents that consult, parents, caregivers and educators were the individuals to whom the highest percentages of services were provided. These data are supported by information obtained in the last question which indicated the three most common goals or subject areas addressed by music therapy consultants were education, socialization, and communication. The extensive use of collaboration and consultation in education reform may be linked to the high instance of education-related reports in this survey.

Over half of the respondents have worked as a music therapist for 10 or more years. Of those, a statistically significant number indicated that they collaborate and consult. One of the questions raised by these findings is how the issue of collaboration and consultation is addressed in music therapy education programs. Interdisciplinary collaboration is clearly outlined in the 2001 AMTA Professional Competencies (see American Music Therapy Association, 2001) and, therefore, is assumed to be in the curriculum. No provision is made in the professional competencies for teaching methods or value of consultation even though consultation is outlined in the standards of clinical practice. Both consultation and collaboration are directly reflected in music therapy research literature. The very nature of conducting research requires interaction and collaboration with other professionals and, in many cases, other modes of treatment. Likewise, research in music therapy often requires the music therapist to act as a consultant in order to educate the related profession(s) on the implications and efficacy of music.

As suggested by several respondents, future studies might be best conducted via internet, utilizing an on-line survey. Due to the time and cost involved in mailing over 2000 surveys, utilizing technology that is becoming increasingly more accessible would be advisable. While there are still individuals that do not have access to a personal computer, an online format may also increase the return rate and may be a more efficient means of data collection by eliminating the "paper trail."

Further study is needed to develop a clear definition of collaborative relationships and consultation as it applies to music therapy and how these skills are best taught. Several respondents indicated they did not conceptualize a clear idea of collaboration and/or con-

sultation based on the survey questions. Future research should seek to define both collaboration and consultation and how each of these techniques are acquired and implemented by music therapists.

References

American Music Therapy Association (2001). *AMTA Member Sourcebook 2001.* Silver Spring, MD: American Music Therapy Association.

Dreeszen, C., Aprill, A., & Deasy, R. (1999). *Learning partnerships: Improving learning in schools with arts partners in the community.* Washington, DC: Arts Education Partnership.

Foley, R. (2001). Professional development needs of secondary school principals of collaborative-based service delivery models. *The High School Journal, 85*(1), 10–23.

Gregory, M. K. (1995). Collaboration for music teacher education between higher education institutions and K–12 schools. *Journal of Research in Music Education, 43,* 47–59.

Hock, M., Hasazi, S. B., & Patten, A. (1990). Collaborations for learning: Strategies for program success. *Music Educators' Journal, 76,* 44–48.

Jellison, J., & Gainer, E. (1995). Into the mainstream: A case-study of a child's participation in music education and music therapy. *Journal of Music Therapy, 32,* 228–247.

Kampwirth, T. J. (1999). *Collaborative consultation in the schools: Effective practices for students with learning and behavior problems.* Upper Saddle River, NJ: Merrill.

Kastan, J. (2000). School-based mental health program development: A case study of interorganizational collaboration. *Journal of Health Politics, Policy and Law, 25*(5), 845–862.

Landrum, M. (2001). An evaluation of the catalyst program: Consultation and collaboration in gifted education. *Gifted Child Quarterly, 45*(2), 139–151.

Leedy, P. D., & Ormrod, J. (2001). *Practical research: Planning and design (7th ed).* Upper Saddle River, NJ: Merrill.

McCoy, C. W. (2000). The excitement of collaboration. *Music Educators' Journal, 87,* 37–44.

Palsha, S., & Wesley, P. (1998). Improving quality in early childhood environments through on-site consultation. *Teaching Early Childhood Special Education, 18*(4), 243–253.

Plouffe, C. (1999). The role of non-solicited qualitative input in survey-based research: An empirical example of interpretation and analysis. *Journal of Marketing Research, 36*(2), 228–234.

Porter, L., & McKenzie, S. (2000). *Professional collaboration with parents of children with disabilities.* London: Whurr Publishers.

Reuer, B. (1996). Posturing for the changing world: Consulting as a career option. *Music Therapy Perspectives, 14,* 16–20.

Robinson, M. (1998). A collaboration model for school and community. *Arts Education Policy Review, 100*(2), 32–33.

Rubin, H. (1998). *Building collaboration: A twelve step process, in Collaboration skills for educators and non-profit leaders.* Chicago: Lyceum Books, Inc.

Sandler, A. (1997). Physical and occupational therapy services: Use of a consultative therapy model in the schools. *Preventing School Failure, 41*(4), 164–165.

Smith, L. C. (2001). Life history as a key factor in understanding teacher collaboration and classroom practice. *Teacher Education Quarterly, 28*(3), 111–125.

Stankiewicz, M. A. (2001). Community/Schools Partnership for the Arts: Collaboration, politics, and policy. *Arts Education Policy Review, 102*(6), 3–10.

Welch, M. (1998). Collaboration: Staying on the bandwagon. *Journal of Teacher Education, 49*(1), 26–38.