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Inter-Professional Collaboration: Perceptions and Practices with Youth with Complex Problems

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Youth with complex problems are frequently served by multiple public systems, including mental health, child welfare, juvenile justice, and education. Effective inter-professional collaboration is necessary to meet the needs of these youth, yet relationships among individual characteristics of service providers and their collaborative activities have not been examined. This study explores inter-professional beliefs, perceived competencies, and practices of licensed social workers serving youth with complex problems, using data from the National Association of Social Workers Workforce Study. Our analyses suggest that perceived importance of collaboration may contribute to and predict collaborative activities ($B = 1.05$, $SE = .13$, $\beta = .30$, $p < .001$) and this relationship remained positive and significant after controlling for gender, race/ethnicity, years of practice experience, and sector of employment. Better understanding of these inter-professional beliefs, competencies, and practices may help identify training, workforce development, and supervision needs for forensic social work with this vulnerable population.

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Of the 13% of youth within the U.S. who receive special education services, most are also diagnosed with emotional disturbances (Wagner, Cameto, & Guzmán, 2003). Outcomes for these youth have been described as "particularly troubling," including high rates of academic failure, poor social adjustment, and juvenile justice system involvement (Fabelo et al., 2011; Rausch, 2006; Wagner, 1995). Youth classified as having very complex problems are those youth with challenges requiring intervention from multiple public systems, including mental health, child welfare, juvenile justice, special education, and so on. Empirical evidence has established links between child maltreatment and later delinquency, as well as between institutional placements in the child welfare and juvenile justice systems and a range of negative outcomes (Petro, 2006; Ryan, Testa, & Zhai, 2008). Similarly, recent research examining the "school-to-prison pipeline" connects youth identified as at-risk in the education system as being at elevated risk for subsequent involved in the juvenile justice system (Fabelo et al., 2011). Yet, inadequate cross-agency and cross-system communication and collaboration among these child-serving, professional entities have been of concern in the United States for decades (Bandler, 1973; Herz & Ryan, 2008; Kearney, Bloom-Ellis, & Thompson, 2012; Joint Commission on Mental Health of Children, 1969).

Collaboration is defined as the act of cooperating with an agency or instrumentality with which one is not immediately connected (see www.merriam-webster.com). Inter-professional collaboration differs from inter-disciplinary collaboration as it occurs with individuals representing various professions (often law, healthcare, and social work, each which maintains a separate code of ethics and professional responsibility). Yet, D'Amour, Ferrada-Videla, Rodriguez, and Beaulieu (2005) found that the terms *inter-professional collaboration* and even merely *collaboration*, are used in a myriad of ways with a variety of meanings. The Ontario College of Family Physicians defined *collaborative practice* as, "an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided" (Way, Jones, & Busing, 2000, p. 3). But D'Amour et al. (2005, p. 126) contended that "it is unrealistic to think that simply bringing professionals together in teams will lead to collaboration." For the purpose of this research, we use D'Amour and colleagues' definition of *inter-professional collaboration* as (a) collective action focused on client needs and (b) a team-approach that incorporates the perspectives of each professional.

Recent social policy initiatives designed to address these concerns have focused on the importance of family involvement, information sharing across systems, therapeutic jurisprudence (a holistic approach to practicing law which considers the effects of law both therapeutic and anti-therapeutic on individuals, families, and communities involved in the courts), and preparation of the child-serving workforce to collaborate in addressing the complex needs of multi-problem youth and their families (Center for Juvenile Justice Reform, 2008; Wexler, 2008). Although the need for collaborative approaches

to support youth with very complex needs has recently been documented (McCarter, Haber, & Kazemi, 2010), little work has been done on the inter-professional collaborative attitudes, competencies, and practices of licensed social workers serving this population. In one of the few studies, Smith and Mogro-Wilson (2007) examined the associations of organizational conditions and individual characteristics with the collaborative activities of front-line staff in child welfare and substance abuse treatment agencies. They found that collaborative practice was positively associated both with self-reported knowledge and skills in collaboration, and with perceptions of the advantages of collaboration. Individual factors accounted for nearly three-quarters of the variance in collaborative practice (Smith & Mogro-Wilson, 2007). McCarter et al. (2010) have suggested that collaborative practice for these youth is complicated by the need to work with other service sectors, the multiple systems of care present, and the complex challenges of working with at-risk youth (p. 466). To identify workforce development needs of providers working with these vulnerable youth, this study examined the collaborative beliefs, perceived competencies, and practices of licensed social workers serving youth with very complex problems, using data from the National Association of Social Workers (NASW) Workforce Study (NASW, 2006). Social cognitive theory, which emphasizes the importance of self-efficacy, served as the conceptual framework for the study. Specific aims were to

1. Develop a profile of licensed social workers serving children and families with very complex problems in the United States, including their sociodemographic background, common presenting problems of youth on their caseloads, systems they interacted with most frequently on behalf of youth, past training experiences, and training needs.
2. Examine these social workers' beliefs in importance of collaboration, satisfaction with collaboration efficacy, and collaboration activities.
3. Describe the relationships between belief in the importance of inter-professional collaboration, satisfaction with collaboration efficacy, and collaboration activities of licensed social workers, controlling for gender (female/male), age, race/ethnicity (minority/majority) years of practice experience and employment sector and setting.

We hypothesized that:

H1: Belief in the importance of collaboration and satisfaction with collaboration efficacy would be positively and significantly related to collaboration activities among licensed social workers working with children and families with complex problems.

H2: This relationship would remain positive and significant controlling for gender (female/male), race/ethnicity (minority or majority), years of practice experience, and sector of employment (government vs. non-government setting).

METHOD

Data and Sample

This study was a secondary analysis of data from the 2004 NASW National Study of Licensed Social Workers (Center for Health Workforce Studies, School of Public Health, University at Albany, 2006). The original research used a cross-sectional, survey design with a stratified random sample of approximately 10,000 licensed social workers in the continental United States. The researchers gathered data from front-line workers to gain a better understanding of the context of their practice, the services they provided, and the characteristics of the clients they served. Using the state licensing lists of 48 states (all except Delaware and Hawaii) and the District of Columbia, a random sample of licensed social workers stratified by region was drawn to participate in a self-administered mail survey. Survey responses were collected using a three-step mail process, with follow-up mailings sent to initial nonrespondents. This strategy resulted in a survey response rate of 49%.

The approximately 3,000 participants who provided services to individuals 21 years of age or under were asked to complete an additional section on services for children and families. The analysis reported here examined the 1,279 participants who indicated that 51% or more of their caseload of children had very complex (versus complex or not complex) problems. The rationale for this sampling strategy was that this subset of licensed social workers would be expected to have the greatest training needs and the most interactions with one or more other professional service systems.

Variables and Measures

The survey included four sections which gathered data on participants' backgrounds, social work practice, services to clients, and workplace issues. In this analysis, survey items from the background, social work practice, services for children and families, and workplace issues sections were used to examine the relationships among the perceived importance of inter-professional collaboration, satisfaction with collaboration efficacy, and frequency of collaborative activities. Measures used for perceived importance of collaboration, satisfaction with collaboration efficacy, frequency of collaboration activities, and demographic variables are outlined below.

Perceived importance of collaboration was assessed with one item: How do you assess the importance of interagency coordination in assisting you to improve care provided to children and their families? Participants responded on a 5-point scale from 1 (*not at all*) to 5 (*very*).

Satisfaction with collaboration efficacy was measured using a composite score from five items that asked participants to rate their satisfaction with

their ability to engage in these collaborative activities: (a) help clients navigate through the social services system, (b) coordinate care between the medical and mental health communities to address the needs of clients, (c) address complex and chronic care problems of clients, (d) influence the design of services to better meet client needs, and (e) access community resources for clients. On each of the five items, participants responded on a 5-point scale from 1 (*never*) to 5 (*always*).

Collaborative activities were measured using a composite score from six items on which participants rated their frequency of engagement in the specific collaborative activities: (a) helping clients address a range of problems, including psychological, medical, and social issues; (b) working with community organizations to adapt the service delivery system; (c) communicating with other professions; (d) communicating with families; (e) using community resources; and (f) acting as an advocate. For each of the six items, participants responded on a 5-point scale from 1 (*never*) to 5 (*always*).

Descriptive information from participants about their personal backgrounds, practice experience and settings, and system interactions were also examined. Age was measured using six ordinal categories: 25 years and under, 26–34, 35–44, 45–54, 55–64, and 65 and over. Racial/ethnic status consisted of six categories: Asian/Pacific Islander, Black/African-American, Hispanic/Latino, White (Non-Hispanic), Native American/Alaskan Native, and Other.

Data Analyses

The data were analyzed in two steps. In Step 1, descriptive statistics were used to calculate frequencies and percentages that described participants' personal and professional backgrounds. In Step 2, linear regression analyses were conducted to examine the relationships among perceived importance of collaboration, satisfaction with collaboration efficacy, and frequency of collaborative activities.

RESULTS

Sample Description

The great majority (80%) of the 1,279 participants were currently in practice. As shown in Table 1, most were White (85%), female (84%) MSWs (78%) The median age was 45–54 years. Over three-quarters (78%) reported providing services to children and their families for 6 or more years, the remaining 22% had done so for 5 years or less. The participants' practice sectors and settings varied, with a majority working in government (37%) and private non-profit (37%) sectors. Common practice settings included social service agencies

TABLE 1 Sociodemographic Statistics for the Study Sample ($n = 1,279$)

Background and practice	%	*n*
Background		
Age		
25 and under	1.0	13
26–34	17.6	225
35–44	22.8	291
45–54	31.1	397
55–64	23.2	296
65 and older	4.4	5.6
Gender		
Male	16.0	201
Female	84.0	1,059
Race/ethnic status		
White	85.1	1,080
African American	6.4	81
Latino	5.2	66
Other	3.4	42
Highest social work degree		
None	8.4	108
BSW	10.8	138
MSW	78.4	1,003
DSW or PhD	2.3	30
Practice		
Years of social work practice		
5 years or less	22.3	282
6 or more years	77.7	982
Years of practice with children/families		
5 years or less	21.7	274
6 or more years	78.3	986
Employment sector		
Government	37.0	432
Private nonprofit	36.7	428
Private practice	14.0	163
Private for profit	12.3	143
Practice setting		
Social services	18.1	194
Private practice	11.4	122
School	10.9	117
Medical	10.0	107
Behavioral health	10.0	107

(18%), private solo practices (11%), schools (11%), hospitals/medical centers (10%), and behavioral health clinics/outpatient facilities (10%).

Presenting Problems Among Children Served

The most frequent presenting problems reported among the children in participants' caseloads included challenges related to family functioning, mental health, school, abuse/neglect, and socioeconomic disadvantage (see Table 2).

TABLE 2 Frequency of Family and Educational, Social and Community Service and Criminal Justice Oriented Presenting Problems Among Children on Participants' Caseloads

Presenting problems	*M*	*SD*
Family and educational		
Family functioning	4.2	0.9
School problems	3.7	1.1
Socioeconomic status disadvantage	3.6	1.1
Social and community		
Mental health	4.0	1.0
Substance abuse	3.1	1.1
Medical	2.8	1.2
Disability	2.7	1.2
End of life care	1.5	0.9
Criminal justice		
Abuse/neglect	3.7	1.1
Foster care	2.9	1.3
Juvenile justice	2.7	1.2
Adoption/reunification	2.5	1.2

Items were rated on a scale from 1 (*never*) to 5 (*always*) ($N = 1279$).

Systems Interacted with Most Frequently on Behalf of Children

As shown in Table 3, participants reported interacting with a variety of other systems on behalf of children. The majority interacted most frequently with mental health (70%) and school (60%) systems. Over half (51%) reported frequent interactions with protective services. Other systems which participants cited frequent contact with included the court (36%), foster care (33%), and healthcare systems (31%).

TABLE 3 Systems Interacted with Most Frequently by Social Workers on Behalf of Children ($n = 1,279$)

System	%	*n*
Mental health	69.8	893
Schools	60.0	768
Protective services	50.9	651
Courts	36.0	460
Foster care	32.8	420
Health	30.7	393
Supplemental services	20.6	263
Police/criminal justice	18.9	242
Social/recreational	14.5	185
Legal aid/attorneys	8.0	102
Income maintenance	7.7	99

TABLE 4 Past Continuing Education/Training (General and Children and Families) ($n = 1,279$)

	General training (last 2 years)		Children and families specific training (ever participate)	
Type of training	%	*n*	%	*n*
Seminars/workshops	83.0	1,062	82.8	1059
Interdisciplinary seminars/workshops	—	—	82.3	1052
Conferences	82.0	1,049	86.3	1104
Courses in social work school	—	—	75.5	966
Courses in other higher education	—	—	40.3	516
On the job training	41.3	528	69.0	883
Professional association programs	32.0	409	—	—
Supervised clinical practice	26.6	340	61.1	782
Agency field placement	—	—	56.6	724
Certificate programs	24.7	316	—	—
Supervised practice	15.6	200	—	—
Academic credit courses	13.9	178	—	—
Distance learning programs	6.8	87	9.8	125
Other	4.6	59	2.3	30
None	1.4	18	—	—

Training Experiences and Desires for Future Training

Table 4 gives respondents' previous continuing education/training experiences, and Table 5 lists their desired training topics. The vast majority reported participating in seminars or workshops (83%) and conferences (82%) in the past 2 years. Most had received training for work with children and families in the past, via conferences (86%), seminars/workshops (83%), and courses in social work school (76%). As shown in Table 5, however, most (86%) desired additional training on child and family issues. Participants reported a desire for additional training in clinical practice (49%), trauma/disaster (31%), and best practices (23%). Training needs related to interprofessional collaboration included professional ethics (19%), interdisciplinary practice (12%), and community organizing (8%).

Perceived Importance of Collaboration and Satisfaction with Collaboration Efficacy

Participants noted the importance of inter-professional collaboration (see Table 6). On average, they viewed interagency coordination as important to improving children's care ($M = 4.1$, $SD = 1.0$). Participants also indicated that they were generally satisfied with their ability to address the complex problems of clients ($M = 3.8$, $SD = 1.0$), help clients navigate through the social services system ($M = 3.6$, $SD = 0.9$), coordinate care between the medical and mental health communities to address the needs of clients ($M = 3.5$, $SD = 1.0$), and

TABLE 5 Future Training Wants Among the Study Sample (n = 1,279)

Training wants	%	*n*
Child/family issues	86.1	1,087
Clinical practice	48.9	625
Trauma/disaster	30.6	392
Specialty practice area	29.9	383
Best practices	22.8	292
Program development	21.3	273
Medication use	19.4	248
Substance abuse	19.2	245
Professional ethics	18.9	242
Administration	18.7	239
Cultural competency	13.7	175
Interdisciplinary practice	12.4	159
Rural service	10.0	128
Paperwork management	9.3	119
Community organizing	8.1	103
Care management	5.6	72
Telehealth	2.1	27

TABLE 6 Descriptive Statistics for Items on Composite Scales

	Descriptive statistics						
Variables	*n*	*M*	*SD*	Mode	Median	Minimum	Maximum
Perceived importance of collaboration	1,239	4.1	1.0	5.0	4.0	1.0	5.0
Satisfaction with collaboration efficacy total score	983	17.6	3.6	18.0	18.0	5.0	25.0
Help clients navigate systems	1,101	3.6	0.9	4.0	4.0	1.0	5.0
Coordinate care	1,079	3.5	1.0	4.0	4.0	1.0	5.0
Address complex/chronic issues	1,119	3.8	1.0	4.0	4.0	1.0	5.0
Influence service design	1,110	3.2	1.2	3.0	3.0	1.0	5.0
Access community resources	1,117	3.5	1.0	4.0	4.0	1.0	5.0
Collaboration activities total score	653	24.5	3.2	24.0	25.0	12.0	30.0
Help clients address range of problems	1,133	4.4	0.7	5.0	4.0	1.0	5.0
Work with community organizations to adapt service delivery system	1,015	3.4	1.2	4.0	3.0	1.0	5.0
Communicate with other professions	866	4.2	0.9	5.0	4.0	1.0	5.0
Communicate with families	1,242	4.5	0.9	5.0	5.0	1.0	5.0
Use community resources	1,251	3.8	1.3	4.0	4.0	1.0	5.0
Act as advocate	1,249	4.1	1.1	5.0	4.0	1.0	5.0

Items were rated on a scale from 1 (*not at all*) to 5 (*very*).

TABLE 7 Linear Regression Results for Ability of Perceived Importance of Collaboration to Predict Satisfaction on Collaboration Efficacy and Collaboration Activities ($n = 1,279$)

Outcome	B	SE	β
Satisfaction with collaboration efficacy	0.09	.12	.02
Perceived importance of collaboration	1.05	.13	.30***

***$p < .001$.

access community resources for clients ($M = 3.5$, $SD = 1.0$). They reported feeling least satisfied with their ability to influence the design of services to better meet client needs ($M = 3.2$, $SD = 1.2$). The total mean score on satisfaction with collaboration efficacy was 17.6 ($SD = 3.6$) out of 25, suggesting a satisfactory level of efficacy, though with room for improvement.

Frequency of Collaborative Activities

Participants reported a moderately high level of inter-professional collaborative activities, with an average total score on this scale of 24.5 ($SD = 3.2$) out of 30. The greatest collaboration was reported in the area of communicating with children's families ($M = 4.5$, $SD = 0.9$), followed by helping clients address a range of problems ($M = 4.4$, $SD = 0.7$), communicating with other professionals ($M = 4.2$, $SD = 0.9$), acting as an advocate ($M = 4.1$, $SD = 1.1$), and using community resources ($M = 3.8$, $SD = 1.3$). The lowest average score was for working with community organizations to adapt delivery systems ($M = 3.4$, $SD = 1.2$).

Regression Analyses

As shown in Table 7, two linear regressions were conducted to determine whether perceived importance of collaboration predicted satisfaction with collaboration efficacy and also predicted collaboration activities. The first linear regression analysis (perceived importance of collaboration by collaboration efficacy) did not yield significant findings ($B = .09$, $SE = .12$, $\beta = .02$, $p = .47$), indicating no predictive relationship between the variables. The second linear regression model examined whether perceived importance of collaboration predicted collaborative activities and showed a significant and positive predictive relationship between the variables ($B = 1.05$, $SE = .13$, $\beta = .30$, $p < .001$). This relationship remained positive and significant after controlling for gender (female/male), race/ethnicity (minority/majority), years of practice experience, and sector of employment (government/non-government setting). These findings suggest that licensed social workers who perceived inter-professional collaboration as important, engaged more often in collaborative activities.

DISCUSSION

This study surveyed licensed social workers serving children and families with very complex problems because they are likely to interact with multiple professional service systems and thus may have the greatest need for collaborative practices. The most common presenting problems for these children and youth are related to family functioning, mental health, abuse/neglect, school problems, and socioeconomic disadvantage. The majority of the youth and their families interact with the mental health and school systems, roughly half of the youth are involved with protective services, and many of the youth report court, foster care, and healthcare system involvement. To work with these youth and their families, the majority of the social workers surveyed had participated in seminars or workshops in the last two years but most said that they desired additional training on child and family issues.

Given the very complex problems, multiple system involvement, and training needs of this population, we also examined practitioners' collaborative beliefs, perceived competencies, and practices; and the associations among these variables. Participating social workers supported inter-professional collaboration and saw it as important to improving children's care.

The perceived importance of collaboration was not, however, a significant predictor of satisfaction with collaboration efficacy. Collaboration perceptions or the belief in the importance of collaboration, however, was positively and significantly related to collaboration practices among these licensed social workers who work with children and families with complex problems, and this relationship remained positive and significant after controlling for gender, race/ethnicity, years of practice experience, and sector of employment. These findings are consistent with those of Smith and Mogro-Wilson (2007), as well as with the theory of planned behaviors and social cognitive theory (Ajzen, 1985; Bandura, 1997; Holden, Anastas, Meenaghan, & Metrey, 2002; Holden, Meenaghan, & Anastas, 2003) and also support professional literature suggesting that practitioners not only understand a problem holistically, but intervene collaboratively, using multiple disciplinary strategies and mixed methods (McCarter et al., 2010).

Limitations

Although these findings make an important contribution to our knowledge about licensed social workers who serve children with very complex problems, some limitations of the data must be recognized, most notably, those regarding generalizability and response bias. The sample included only licensed social workers, and primarily those licensed at the MSW-level; and, thus, the findings cannot be generalized to unlicensed social workers, and

they must be generalized with caution to licensed BSW-level social workers. Though this was a probability and representative sample of the LCSW population, the sample was mostly White women and is therefore limited demographically. The definition and implementation of inter-professional collaboration is most certainly shaped by not only education and professional experience, but also by gender, culture, and lived experience (D'Amour et al., 2005). Also, the response rate of 49% fell below the desirable 70% threshold, creating concern that those who responded may have differed in some systematic way from non-respondents. Given the sponsorship of the survey by NASW, members of that organization may have been more likely to respond than nonmembers. Finally, because of the nature of many of the survey items, those with front-line, direct practice experience may have been more likely to respond than those working in areas such as administration or research.

CONCLUSION

As the problems faced by children and their families become even more complex, the interdependence of service providers becomes more important, and several scholar suggest this make inter-professional collaboration a necessity (D'Amour et al., 2005; Forbes & Watson, 2011). This implementation has implications for forensic social work education, training and professional development, and ethics.

Implications for Education, Training and Professional Development, and Ethics

The Council on Social Work Education's Educational Policy and Accreditation Standards (2008) require collaborative effort. In EPAS 2.1.8 (Engage in policy practice to advance social and economic well-being and to deliver effective social work services), students are expected to collaborate with colleagues and clients for effective policy action. With this policy in place, curricula and field placements should include inter-professional collaboration. Students should practice interdisciplinary collaboration as a foundation for inter-professional collaboration complete with exploration of differing client responsibilities, codes of ethics, power, and boundaries.

D'Amour and her colleagues (2005) found that sharing, partnership, interdependency, and power are all key elements in inter-professional collaboration. And they suggest that, as professions become more specialized to respond to the increasing complexity of client needs, training in developing effective inter-professional teams becomes paramount. This training might include a basic understanding of each of the professions represented

on the team, rapport and trust-building among team members, a shared definition of the problems to be addressed, responsibilities of each team member in addressing the identified problems, candid discussions of the role of power and decision-making authority (including the client) and how best to incorporate the client. Specific agencies, hospitals, courts, and schools should consider offering continuing education credits in building successful inter-professional teams focused on improving client outcomes.

The NASW's Code of Ethics also specifically mentions collaboration in Section 2.03: Interdisciplinary Collaboration:

> (a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.
>
> (b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

Given these guidelines within the NASW Code of Ethics, social workers should consider how they currently work inter-professionally and how divergent ethical obligations are reconciled. If further work or clarification is necessary, agencies may investigate further training and professional development opportunities for their staff members.

Finally, forensic social workers, who commonly comprise front-line staff, have a wealth of information to offer that can help to move inter-professional collaboration from theory into practice (Guile, 2012). As evidenced in our study, licensed social workers have a commitment to collaboration and use collaborative practices quite often. These findings offer a better understanding of the collaborative beliefs, competencies, and practices of social workers that may help to identify supervision and training needs, examine professional ethical codes, and inform curriculum design; ultimately improving policy and practice for families with youth with very complex problems. Future work in this area might consider mixed-methods studies that could gather firsthand accounts of what factors facilitated or created barriers to inter-professional collaboration. These could be used to develop or improve evidence-based practice with children in need of services from multiple systems of care. Moreover, research that evaluates the effectiveness of existing evidence-based practices can be further examined for the extent to which they address inter-professional collaborative practice with youth with complex challenges and needs.

REFERENCES

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckman (Eds.), *Action-control: From cognition to behavior* (pp. 11–39). Heidelberg, Germany: Springer.

Bandler, B. (1973). Interprofessional collaboration in training in mental health. *American Journal of Orthopsychiatry*, *43*(1), 97–107.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY: Freeman Publishing.

Center for Health Workforce Studies, School of Public Health, University at Albany. (2006). *Licensed social workers in the United States, 2004*. Washington, DC: National Association of Social Workers. Retrieved from http://workforce.socialworkers.org/studies/fullStudy0806.pdf

Center for Juvenile Justice Reform, Georgetown University. (2008). *Bridging two worlds: Youth involved in the child welfare and juvenile justice systems: A policy guide for improving outcomes*. Washington, DC: Author. Retrieved from http://www.napcwa.org/home/docs/BridgingWorldsPolGuide.pdf

Council on Social Work Education. (2008). *2008 Educational policy and accreditation standards*. Retrieved from http://www.cswe.org/File.aspx?id=13780

D'Amour, D., Ferrada-Videla, M., Rodriguez, L. S. M., & Beaulieu, M.-D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, *1*, 116–131.

Fabelo, T., Thompson, M. D., Plotkin, M., Carmichael, D., Marchbanks, M. P., & Booth, E. A. (2011). *Breaking schools' rules: A statewide study of how school discipline relates to students' success and juvenile justice involvement*. New York, NY: Council of State Governments Justice Center. Retrieved from http://csgjusticecenter.org/wp-content/uploads/2012/08/Breaking_Schools_Rules_Report_Final.pdf

Forbes, J., & Watson, C. (2011). *The transformation of children's services: Examining and debating the complexities of inter/professional working*. Philadelphia, PA: Routledge, Taylor, & Francis Group.

Guile, D. (2012). Inter-professional working and learning: "Recontextualising" lessons from "project work" for programmes of initial professional formation. *Journal of Education and Work*, *25*(1), 79–99.

Herz, D. C., & Ryan, J. P. (2008). *Building multisystem approaches in child welfare and juvenile justice*. Washington, DC: Center for Juvenile Justice Reform, Georgetown University. Retrieved from http://cjjr.georgetown.edu/pdfs/pre_work/BuildingMultisystemApproachesinChildWelfareandJuvenileJustice.pdf

Holden, G., Anastas, J., Meenaghan, T., & Metrey, G. (2002). Outcomes of social work education: The case for social work self efficacy. *Journal of Social Work Education*, *38*(1), 115–133.

Holden, G., Meenaghan, T., & Anastas, J. (2003). Determining attainment of the EPAS foundation program objectives: Evidence for the use of self-efficacy as an outcome. *Journal of Social Work Education*, *39*, 425–440.

Joint Commission on Mental Health of Children. (1969). *Crisis in child mental health: Challenge for the 1970's. Report of the Joint Commission on Mental Health of Children*. New York, NY: Harper & Row.

Kearney, K., Bloom-Ellis, B., & Thompson, R. (2012). Breaking down the silos: Lessons learned from the expansion of performance-based contracting to residential treatment services in Illinois. *Journal of Public Child Welfare*, *6*, 83–107. doi:10.1080/15548732.2012.644220

McCarter, S. A., Haber, M. G., & Kazemi, D. (2010). Models to guide system reform for at-risk youth. *Child and Youth Care Forum*, *39*, 465–479. doi:10.1007/s10566-010-9113-7.

National Association of Social Workers. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers*. Washington, DC: Author.

Perlin, M. L. (2012). "Justice's beautiful face": Bob Sadoff and the redemptive promise of therapeutic jurisprudence. *Journal of Psychiatry & Law*, *40*, 265–292.

Petro, J. (2006). *Increasing collaboration and coordination of the child welfare and juvenile justice systems to better serve dual jurisdiction youth: A literature review*. Washington, DC: Child Welfare League of America, Research and Evaluation Division. Retrieved from http://www.cwla.org/programs/juvenilejustice/jjlitreview.pdf

Rausch, M. (2006, Fall). *Discipline, disability, and race: Disproportionality in Indiana schools*. Bloomington, IN: Center for Evaluation and Education Policy. Retrieved from http://www.indiana.edu/~equity/docs/discipline_disability_race_indiana.pdf

Ryan, J. P., Testa, M. F., & Zhai, F. (2008). African American youth in foster care and the risk of delinquency: The value of social bonds and permanence. *Child Welfare*, *87*, 115–140.

Smith, B., & Mogro-Wilson, C. (2007). Multi-level influences on the practice of interagency collaboration in child welfare and substance abuse treatment. *Children and Youth Services Review*, *29*, 545–556.

Wagner, M. (1995). Outcomes for youths with serious emotional disturbance in secondary school and early adulthood. *The Future of Children*, *5*(2), 90–112.

Wagner, M., Cameto, R., & Guzmán, A. (2003). *NLTS2 data brief: Who are secondary students in special education today. A report from the National Longitudinal Transition Study-2*. Retrieved from www.ncset.org/publications/viewdesc.asp?id=1008.

Way, D., Jones, L., & Busing, N. (2000, May). *Implementation strategies: Collaboration in primary care–family doctors & nurse practitioners delivering shared care*. Toronto, Canada: Ontario College of Family Physicians.

Wexler, D. (2008). Two decades of therapeutic jurisprudence. *Touro Law Review*, *24*, 1–13.