Alcohol and drug service providers' perceptions of interagency collaboration with child welfare services

Verronda L. Moore

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ALCOHOL AND DRUG SERVICE PROVIDERS’ PERCEPTIONS OF INTERAGENCY COLLABORATION WITH CHILD WELFARE SERVICES

A Dissertation Presented

to
The Faculty of the School of Education
Department of Leadership Studies

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

by
Verronda L. Moore
San Francisco
May 2007
This dissertation, written under the direction of the candidate’s dissertation committee and approved by the members of the committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Education. The content and research methodologies presented in this work represent the work of the candidate alone.

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\[5-10-07\]

\[\text{Date}\]
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DEDICATION

To my grandmother, Ruby L. McGaffie, sister, Tamela L. Moore, and nephew, LaDarion B. Elliott—my greatest supporters
Thank you for your kindness, patience, support, and intercessory prayers during this most challenging process. I will forever cherish your commitment to helping me to persevere through the tough times and believing in my ability to succeed. Most importantly, I appreciate the unconditional love that you have demonstrated through your unselfish acts of kindness.

To my late Grandfather / Great Patriarch, Papa Anise McGaffie —my hero
Thank you for instilling the value of education and perseverance in me at a very early age. To my late and loving parents, Melvin L. Moore and Ophelia McGaffie Moore, thank you for giving birth to me, encouraging me, and being my biggest cheerleaders.
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CHAPTER I
THE RESEARCH PROBLEM

Statement of the Problem

Interagency collaboration has been seen as ensuring that the totality of people’s needs are both recognized and met, achieving economies in the use of resources and bridging the gap between and with statutory and voluntary agencies (Farmakopoilou, 2002). According to the social exchange perspective, the motivation to collaborate is internal to each organization. Interagency collaborations form when members of organizations perceive mutual benefits from interacting. For this reason, in 1999, the Recovery Institute implemented the System of Care model to improve the quality of services to county residents in Northern California and interagency collaboration was identified as a key component of the model.

Gardner (1998) defines collaboration as the creation of a community process to plan a service system for clients where no new programs are started without participation by existing programs. Although interagency collaboration is a vehicle through which different organizations can pool their intellectual and institutional resources, the System of Care model was purposefully designed to create an integrated service delivery system (comprised of several agencies and programs) that could be easily accessed through a single point of contact. Moreover, the model was designed to ensure the provision of appropriate level of services, tailor treatment to meet the needs at all levels, and better manage the county’s alcohol and drug resources (Moore, Trochet, Wirtz, & Hubbard, 2005).
The Recovery Institute contracts with numerous community-based organizations throughout a Northern California county to provide treatment and counseling services to recovering substance abusers. The range of services provided through these organizations includes case management, outpatient counseling, day and residential treatment, detoxification, methadone services, perinatal, and aftercare services (Moore et al., 2005). The Recovery Institute provides monitoring and oversight activities for 40 federal and state funded community-based alcohol and drug services providers in the county. The Recovery Institute along with the contracted agencies also provides direct services to the birth parents and other caretakers involved with Child Welfare Services (CWS) to ensure timely treatment to help with the family preservation or reunification process. There are 17 key leaders from the Recovery Institute that enhance accountability, encourage outcome monitoring, and promote quality improvement. Additionally, there are several key leaders and case workers from the multiple contracted community based organizations that are directly responsible for the leadership and service outcomes for the primary consumers (e.g., birth parents and other caretakers) benefiting from the collaborative.

Moreover, the secondary consumers are key leaders and case workers from the CWS Division, Family Reunification Program. Each of these different members in leadership of the interagency collaboration have differing professional cultures, values, and styles that can either restrict or facilitate cooperation with professionals from other disciplines. Hudson (1987) argues that any study of inter-organizational relationships requires the examination of both the environmental and interagency factors that influence such relationships. This is especially true when considering the background, norms, and
cultures of administrators, supervisors, program coordinators, therapists, social workers, drug recovery specialists, drug counselors, and family service workers. Supervisors and program coordinators may have a style of leadership, which may be the same as that of the administrators of their respective agencies, the program managers / directors or it may be very different. Nonetheless, the interagency collaboration between the Recovery Institute, its contracted service providers, and Child Welfare Services is intended to increase public value by having agencies working together rather than separately (Bardach, 1998). As further noted by Forsyth (1999), collaborative efforts are means to achieve goals that would be beyond the reach of a single organization. Effective collaboration between alcohol and drug service providers (e.g., also referred to as Treatment Providers throughout this study) and the child welfare services community involves balancing the interests of multiple stakeholders with divergent theoretical orientations and approaches to practice. Stakeholders include the consumer of service, family members, community-based service agencies, and the Juvenile Dependency Court, as well as State and Federal funders. Nevertheless, the common denominator to this particular interagency collaboration is casework management (Harley, Donnell, & Rainey, 2003).

A case management model is usually employed with individuals who have complex multifaceted needs that cannot be met by simple information and referral programs (Poulin, 2000). Therefore, professionals need to learn the language of other practitioners for the development of the most appropriate intervention plan for timely treatment and successful family reunification. Moreover, effective collaboration is based on mutual understanding of the unique perspectives and specialization of each discipline
Given the charge by the Juvenile Dependency Court to reunify children to their birth families within 6 – 18 months of the initial removal, it would be beneficial to examine alcohol and drug service providers’ perceptions of leadership and case management strategies that eliminate barriers and promote successful interagency collaboration with child welfare services.

Historically, the relationships between alcohol and drug service providers and child welfare service workers have ranged from harmonious to confrontational and contentious. Much of this conflict has occurred and continues to occur between the therapists, drug counselors, drug recovery specialists, and the respective CWS social workers, and family service workers. Information about the court ordered services is often difficult to ascertain from the CWS social workers for two reasons: one, there is a lack of communication for child and parent visitation scheduling, and other communication exchanges. Second, professionals differ on their perspectives on the length of service interventions. According to Alkema, Shannon, and Wilber (2003), service fragmentation is perpetuated by many factors including consumer needs, provider types, provider models, mutually exclusive funding streams, separate bureaucratic authority, federal and state regulatory oversight, and geographic boundaries.

While local bureaucratic authority, federal and state regulations for service delivery dictate the roles and processes each party plays in the collaborative project, the styles of leadership, communication styles, and approaches to management adapted by the partnerships have not been mandated or sufficiently researched (Bardach, 1998). Research findings suggest that attempts at local collaboration, coordinated services, and accountabilities add new levels of complexity of their own. As noted by Craig (2004),
the first step is to get the key leaders from both government agencies and community
groups around the table that can make decisions. Then move beyond the traditional
bureaucratic chain of command and take it back to the diverse represented networks to
produce enhanced engagement and the development of shared strategies and advocacy
around the issues. Moreover, developing a level of trust and understanding of each
agency’s culture and common language for addressing collaboration are key components
to interagency collaboration.

Bardach (1998) characterizes the behavior of “working cooperatively” as creating
interagency collaborative capacity (ICC). He further asserts that the ICC is functioning
properly when worldviews are reconciled with professional ideologies that cluster within
agency boundaries, but differ across them. Nonetheless, the problem identified in this
study is the need for better understanding of the perceptions about how multiple agencies
collaborate in providing leadership and coordinated case management services between
the parties mentioned and the resulting factors that impact successful interagency
collaboration.

Purpose of the Study

The purpose of this sequential mixed methods study was two-fold. The first was
to examine the perceptions of leaders in providing leadership and case management
services to facilitate successful interagency collaboration. The second purpose was to
examine the perceptions of Treatment Providers regarding the process of interagency
collaboration with Child Welfare Services as a whole and to determine if the direct-
service providers from different agencies hold similar views about the collaboration. The
first phase was to obtain statistical, quantitative results from a sample of key leaders and
The perceptions of coordinated case management and the factors related to the facilitating factors and barriers to interagency collaboration make up the independent variables in this study. Relationships among and between the measures of these variables, the level of transformational leadership, and the most needed additions or changes to the current system of collaboration are the dependent variables. Data was collected for this study through a survey instrument and follow up face-to-face interviews with both leaders and staff from multiple treatment provider agencies in a Northern California County.

Background and Need for Study

Many parents being referred to the child welfare services system are for allegations of child abuse and neglect as a direct result of using and abusing alcohol and other drugs. According to Young, Gardner, and Dennis (1998), every child welfare agency in the nation has attempted to build effective partnerships with Alcohol and Other Drug (AOD) treatment providers due to rising caseloads, increase in the number of
children entering foster care, and the inability of families on welfare (some who are also in the CWS system) to secure employment. However, in 1999, representatives from the Recovery Institute, the Community Service Planning Council, the Public Health and Alcohol and Drug Advisory Boards, and a myriad of stakeholders from the public and private sector embarked upon a study entitled “Changing the Landscape” to examine substance abuse and its impact in a Northern California County. The findings and ten recommendations were presented and formerly adopted by the local Board of Supervisors in 2001.

Subsequently, a new report was completed in 2005 that included a brief status report on the original ten recommendations from the first report to encourage ideas and collaborative efforts to address the adverse consequences of substance abuse (Moore, Trochet, Wirtz, & Hubbard, 2005). Key among those ten recommendations was the establishment that alcohol and other drugs issues and the negative impact on the quality of life were one of the community’s highest priorities. As a result, funding was provided to support the Dependency Drug Court, youth prevention and treatment, and culturally expert service providers to respond to the unique needs of the African American, Hispanic, and Asian Pacific Islander populations. Numerous collaborative projects have been expanded in educational institutions, community coalitions, and child welfare services.

The Child Welfare Services Division, Family Reunification Program is charged with the case management of families to ensure compliance and progress of court orders with case plan service objectives. They also monitor the frequency and quality of visitations between the caretaker and child, and provide on-going assessments of parents’
ability to maintain a safe environment for their children. These case management functions assist in the facilitation efforts for family reunification or other permanency options (e.g., guardianship, adoption, or long term placement) if the reunification process is failing (Anonymous, 2006). The design of child welfare services was redefined by Assembly Bill 63 which called for the creation of California’s Outcomes and Accountability System for Child Welfare Services. The system is based on the federal Child and Family Services Review to gain in depth knowledge of child safety, permanence, and well-being. However, Division 31 regulations and Welfare and Institutions Codes established service funded activities, service delivery roles for supervisors, social workers, and family service workers. As a result, social workers from child welfare services are also responsible for the on-going interagency collaboration with relevant service providers to verify the parents’ attendance and progress in services.

The service providers in turn provide comprehensive case management services to clients and send updated verbal and written progress reports to the social workers to help inform the court review hearings. The intent of the regulations was to clarify and establish federal and state policy makers’ goal to develop a relationship between these entities that will be coordinated and collaborative in impacting family reunification service outcomes. Nevertheless, that has not necessarily been the consistent result. As noted by Glisson and Hemmelgarn (1998), organizational climate rather than interorganizational coordination affects service quality, especially when there is a substantial power differential among individuals or groups of stakeholders. The Child Welfare Services Division has the direct authority to file petitions to remove children from custody and recommend placement in foster homes or institutions, and this
authority may sometimes pose a conflict to the alcohol and drug service providers with
divergent theoretical orientations and approaches to practice. Whereas CWS is focused
on providing a safe environment for the well-being of children, alcohol and drug service
providers primarily focus on treatment and making life better for the recovering parents.

Furthermore, the interactions between the key leaders and case workers are
subject to individual leadership styles of the team members and the organizational culture
of the agencies. The individual ability of the supervisors and the team to effectively lead
and manage the collaborative project within the parameters of their authority and
responsibility as defined by guidelines is influenced by their history, interpersonal
dynamics, culture, expectations, and perceived leadership style. As noted by Thompson,
Socolar, Brown, and Haggerty (2002), collaboration usually begins with cooperation,
which leads to coordination, resulting in collaboration. Therefore, the need for this study
was to examine alcohol and drug service providers’ perceptions of leadership and case
management strategies that eliminate barriers and promote successful interagency
collaboration with child welfare services.

Theoretical Foundation

The theoretical frameworks utilized to examine interagency collaboration were
transformational leadership and organizational culture. Transformational leadership is a
popular theory in the leadership arena that was originally introduced by Burns (1978) and
his associates and has now evolved to be the central perspective in the field by many
researchers (Pawar, 2003). Bass (1985) asserts that transformational leadership theory
rests on the assertion that certain leader behaviors can arouse followers to a higher level
of thinking. Transformational leaders’ articulate vision, and enhance the quality of life
for the people and the organization. They elevate the thinking of people and inspire people to trust and follow their examples. According to Bass and Avolio (1994), transformational leaders engage the full person so that their associates are developed into leaders who in turn influence the culture of their organizations.

Moreover, interagency collaborative projects create an enormous amount of change when considering the leadership styles of individual leaders. Effective leaders must be able to have a balance of motivating the followers in subtle and non-threatening ways to get the work done. This skill requires that a leader be servant-led by not only making followers feel valued, but by upholding integrity and guidelines for human conduct. According to Gardner (2000, p.3) “leaders shape and are shaped”, which supports the theory that leaders and followers have a direct influence upon each other.

Transformational leadership theory shares many of the same characteristics as collaborative leadership. Kouzes and Posner (2002) refer to trust as the heart of collaboration. Leaders must trust others to achieve the mission and goals of the organization. Trust is a significant indicator of an individual’s satisfaction with their organization. When leaders create a climate of trust, employees feel free to be innovative and contribute, thereby helping to reach higher levels of excellence. According to Tucker and Russell (2004), transformational leaders influence three areas of the organizational culture: the internal mindset of the people in the organization, the culture among the people, and the culture beyond the people of the organization. All of these areas affect the culture through teams, innovations, and productivity. Although Langston and Corcoran (2001) argue that collaborative projects create a climate for positive interaction
within and between organizations, transformational leaders assist the existing organization to adapt to the changing environment beyond the single organization.

Cultural change is a significant function of the transformational leadership process. Culture is the heart of an organization’s character and identity (Schein, 2001). Nevertheless, culture in an organization is hidden, yet it is a unifying theme that provides meaning, direction, and mobilization. According to Trice and Beyer (2001), human cultures emerge from people’s struggles to manage uncertainties and create some degree of order in social life. However, the rudiments of organizational culture have powerful effects on behavior. Sackmann (1991) notes that corporate culture influences an organization’s performance, and managers want to know how to influence or change it to obtain the best culture for achieving excellence in performance. Thus, understandings of the concept of culture in organizations focus predominantly on behavior and its functionality. Most organizations are looking for a prescription for success, but culture characteristics vary in organizational settings. Being open, adaptive, or even proactive to change is vital for an organization’s survival. Sackmann (1991) recommends that organizations need to be aware of the following elements:

- Anticipate and respond to changing customer needs
- Accommodate the changing values and needs of their work forces
- Be responsive to political, economic, and legal changes.

Once these elements are accounted for, adjustments can be made to perform with strategic intentions.

Consequently, organizational cultures are created when leaders set social processes in motion to achieve the vision of what their organizations should be like and
what they should try to accomplish. However, with interagency collaborations, each agency has its own organizational culture, including rules and regulations, language, values, and even definitions of collaboration that the individuals carrying out the mission of the project need to understand. Furthermore, since every organizational culture is different, what works for one organization may not work for another. In the article “Defining Organizational Culture,” Schein (2001) states that neither culture nor leadership can be understood independently, rather, it is intertwined. He further asserts that culture is the result of a complex group learning process that is only partially influenced by leader behavior. Transformational leadership can enhance effective leadership through the process of collaboration.

Applying these theoretical frameworks to interagency collaboration will guide this study in the exploration of the optimal combination of the transformational leadership style between key leaders of collaborative projects and factors that make for the most effective and efficient operation of the interagency collaboration.

Research Questions

The research questions explored in this study are (a) What are the perceptions of leaders and staff regarding successful interagency collaboration? (b) What are the perceptions of leaders and staff regarding the challenges and solutions resulting from the collaborative process? (c) What are the factors affecting the benefits and limitations of interagency collaboration? (d) What is the relationship between a transformational leadership style of key leaders and the effective and efficient operation of interagency collaboration?
Definition of Terms

The section provides definitions of terms that have been operationalized for this study.

*Assembly Bill 63 (AB63):* Describes a 2001 legislation that was passed by the California State Legislature in 2004. The bill called for the creation of California’s Outcomes and Accountability System for Child Welfare Services. The system is based on the federal Child and Family Services Review to gain in depth knowledge of child safety, permanence, and well being.

*California Association of Alcoholism and Drug Abuse Counselors (CAADAC):* Describes the largest Alcohol and Other Drug Abuse counseling certification organization in California. CAADAC counselors receive specialized professional training and education in the field of alcoholism and drug abuse and are recognized as experts in treatment and treatment management for clients struggling with the disease of addiction. To learn more, visit the CAADAC web site at [http://www.caadac.org](http://www.caadac.org).

*Child Welfare Services (CWS):* Describes a county operated division to protect children from abuse, neglect, and exploitation by promoting the health, safety, and well being of children.

*Child Welfare Services (CWS) Case/Social Workers:* Describes those persons who are responsible for assessing the risk and safety of the children, ensuring that the parents are complying with court ordered case plans, coordinating with multiple service providers, filing petitions, and submitting progress reports to recommend the return or alternative placement options of dependent children.
Community based organization: Describes the non-profit status of a community organization that is also a paid contractor that provides alcohol and drug prevention, treatment, and counseling services to clients involved in the child welfare service system.

Dependency Court System: Describes a superior court body that declares children dependents of the Juvenile Court. The referee/judge reviews the recommendations of CWS to keep children in out of home placement until the parents comply with a court ordered plan of services and supervision developed to ensure the safety of the child. In accordance with the Welfare and Institutions Code, services may be provided for a period that ranges from 6 - 18 months, depending on the age of the child and case circumstances.

Drug and alcohol counselors: Describes those persons employed by the community-based organizations that provide education and information regarding substance abuse treatment and other support services to clients.

Family Reunification Program: Describes a program under the CWS division designed to reconnect children in out-of-home care with their families by means of a variety of services and support to the children, their families, and their foster parents or other services providers. The children have been declared dependents of the Juvenile Court due to abuse and/or neglect, and placed out of the home of the parent(s).

Family Service Workers: Describes those persons employed by CWS who perform services as requested by CWS Case Workers. These services range from providing transportation for clients to and from school, foster placements, counseling, medical, and court appointments. Additional services include monitoring visitations between children and parents, conducting home safety checks, and providing information regarding community resources.
Key Leaders: Describes those persons (e.g., Executive Directors, Assistant Directors, Program Directors, Supervisors, and Team Leaders) responsible for the administration, leadership, program coordination, and supervision of the case managers in each agency.

Recovery Institute: Describes a county operated division to promote a healthy community and reduce the detrimental effects associated with alcohol and drug use.

Recovery Specialists: Describes those persons employed by the alcohol and drug community-based organizations who monitor the drug and alcohol portion of case plans by drug testing, making face-to-face contacts with the clients, ensuring appropriate treatment is occurring and changing treatment modalities when necessary to support the recovery process. The Recovery Specialists also maintain relationships with CWS and other treatment provider case workers and therapists assigned to the client’s case.

Substance abusers: Describes those persons using or abusing alcohol or other drugs (e.g., prescription and illegal).

System of Care Model: Describes a continuum of services provided to include pre-treatment interventions, detoxification, residential and day treatment, outpatient counseling, and aftercare services. The key components to this model are thorough assessments, treatment matching, and consistent use of AOD tools.

Therapist: Describes those persons who possess a clinical license (Marriage Family Therapist, or Licensed Clinical Social Worker) to provide assessment, counseling services, treatment referrals, and development of treatment plans.
Treatment Providers / Case Workers: Describes those individuals employed by the contracted alcohol and drug community-based organizations that perform case management services as therapists or drug recovery specialists.

Limitations of Study

There are several limitations in this study that affect the extent to which the results can be generalized. The limiting elements in this study are related to the population, the research design, and methodology used.

The generalization of the results is limited by the population and sample used in this study. First, only contracted treatment providers serving the Child Welfare Services organization in one Northern California County participated in the study. Contracts, policies, procedures, and practices vary from county to county which may affect the extent the results from this study can be generalized. Next, the definitions of collaboration vary within and between the agencies and since collaboration is not universally defined, the perceptions of the treatment providers may or may not be different. Finally, the sample used in this study consisted of 65% of the contracted treatment providers in one Northern California County.

The analysis conducted in this study resulted in 114 complete sets of quantitative data. Additionally, the interview population and sample used in this study to capture both the leaders’ self assessment as well as subordinates’ assessment of their leaders’ style in relation to the dimensions of transformational leadership also makes the generalization of the results limited. For example, the twelve interviewees were not equally selected with direct supervisor and subordinate matching due to participants’ willingness to voluntarily participate in the second phase of the research or scheduling availability.
However, the purpose of such a limitation was to enable incorporation of a data-collection design, which included distribution of written surveys followed by in-depth open-ended interviews and observations to obtain specific language and voices of the subject. According to Creswell (2003), all methods have limitations, but bias in any single method could neutralize or cancel biases of other methods through triangulating data sources. Thus, the mixed methods approach allowed for the researcher to get a clearer understanding of phenomenon of the participants’ experiences and perceptions of interagency collaboration with Child Welfare Services.

The research design and methodology used to generate the data for this study has limitations. First, the survey instrument may have included too many questions which may have caused fatigue and incomplete responses. Second, there is no logical way to determine if the participants’ responses to the survey accurately reflect their true perceptions. In addition, there is also no way to determine how the participants interpreted a question. If they responded incorrectly, data would be generated that did not reflect the participants’ true perception of the construct being measured. Nevertheless, the results of this study may begin to provide a picture of existing effective and non-effective collaborative interagency practices with Child Welfare Services.

This study focused on how to engage and facilitate in successful interagency collaboration by having both key leaders as well as their staff who participate in collaborative processes reflect on and examine the factors that contribute to the success and limitations of collaborative practices. Although this study focused on alcohol and drug service providers’ perceptions of interagency collaboration, the findings may be
applicable to any collaborative activity with Child Welfare Services across the State of California and beyond.

**Significance of Study**

Interagency collaboration is an essential component of the family preservation and reunification process for Child Welfare Services. The results of this study will inform government agencies and community based organizations of how they can better employ strategies to support and strengthen effective engagement and facilitation practices for successful interagency collaboration. Findings from this research could have policy implications for budgetary expenditures, inter-professional relationships, education, and training for practitioners in the human services profession. For example, if it were possible to recognize and understand the differences in style, communication approaches to problem solving, and leadership roles in a collaborative environment, perhaps training programs in the areas of engaging in the process of collaboration and its prerequisites rather than teaching interagency collaboration as a finished product.

Collaboration activities allow for the integration of services to represent the most rational means of delivery services by combining resources, expertise or facilities for families in need that an individual agency may be unlikely to accomplish. Henceforth, the information gained from this mixed methods research design may be useful for system planners to measure change in collaborative process over time to examine the relationship between collaboration/operational practices, organizational culture, and improving outcomes for child and family consumers of child welfare service agencies across the country.
Summary

Leadership, case management, and interagency collaboration are essential components to the System of Care model to improve the quality of services and ensure timely treatment to help with the family preservation and reunification process to county residents in Northern California. Consequently, each of these different members in leadership of the interagency collaboration have differing professional cultures, values and styles that can either restrict or facilitate cooperation with professionals from other disciplines. Nevertheless, the style of leadership, interpersonal communication, and approaches to management yields the resulting factors that impact successful interagency collaboration.

In the next sections, the pertinent research literature surrounding interagency collaboration, transformational leadership theory, and the effect of organization culture and transformational leadership is reviewed. The methodology employed in this study is described and the findings of this research are presented. A discussion of the findings, conclusions, and implications for successful interagency collaboration practices are presented. Finally, the recommendations for future research are reviewed.
CHAPTER II
REVIEW OF THE LITERATURE

Overview

The review of the literature begins with a review of recent studies in interagency collaboration. The review of the relevant research literature of transformational leadership theory is examined in depth. Recent empirical studies in transformational leadership are then reviewed, as is the effect of organizational culture on the theory’s application. The review concludes with a broad examination of the impact of the Alcohol and Drug Abuse problem in a Northern California County and the rationale to increase public value through the vehicle of interagency collaboration.

Recent Studies on Interagency Collaboration

Bardach (1998) defines interagency collaboration as “any joint activity by two or more agencies that is intended to increase public value by their working together rather than separately” (Bardach 1998, p. 8). There have been several empirical studies of interagency collaboration that focused on factors that impact successful collaboration (Johnson, Zorn, Tam, LaMontague & Johnson, 2003), the extent of collaboration (Thompson, Socolar, Brown & Haggerty, 2002), the cost and benefits of collaboration, policy challenges and other barriers to collaboration (Nicholson, Artz, Armitage, & Fagan, 2000). Although collaboration is not easily measured, previous researchers have integrated the concept that collaboration is a process with stages of development (Alter & Hage, 1993). In a study by Quinn and Cumblad (1994), 133 community-based childcare service providers (e.g., mental health, children and family services, juvenile probation and the educational system) for students with emotional and behavioral disorders were
examined to determine if their perceptions about interagency collaboration were similar or dissimilar. The survey instrument was divided into three parts to solicit opinions about the overall service system, dimensions of interagency collaboration (e.g. leadership, coordination, decision making, and outcomes); and an open-ended question soliciting service providers opinions of the most needed additions or changes to the collaboration. While the study found positive perceptions of the knowledge of other agencies and staff, other barriers existed that constrained the collaboration. The barriers ranged from funding mechanisms, service mandates, and conflict resolution procedures. The study also found that coordination and communication regarding case management needed improvement to gain a clearer picture of the clients’ needs.

Similar to the first study, both case management and interagency teams were used to coordinate operations of a home visitation program for new mothers in seven North Carolina counties. In this mixed method study, Thompson, Socolar, Brown and Haggerty (2002) interviewed 57 participants including 28 administrators and 29 front-line workers first followed by the distribution of written questionnaires to investigate the extent of collaboration, factors affecting collaboration, and the benefits and costs of collaboration. Forty-eight surveys (84% participation) were returned for analysis. The study revealed that leadership was the only common factor found by respondents in all seven counties as facilitating collaboration, but other factors helped to sustain the collaborative efforts. These factors included a positive approach to conflict management, diverse agency representation on advisory councils, availability of funding, and support of collaborative endeavors (e.g. work meetings, and shared information). On the other hand, the barriers to collaboration were restrictive confidentiality and eligibility policies, lack of consistent
leadership and key players due to workforce turnovers, lack of administrative level collaboration between agencies, and trust. Although service coordination and a positive attitude foster collaboration, understanding the other agency’s organizational culture and needs strengthens interagency relationships. Glisson and Hemmelgam (1998) found that organizational climate rather than interorganizational coordination affected service quality. That is, understanding the history of different groups, their philosophies, technical language and the stakes for specific constituents.

Johnson, Zorn, Tam, LaMontague and Johnson (2003) conducted a study to determine the factors that contribute or inhibit successful interagency collaboration and identified solutions to either minimize or optimize their occurrences. Thirty-three stakeholders from nine state departments and three private social service agencies who service children and families were the subjects of this study. Similar to the second study, Johnson et al. (2003) found that commitment, communication, strong leadership from key decision makers, and understanding the culture of collaborating agencies facilitated successful collaboration. Consequently, lack of common vision/goals, communication, trust, and of support from upper management, or leadership, were the major factors that hindered effective collaboration.

Critical to the work of interagency collaboration is the creation of a new relational community where members interact with other organizations. Foster-Fishman, Berkowitz, Lounsbury, Jacobson, and Allen (2001) assert that collaboration is ultimately about developing the social relationships needed to achieve desired outcomes. However, attention to internal group dynamics is necessary given that inter-organizational projects
often involve members who share a history of conflict or have little experience working collaboratively with others.

Nicholson, Artz, Armitage, and Fagan (2000) pilot research investigated the purposes, processes, and outcomes in collaborative practice. Six case studies in three different programs were the focus of this qualitative study. The findings highlighted that collaboration is an evolutionary process that requires certain prerequisites for success. These prerequisites being shared physical space, opportunities for formal and informal communication, consensual decision-making, team/group coordination, leadership, and organizational support. Moreover, cultivating these prerequisites will build strong external relationships with the members of the collaboration.

The key findings also reveal that the process of collaborating across disciplines requires frequent communication, non-authoritarian leadership, shared values, and facilitative support from the organization by providing structure. For example, in three of the case studies, the workers reported that support from the organization was questionable in that caseloads were high, resources were inadequate, and hiring staff that lacked experience in collaborative approaches. Nevertheless, the informants reported that despite the variety of challenges associated with interagency collaboration, the benefits of teamwork, providing more comprehensive services, and tailoring services to the unique needs of individual consumers minimizes the challenges. Nicholson et al. (2000) argue that collaboration is hindered in competitive environments with conflicting expectations. However, findings from their study concluded that power sharing, coordination, and constant communications are collective efforts that produce the benefits for the collaboration.
In summary, the literature reviewed on interagency collaboration suggests that the components that influence collaboration include quality leadership, conflict management, cooperation, tending to the communication process to build trust, developing a common language, and understanding the organizational culture of each agency. The studies also suggest that the outcomes of interorganizational coordination can be more beneficial than the cumulative efforts of individual agencies working separately. Each agency may not have the capacity to address the challenges related to individuals, complex families, and communities. Thus, interagency collaboration becomes a vehicle through which different organizations can pool their intellectual and institutional resources to offer more seamless service delivery to adults and families in need (Alkema, Shannon & Wilber, 2003).

Transformational Leadership Theory

Another dimension of effective interagency collaboration is leadership. As the literature review suggests, leaders have a key role in facilitating the collaborative process and improving organizational performance (Nissen, Merrigan & Kraft, 2005). Transformational leadership is a part of the “New Leadership” paradigm and as its name implies, the approach is a process that changes and transforms individuals (Bryman, 1992). However, Burns (1978) was the first to specify the distinction between transformational and transactional leadership styles. Transactional leaders attempt to satisfy the current needs of followers by focusing attention on exchanges of rewards and punishment to influence performance. On the other hand, transformational leaders attempt to raise the needs of followers and promote dynamic change of individuals, groups, and organizations by appealing to higher ideals and moral values (Yammarino &
Bass, 1990). Transformational leadership theory explains the unique connection between the leader and his/her followers that accounts for extraordinary performance and accomplishments for the larger group, unit, and organization.

Moreover, the foundational principles of transformational leadership were initiated in the work of Max Weber on charismatic leadership. Weber (1947) described charisma as “a special personality characteristic that gives a person superhuman or exceptional powers and is reserved for a few, is of divine origin, and results in the person being treated as a leader.” (Northhouse, 2001, pg. 133). House (1977) extended his theory of charismatic leadership and suggested that charismatic leaders are dominant and have a strong desire to influence their followers. They are strong, competent role models who communicate high expectations and exhibit confidence in their followers. As a result, followers trust in the leader’s ideology and similarities rise between the follower’s and leader’s beliefs as well as to the collective identity of the organization.

Bass (1985) extended the work of Burns and House by giving more attention to the emotional elements and origins of charisma. Bass argues that transformational leadership motivates followers to do more than the expected. Organizations that have transformational leaders produce greater team effectiveness. Bass (1985) observed a correlation between transformational leaders and team effectiveness. He found that this type of leadership served as a role model for team members and increased cooperation in interagency collaborations. As the world beyond a single organization changes, transformational leaders help the existing organization adapt to the developing environment (Mink, 1992).
Concurrent with this new paradigm in transformational leadership is the concept of “servant leadership.” In a study by Stone, Russell, & Patterson (2004), they examined the similarities and differences between servant leadership and transformational leadership. The authors contend that the similarities of the two styles of leadership are people-oriented. They further argue that the styles are complementary ideologies in that both transformational leaders and servant leaders are visionaries, serve as role models, show consideration for others, empower, teach, listen, communicate, and influence followers. On the other hand, the researchers found the primary difference between the two styles is the focus of the leader. For example, the servant leader is focused on the individual while the transformational leader is focused on the organization and building follower’s commitment toward organizational objectives.

Recent Empirical Research in Transformational Leadership

Bass’ empirical studies identified that transformational leadership is composed of four key dimensions: inspirational motivation, idealized influence, individualized consideration and intellectual stimulation. This type of leadership encourages followers to take on leadership roles and perform beyond the established standards or goals (Bass & Avolio 1994). According to Judge and Bono (2000), research on transformational leadership has become one of the dominant leadership theories in the organizational sciences. Recent empirical studies have examined the differential effects of transformational leadership (Arnold, Barling, & Kelloway, 2001), and leaders’ and followers’ assessment of the level of transformational leadership (Carless, 1998 & 2001; Lim & Polyhart, 2004; and Tracey & Hinkin, 1998) utilizing the Multifactor Leadership Questionnaire (MLQ) instrument as developed by Bass and Avolio (1990). Moreover, in
a quantitative study by Arnold et al. (2001) of 177 professionals that composed 42 teams from the Executive MBA program, transformational leadership was found to have positive effects on trust, commitment, and team efficacy beyond the perceptions of the iron cage of strong group norms and values. The results of the study conclude that organizations that have a team/collaborative structure may find that teams/collaborative projects will benefit most from a focus on transformational leadership.

In a study similar in some aspects to the proposed study, Carless’ (1998) assessed the three subcomponents (i.e. charismatic, individualized consideration, and intellectual stimulation) of the transformational leadership traits of branch managers as measured by 1440 subordinates of an Australian international banking institution. The study found that actual charismatic characteristics were different from the intellectual stimulation and consideration behaviors, but the same respondents who scored high in one also scored high in others. Kouzes and Posner (1993) identified visionary leadership as a new component of transformational leadership as measured by their Leadership Practices Inventory (LPI) assessment instrument. The five key dimensions for assessing leadership of the LPI are challenging the process, inspiring a shared vision, enabling others to act, modeling the way, and encouraging the heart. Carless’ (2001) utilized the same international financial institution from her 1998 study of 1,440 subordinates and leaders to examine the construct validity of the LPI. She found that the LPI was a valid measure for assessing the construct of transformational leadership as defined by Kouzes and Posner, but that the distinctions among separate transformational leader behaviors were either not captured by the LPI, or the differences were not noticed by the subordinates.
Tracy and Hinkin (1998) analyzed the dimensions of transformational leadership by comparing the MLQ with the four scales as developed by Yuki’s (1990) Managerial Practices Survey (MPS) to assess the distinct constructs validity. Yuki’s integrative dimensions of the MPS taxonomy included clarifying, inspiring, supporting, and team building. Examination of the definitions as offered by Yuki are similar to the elements of the four transformational leadership dimensions as developed by Bass and Avolio. For example, inspirational motivation behaviors are a mixture of clarifying, team building, and inspiring. Supporting practices such as being considerate, listening to the concerns of others, encouraging new followers to try new approaches to problem solving / conflict management are similar to the definitions of individualized consideration and intellectual stimulation (Bass & Avolio, 1994). Nevertheless, Tracy and Hinkin (1998) conducted a study of 291 lower and middle managers from 47 hotels across the United States utilizing both the MLQ and MPS survey instruments and found that there was a general distinction between transformational leadership and managerial practices. However, the researchers concluded that the linkage between the transformational leadership and the leader’s ability should entail the talent to communicate both the vision and the follower’s role in the team to accomplish the vision.

A quantitative study by Felfe and Schyns (2004) examined the relationship between the similarity of styles of leadership between 213 supervisors from two public administration offices rated their own leadership behavior as well as their leaders’ behavior. Similar to the previous study, the MLQ was used to assess both the self-rated and perceived transformational leadership behavior. The participants were separated into four groups, based on the similarities of their respective leadership styles (e.g., similar
low transformational leadership, similar high transformational leadership, dissimilar high transformational leadership of leader, and dissimilar low transformational leadership of leader). The researchers hypothesized that the perceived similarities in the transformational leadership styles would correlate positively to positive outcomes and negatively to negative outcomes. The results of the study indicated that while the highest correlation was between the similar styles as predicted, the reverse patterns were found with the dissimilar styles. For instance, dissimilar low leadership transformational leadership correlated more positively with performance than dissimilar high leader transformational leadership scores.

In contrast to the previous study, Yammarino, Dubinsky, and Alan (1994) conducted an exploratory study which focused on the perceptions rather than the actual behaviors of superiors and subordinates. The domestic sales organization (174 salespersons and 38 sales supervisors) of a $1 billion multinational medical products firm participated in a 61 item survey using a modified version of the MLQ to assess the dimensions of transformational leaders. The researchers hypothesized that relationships derived from transformational leadership theory are based on individual differences and will hold at the dyads within groups and between dyads. However, the results of the study indicated that the expected relationships held only at the individual (superiors and subordinate) level of analysis and not holding with the perceptions at higher (dyad, group) level of analysis. Implications of this study on interagency collaboration suggest that leaders must be cognizant of the particular dimensions of leadership in use at their individual agencies to foster internal relationships thereby affecting external relationships for improved collaborative outcomes.
The link between satisfaction and performance may not necessarily apply in coordinated services involving multiple service providers. However, Keller (1995) suggests that the effects of transformational leadership style may differ based on the type of work being performed or supervised. In a survey study of 66 industrial research and development project groups, Keller found transformational leadership accounted for higher project quality in research projects. Nevertheless, in the same study, he found that a more directive leadership behavior style resulted in higher project quality in developmental projects. Perhaps the implication of this study lies in the fact that specific variations of transformational leadership styles need to be developed for types of endeavors, specialized professions, or organizational cultures. In summary, the cumulative results of the aforementioned studies are also indicative that promoting a culture of transformational leadership at all functional levels within organizations will benefit the process of interagency collaboration.

**Organizational Culture and Transformational Leadership**

Schein (1992) defines culture as the basic assumptions and beliefs shared by members of a group or organization. The underlying beliefs of an organization’s culture are learned responses to problems of survival in the external environment and problems of internal integration (Yukl, 1994). When multiple agencies form a collaborative project, multiple objectives are established, with differing priorities. However, Schein (1992) argues that objectives and strategies cannot be achieved effectively without cooperative effort, rules or customs about how to handle interpersonal relationships, and a shared consensus about the meaning of words and symbols. Organizational culture is a social energy that moves people to act. Nevertheless, when culture exists, then criteria for
leadership are determined. Transformational leadership affects the culture among the people through teams, innovation, and productivity (Tucker et al., 2004). However, interagency collaboration introduces a new culture to the organization. Interagency collaborative projects allow for multiple agencies to address the complex and interconnected challenges of the 21st century. Schein (2001) notes that leader’s then need to be aware of and manage the elements of the embedded cultures if they are to lead and survive in a changing environment. Although culture is the heart of the organization’s character and identity, transformational leadership strategies are critical for achieving a greater impact, increasing results, and improving organizational and individual performance. Furthermore, transformational leaders are committed to opening channels of communication, team building, and initiating a process for working together for what is best for the community as a whole rather than focusing on narrow interests of the individual.

Transformational leadership is a topic of on-going interest amongst educators, managers, and change consultants. According to Avery (1999), successful leadership across organizational boundaries demands the leader’s ability to organize and energize busy people who do not directly report to one authority towards a common goal. The challenge for this type of leadership is to clearly identify and define the “what” (business results) and the “why” (the relationship), and get the team’s commitment. In order to accomplish this, transformational leaders must do their homework to see what energizes others to achieve. Once the needs and wants of others are identified, a shared commitment is developed which drives the team members to find the skills and resources needed to accomplish the goals.
Leadership is being a person of influence to motivate a group towards a common goal. Being a person of influence requires flexibility, having the ability to encourage, coach, and apply transformational leadership styles for maximum teamwork participation and productivity. In short, transformational leaders understand the importance of shared leadership and they create space for others to lead for effective interagency collaboration. Transformational leadership is similar to collaborative leadership as noted by Rubin (2002) who concluded that collaborative leaders are interpersonal and inter-institutional relationship managers. However, this style of leadership does not require one to give up authority. For instance, in a traditional sense, this power is having authority over people to get things done.

Consequently, as noted by Avery (1999), having the power over people does not work outside of the agency’s reporting chain. Instead, collaborative leadership operates on integrative power that is without limits to energize and focus people through and across communication networks, thereby transforming organizational culture into a shared meaning of high performing collaboration for a shared mutual benefit. Thus, effective transformational leadership is characterized by both task and relationship factors.

In summary, leadership in interagency collaborative projects requires persuasive and motivational skills, managing boundaries and constraints, and effective liaison and monitoring abilities (Nurick, 1993). Transformational leaders have a major influence upon organizational culture. Their primary focus is upon creating a change process that continually causes people within the organization to learn and grow. Successful interagency collaboration can be beneficial when communication skills, leadership
ability, conflict management, respect for others’ work, and trust make up the ingredients of the individuals that comprise the group. Consequently, interagency collaborative projects need transformational leaders since cultural change is an essential part of the transformational leadership process. Transformational leaders optimize an energy exchange between the leaders and followers for the benefit of the followers and the mission of the organization.

*Impact of the Alcohol and Drug Abuse Problem in a Northern California County*

The other consideration to include in the study of perceptions of interagency collaboration, effective leadership, and organizational culture is the impact of the alcohol and drug abuse problem. In Northern California, alcohol is the primary substance of choice and its use is often a significant risk factor in child abuse (Moore, Trochet, Wirtz, and Hubbard, 2005). Based on the California Health Interview Survey (CHIS), nearly 516,126 persons (60% of the population) in a Northern California County consumed alcohol in the 30 days preceding the survey, and 141,396 (16% of the population) reported binge drinking in the 30 days preceding the survey. While the CHIS estimates must be reviewed with caution, they do provide a critical baseline to frame the consumption issue. According to the Department of Alcohol and Drug Services System of Care report (Fiscal year 2002/2003), the substances reported as most frequently used were alcohol (19%) followed by marijuana (17%) and methamphetamines (16%). However, methamphetamine is the most impacting drug of choice for parents involved in the Dependency Drug Court in a Northern California County.

Between 2003 and 2004, there were over 7,000 treatment admissions for alcohol and other drugs (AOD) for 6,000 non-duplicated individuals who sought and received
services from publicly funded community-based treatment programs. Unfortunately, statistics are not available to estimate the number of individuals receiving treatment services through private agencies, hospitals, Employee Assistance Programs or 12-step recovery programs like Alcoholics Anonymous or Narcotics Anonymous. Nevertheless, in light of these additional private resources, the demand for services exceeds capacity (Moore, Trochet, Wirtz, & Hubbard, 2005). In response to the substance abuse problem in Northern California, the county provides funding for the Recovery Institute along with 40 AOD treatment providers to provide direct services to the birth parents and caretakers of Child Welfare Services (CWS) to ensure timely treatment to help with the family reunification process. The collaborative partnerships are intended to increase public value that would be beyond the reach of a single organization.

1 The University of California Los Angeles Center for Health Policy Research, in collaboration with the California Department of Health Services and the Public Health Institute conducted a large scale telephone survey of California residents. The survey encompassed most aspects of health including alcohol use, nutrition, exercise, brushing teeth, etc.) The sample responses were then extrapolated to project responses for the entire county. The adult sample included anyone over the age of 18. Approximately 1,231 persons were sampled. However, the data for this section was pulled for persons between the ages of 18 and 64.

2 Alcohol prevalence /consumption are defined as consuming at least 1 drink of alcohol in the month preceding the survey.
Summary

The review of literature and related research provided a theoretical foundation in transformational leadership theory, organizational culture, and the need for transformational leadership for successful interagency collaboration. The literature suggests that the outcomes of interorganizational coordination can be more beneficial than the cumulative efforts of individual agencies working separately. However, perceptions of organizational contexts influence leadership behaviors. Service providers’ perceptions of interagency collaborations with Child Welfare Services are important to understand even if they are misperceptions. Lewin (1936) asserts that people respond based on their perceptions of reality and not reality itself. Therefore, this research emphasized the importance of examining alcohol and drug service providers’ perceptions of interagency collaboration and leadership for building trust, developing a common language, and facilitating case management and effective communication for successful outcomes.
CHAPTER III

METHODOLOGY

Restatement of the Problem

The purpose of this sequential mixed methods study was two-fold. The first was to examine the perceptions of leaders in providing leadership and case management services to facilitate successful interagency collaboration. The second purpose was to examine the perceptions of Treatment Providers regarding the process of interagency collaboration with Child Welfare Services as a whole and to determine if the direct-service providers from different agencies hold similar views about the collaboration. Key leaders and staff from the Recovery Institute and multiple alcohol and drug service providers in a Northern California County were the focus of this study. Interestingly, multiple agencies have decided to work together to provide case management services to help with the family preservation and reunification process for recovering substance abusing caretakers, but little is known about how the collaboration is working for the agents in the respective organizations.

While numerous studies (Alkema, Shannon, and Wilber, 2003; Bardach, 1998; Craig, 2004; Farmakopoilou, 2002; Harley, Donnell, & Rainey, 2003; Hudson, 1987; Johnson, Zorn, Tam, LaMontague, & Johnson, 2003; Thompson, Socolar, Brown, & Haggerty, 2002; Nicholson, Artz, Armitage, & Fagan, 2000; and Quinn & Cumblad, 1994) of interagency collaboration have been conducted, examining the perceived effectiveness of an interagency collaborative project with Child Welfare Services has been unexplored. Therefore, the need for this study was to examine alcohol and drug service providers’ perceptions of leadership and case management strategies that
eliminate barriers and promote successful interagency collaboration with child welfare services.

The perceptions of coordinated case management and the factors related to the facilitating factors and barriers to interagency collaboration make up the independent variables in this study. Relationships among and between the measures of these variables, the level of transformational leadership, and opinions of the most needed additions or changes to the current system of collaboration are the dependent variables. Data was collected for this study through a survey administered to both leaders and staff from multiple treatment provider agencies in a Northern California County.

This chapter is divided into four sections. First, the research design is described. Second, the sampling and data collection procedures that were utilized to determine the population and sample are described. Next, an explanation of the process used to create the survey instrument is detailed. Finally, the preliminary data analysis of the data is outlined.

Research Design

The research design was a two-part (mixed methodology) study to capture the best of both qualitative and quantitative approaches to balance the subjective interpretation of the researcher with objective universal questionnaire categories. A mixed methodology is combining both a quantitative and qualitative data into a single study. Researchers employ a mixed methods design to converge or confirm findings from different data sources. According to Creswell (2003), the mixed methods approach allows for both the collecting of diverse types of data from generalized results to more detailed views from participants. The researcher first distributed survey questionnaires to
collect data followed by open-ended interviews to obtain specific language and voices on the subject. The quantitative study utilized written survey questionnaires to examine the level of transformational leadership used by the key leaders and their staff of the collaboration and the perceptions of service providers concerning interagency collaboration.

After the surveys were completed, individual interviews were conducted to follow up with five key leaders and seven key staff members from the alcohol and drug service providers. The purpose of the interviews were to obtain specific language for the qualitative study in order to further explain the quantitative findings regarding the perceptions of the factors that hinder and contribute to the success of the collaboration.

**Population and Sample for the Quantitative Method**

The population sample for this study targeted the key leaders and staff members from the Recovery Institute that enhance accountability, encourage outcome monitoring and promote quality improvement. In addition, the key leaders and case workers from the contracted community based treatment providers that are directly responsible for the leadership and case management for the consumers benefiting from the collaborative project with child welfare services were also a part of the targeted population sample.

In November of 2006, the Recovery Institute’s Alcohol and Drug Services resource list indicated that there were 27 contracted providers and 3 county units that provide treatment services to caretakers involved in Child Welfare Services. The providers working in these agencies were the population selected for this study. The sampling frame for this study was developed by taking the following steps: (a) identifying the agency administrators of each organization and their mailing addresses by
using the 2006 Alcohol and Drug Services Resource list; (b) accessing each agency’s website (where available) to get the mailing addresses, names, and email addresses of the listed Executive Directors and cross referencing this list with the Alcohol and Drug Services Resource list; and (c) compiling a complete list of agency administrators’ mailing and email addresses. Agencies that provided only prevention/early intervention or did not service child welfare services were eliminated from the study because they did not have experience in providing coordinated case management with child welfare services. After conducting this sampling frame, 22 contracted providers and 3 county units met the criteria and were invited to participate in this study.

Once the sampling frame was identified, steps were taken to obtain the targeted sample for this study. Initially, permission from the Institutional Review Board for the Protection of Human Subjects at the University of San Francisco was obtained before any data were collected (see Appendix A). Next permission from the county’s agency administrator of the Recovery Institute was obtained (see Appendix B). Finally permission from the agency administrators from each of the 22 community contracted treatment providers were also obtained before any data were collected (see Appendix C). Data were collected using traditional paper-based surveys since not all agencies had websites or internet access for their employees.

Initially letters and a flyer were mailed to the agency administrators describing the purpose of research study, the targeted participants, and the approximate time it would take (15 – 20 minutes) to complete the surveys. After the initial mailings were sent out, a follow up email was developed and sent to the program coordinator for mass email distribution to the contracted community treatment providers. The researcher telephoned
the non-respondents and finally, a second e-mail was sent to the remaining non-respondents. Both email communications can be found in Appendix D. Of the 25 agencies, one agency declined to participate due to limited resources, four did not respond, and 20 consented to participate in the study. However, three of the 20 agencies explained that they could not return the completed surveys within the researchers’ timeline due to other time-sensitive priorities or events. Therefore, the researcher had to eliminate the three agencies resulting in seventeen agencies participating as the population sample. Once the agency administrators gave permission to participate in the study, the researcher hand-delivered the 37 requested leader surveys and 139 staff surveys (see Appendix E for a numerical breakdown of the surveys distributed versus completed surveys returned). The researcher also attached the introduction letter and informed consent forms to the surveys for each research participant (see Appendix F). If the researcher was not invited to the individual agency’s general staff meeting, then the point of contact also received a one-page summary detailing instructions for completing the surveys.

For this study, 123 treatment providers (29 leaders and 94 staff) from the sample of 176 potential participants (70%) returned the surveys. Consequently, 9 respondent scores were eliminated from the data set if they did not answer a minimum of 7 of 9 questions, 8 of 10 questions, 18 of 20 questions, or 24 of 30 questions related to the appropriate variable within sections 2 through 6 of the survey instrument. This resulted in a sample size of 114 (29 leaders and 85 staff) complete data sets, representing 65% of the total eligible sample of participants. The return rate for this study was lower than the 84% found in a comparable study by Thompson, Socolar, Brown and Haggerty (2002).
However, the return rate was higher than those found in other comparable studies: Quinn and Cumblad (1994) – 64 percent, Tracey and Hinkin (1998) – 56 percent, and Carless (2001) – 54 percent. The return rate of the data collected for this study indicates that the use of traditional paper-based surveys may be preferential to the use of web-based surveys.

*Population and Sample for the Qualitative Method*

The population sample for the qualitative phase of the study targeted the key leaders and staff members from both the Recovery Institute and contracted community based treatment providers. After written questionnaires were administered to the 29 leaders and 94 staff from both the county and contracted community treatment providers involved in the collaboration, interviews were conducted with selected individual key leaders and key staff members that provide coordinated services with child welfare services.

For the selection process, the researcher requested the Alcohol and Drug Administrator from the Recovery Institute to generate a list from the county key leaders and staff. In addition to the 26 leaders and 73 staff members from the community and the list of 3 leaders and 21 staff members supplied by the county administrator, the researcher randomly selected every 10th name from the combined list to conduct follow up face-to-face interviews with twelve participants. Interviewees selected for the study were contacted directly by the researcher via email, followed by a telephone call to schedule the date and time for the interview. In cases where the randomly selected twelve participants declined to participate or were not available due to scheduling conflicts, the researcher requested the agency administrator to generate a list of potential
key staff members to follow up with face-to-face interviews. This equated to a sample size of five leaders (three from the community and two from the county) and seven staff members (four from the community and three from the county) participating in the interview phase of the study. Consequently, the twelve interview population and sample used in this study were not equally matched with direct supervisor to subordinate from the same agency.

The researcher conducted the interviews at the agency’s site in either a conference room or the interviewee’s office. Interviews were 20 – 30 minutes in length. An interview guide of pre-determined open-ended questions to ascertain participants’ reflections about the collaboration were generally covered in each interview. However, questions were not distributed in advance in order to allow the reflections to be original, unrehearsed, and candid responses. All other respondents from both the county and contracted treatment providers voluntarily participated in completing the written surveys. Contributors to this phase of the study included: executive director (1), program director (2), mental health program coordinator (2), senior mental health counselor (3), certified drug counselor (2), recovery specialist (1), and a staff who identified themselves as “other counselor” (1). Four leaders have been employed between 6 – 10 years at their current agency and one has been employed 3 – 5 years. One leader has been in their current position of leadership for 6 – 10 years, while two have held their positions for 3 – 5 years, and two for 2 years or less. In the education category, two leaders have a master’s degree, two have an associate arts / science degree and one leader has completed some college level courses. Of the five leaders interviewed, one is a Licensed Clinical Social Worker (LCSW), two have a California Association of Alcoholism and Drug
Abuse Counselors (CAADAC) Accreditation and one leader possesses both a California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation and Licensed Clinical Social Worker (LCSW). Figures 1 and 2 provide a demographic breakdown of the research participants (leaders and staff) employed in both the Recovery Institute and the contracted community organizations.

Figure 1  Demographics of Interview Research Participants for Leaders

The demographics of the seven key staff members for this study are the following: Three staff have been employed between 6 – 10 years at their current agency, two for 3 – 5 years, and two have been with their agency for 2 years or less. In the education category, three staff members have master degrees, one has an associate arts / science degree, two have completed some college level courses, and one disclosed that a high school diploma is their highest level of education. Of the seven participants, one has
a California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation and three have a California Addiction Specialist Certification (CAS).

Figure 2 Demographics of Interview Research Participants for Staff

![Bar chart showing years of experience](image)

**Instrumentation**

For the quantitative portion of this study, the researcher designed two written survey questionnaires entitled “Interagency Collaboration Agency Staff (ICAS)” (Form A) and “Interagency Collaboration Agency Leadership (ICAL)” (Form B) to examine the perceptions’ of service providers concerning interagency collaboration. The researcher developed an eighty item instrument for staff and an eighty-one item instrument for leaders. The survey was divided into six sections utilizing diverse scales of measurement to collect demographics about educational background and length of employment to
examine particular dimensions (i.e., coordinated case management, leadership, communication, facilitating factors or barriers) of interagency collaboration.

The questionnaire was designed in the following manner: First, literature was reviewed on previous studies related to this study in order to identify the different variables as well as to create the questions for the survey. Second, the researcher reviewed instruments from Virginia, California, and other projects to select items appropriate to assessing an individual’s perception of collaboration. Third, a modified adaptation of the Multifactor Leadership Questionnaire (Bass & Avolio, 1995) was developed to assess the level of transformational leadership used by the key leaders and the overall leadership behaviors of the collaborate project staff. Fourth, the researcher designed written samples of the ICAS and ICAL survey instruments and solicited input from seven validation experts (the profiles can be found in Appendix G). The experts’ experience ranged from the field of academia (e.g., leadership studies, research methods, and statistics) to the field of Child Welfare Services, Mental Health, and Alcohol and Drug Services. The validation experts were charged with checking the validity of the survey questionnaires to ensure the comprehensiveness and relevance to the purposes of the study in addition to how appropriate the items were for the target population.

Next, follow up emails, telephone conferences, and interviews were conducted with several validation experts to obtain further feedback for enhancing the survey instruments. Several suggestions were made to improve the validity of the instruments and modifications were made. Finally, prior to finalizing the survey instruments, the researcher attempted to pilot the survey to confirm the validity of the instrument. Invitations were mailed to a random sample from a total of seven current and previously
contracted treatment providers to determine how long the instrument takes to complete, how appropriate the items are for the target population, and if the directions were clear to follow. Consequently, out of the seven invited agencies, only one agency consented to participate in the pilot study, two did not respond and four cited limited resources (e.g., unable to justify billing the hours to current funding sources for staff’s participation). Therefore, the survey items were tested with four staff members and one leader from a community agency who both responded to each item and gave feedback if any confusion in the wording existed. When modifications were recommended, one question was added, the language was revised in two questions, and the choice rankings in section 6 were increased from 4 to the top 5 ranking order to elicit answers to the four general research questions posed. Finally, the reliability of the survey was estimated and submitted to the IRBPHS for review.

Furthermore, for the follow up qualitative methodology, the researcher utilized twelve face-to-face interviews to obtain specific insights to better understand the research problem. The interviews lasted between 20 – 30 minutes, and the researcher utilized audio recordings and note-taking to capture reflections. The interviews took place at the participants’ agency or an agreed upon alternative location. Analyzing data utilizing a mixed methods approach allowed for the exploration of the variables under investigation in greater detail, an examination of the similarities and discrepancies in reporting, and triangulation of the findings using quantitative and qualitative data. The interview questionnaires were confidential and anonymous and were not submitted to participants prior to the scheduled interview. (A copy of the interview questionnaires are attached in Appendix H.)
Description of the ICAS and ICAL Survey Questionnaires

The experts validated the survey questionnaire which consisted of six main sections. The first section was comprised of four items (five for leaders) to capture a data profile summary of the demographics (e.g., length of agency employment, position title, years of experience in leadership position, highest level of education, and possession of accredited certificates or licenses) of the volunteer research participants. The 9 items in the second section were created to measure opinions about coordinated case management with Child Welfare Services using a five-point scale from 1 (strongly disagree), 2 (disagree), 3 (unsure), 4 (agree) to 5 (strongly agree). In section three, 10 questions were created to measure participants’ perceptions of particular dimensions of interagency collaboration such as leadership styles and communication procedures using a three-point continuum ranging from 1 (positive perception), 2 (unsure) to 3 (negative perception).

The fourth section had 20 items designed to measure the five key dimensions (e.g., inspirational motivation, idealized influence (attributes), idealized influence (behavior), individualized consideration, and intellectual stimulation) of transformational leadership and the overall leadership behaviors of the team using a 3-point scale from 1 (not at all), 2 (somewhat frequently) to 3 (most frequently, if not always). In section five, participants were prompted to rate 30 items of potential facilitating factors or barriers to collaboration from helpful to problematic. Finally, questions in section six had 8 items for service providers to identify five of the most needed additions or changes to the current system of collaboration and place their selections in ranking order from 1 – 5 with a ranking of 1 representing the most needed addition/change.
Demographic Questionnaire

The demographic questionnaire for the agency’s leadership included the following questions directly related to the background information of the respondents (demographic category question number three is excluded from the staff form):

1. How long have you been employed with your agency?
   - ☐ 2 years or less
   - ☐ 3 – 5 years
   - ☐ 6 – 10 years
   - ☐ 11 years or more

2. What is your position title?
   - ☐ Agency Administrator
   - ☐ Executive Director
   - ☐ Assistant Director
   - ☐ Program Director
   - ☐ Supervisor
   - ☐ Mental Health Program Coordinator
   - ☐ Other (please specify __________________________)

3. How long have you been in the position of leadership?
   - ☐ 2 years or less
   - ☐ 3 – 5 years
   - ☐ 6 – 10 years
   - ☐ 11 years or more
4. Highest level of education (please check all that apply):

- High school diploma
- GED
- Some college
- Associate Arts / Science (AA/AS)
- Bachelor Degree
- Master’s Degree
- Doctorate Degree

5. Possession of certification / license (please check all that apply):

- California Addiction Specialist Certification (CAS)
- California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation
- Licensed Clinical Social Worker (LCSW)
- Marriage Family Therapist (MFT)

Data Collection and Analysis

The quantitative raw data analysis for this study was manually coded in an excel document and exported into an SPSS database. Each agency was given an alphabet code and each participant of the representing agencies was assigned a numeric identification. The data were visually reviewed by the researcher and two assistants for missing values and outliers. Inaccurate or missing data were corrected or eliminated. For example, raw data were missing from three respondents representing two different agencies. Missing values were checked against the original surveys by agency and corresponding staff identifications for corrections. Several items in section 6 were ranked incorrectly by 4 of
the 29 leader respondents (representing 13.8%), and 24 of the 85 staff respondents (representing 28.2%). However, this may be attributed to the respondents misinterpreting the instructions or in some cases the rankings represented the respondents’ perceptions of the priority of most needed additions or changes to the current system of collaboration.

The qualitative data analysis for this study consisted of a transcription of the audio recorded interviews that include systematic procedures to generate categories and coding themes relative to the identified research questions and to determine the relationships among them. The selective application of the following interview guides established for individual participants were used to answer each of the four research questions based in addition to other data collection and observations:

For Leaders

1. What is your understanding of the vision and goals for your program, and how do you articulate this to your employees?

2. What facilitating factors contributed to the success of the collaboration?

3. How would you describe the benefits of collaboration?

4. What are the barriers (if any) that inhibit the success of collaboration?

5. In what ways do you involve your team in making decisions?

6. What changes (if any) would you recommend to the existing collaborative project?
For Staff

1. What is your understanding of the vision and goals for your program, and how does your leader articulate this to you?

2. What facilitating factors contributed to the success of the collaboration?

3. How would you describe the benefits of collaboration?

4. What are the barriers (if any) that inhibit the success of collaboration?

5. In what ways does your leader involve the team in making decisions?

6. What changes (if any) would you recommend to the existing collaborative project?

The interview questions and survey questionnaires are listed in Appendices H, I, and J respectively.

The data collection for the research questions were as follows:

*Research Question 1: What are the perceptions of leaders and staff regarding successful interagency collaboration?*

Data for this research question consisted of responses from the 8 items listed in section two of the survey questionnaire as well as current answers provided from the interviewees of the questions: What facilitating factors contributed to the success of the collaboration? What ways do you involve your team in making decisions? (Rephrased for staff)
Research Question 2: What are the perceptions of leaders and staff regarding the challenges and solutions resulting from the collaborative process?

Data for this research question consisted of answers from the diverse reflections from the interviewees of the questions: What are the barriers (if any) that inhibit the success of collaboration? What changes (if any) would you recommend to the existing collaborative project? Additional data analysis was extracted from the following sections of the survey questionnaire:

- the 10 items listed in section three
- the 15 items (barriers) listed in section five
- the 8 items in section six of the survey

Research Question 3: What are the factors affecting the benefits and limitations of interagency collaboration?

Data for this research question consisted of field observations, current literature on interagency collaboration, and the rated responses to the 15 items (facilitating factors) listed in section five of the survey questionnaire. In addition, the answers provided from the interviewees of the questions: What facilitating factors contributed to the success of the collaboration? How would you describe the benefits of collaboration?

Research Question 4: What is the relationship between a transformational leadership style of key leaders and the effective and efficient operation of interagency collaboration?

Data for this research question consisted of a combination of responses from the 20 items listed in section four of the survey questionnaires. In addition, answers provided
from the interviewees of the questions: What is your understanding of the vision and goals for your program, and how do you articulate this to your employees? What ways do you involve your team in making decisions? (Rephrased for staff)

*Human Subjects Protection*

An application outlining the methodology as described was submitted to the Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco. Upon review and subsequent approval from the IRBPHS, the researcher proceeded to conduct the research with the population sample as outlined in the application. Subjects were advised that their participation in this study may translate into the loss of confidentiality even if the researcher utilized pseudonyms in all reports or publications resulting from this study. All data collected (i.e., audio recordings, transcribed notes, and agency documents) were coded and filed in a locked safe belonging to the researcher to minimize the risk of loss of confidentiality. A copy of each permission letter detailing the process may be found in Appendix F.

*Researcher’s Profile*

The researcher is a doctoral student at the University of San Francisco, School of Education in the Organization and Leadership Department. She received the Merit Scholarship Award in 2004 and was selected to present on the topic of “Emotional Intelligence & Its Educational Application” in 2005 at the 3rd Annual International Conference on Education in Honolulu, Hawaii. She is a member of Phi Delta Kappa International, San Francisco Chapter and Alpha Kappa Alpha Sorority, Incorporated. She earned a Master’s of Social Work (MSW) degree in Social Work from California State University, Sacramento and a Bachelor of Science degree in Applied Behavioral Sciences
from the University of California, Davis. The researcher’s interests are in the areas of interagency collaboration, organization culture, social work, and all aspects of leadership development.

The researcher has over 17 years of experience in human services related fields including child welfare services and juvenile justice. She is currently employed with the County of Sacramento, Department of Health & Human Services - Child Protective Services (CPS) Division where she is actively involved with interagency collaborative projects, training, and staff development. She is an adjunct professor in the Division of Social Work at California State University, Sacramento where she teaches at the graduate student level. Additionally, she is also an adjunct instructor at the Sacramento Regional Criminal Justice Public Safety Center of American River College where she teaches in the core academies for probation officers and juvenile correctional officers from multi-county agencies. She has been an invited guest lecturer for undergraduate and graduate courses at California State University, Sacramento’s Division of Social Work and the University of Phoenix, respectively. She has also worked as an academic advisor/counselor at Sierra Community College as an adjunct faculty.
CHAPTER IV

FINDINGS

This chapter presents the findings and data analysis used to answer the research questions established in the previous chapters. Data was collected for this study through a survey administered to both leaders and staff from multiple treatment provider agencies in a Northern California county. Data analysis for this study is primarily comprised of descriptive statistics, and Pearson correlations to determine the degree of correlation within and between each of the variables described on both the leader and staff survey instruments. First, descriptive statistics were used to describe which participants agreed and disagreed the most regarding the opinions of coordinated case management with child welfare services. Second, the degree of correlation between groups of each variable is described. These analyses explored what relationships the demographic variables (e.g., length of employment, position title, highest level of education, and possession of a certification or license) contribute to a more positive or negative perception of the particular dimensions of interagency collaboration with child welfare services.

Next, the patterns of responses are also compared to determine if there are differences in the perceptions of the facilitating factors and barriers to collaboration based on position title. Finally, Pearson correlations are used to determine the degree of correlation between the leader and staff perceptions of both the facilitating factors and barriers to collaboration. Several interesting trends emerged and are discussed as they related to each research question.

The results from these analyses are presented in three phases. The results of the analysis used to answer the four research questions in this study are presented. Next, the
data related to specific facilitating factors and barriers to successful collaboration are presented. In the final phase, correlations between the leader and staff rankings are compared with the total sample to determine if there are any similar outcomes with multiple treatment providers.

**Research Question 1**

What are the perceptions of leaders and staff regarding successful interagency collaboration?

Findings from the data collected from questions 1 – 9 in section 2 were used to address this research question. These items requested the treatment providers to assess the major goal of the collaborative project, the communication exchange process, and whether or not the collaboration is beneficial to the success of coordinated case management with child welfare services. Respondents ranged from “strongly disagree” to “strongly agree.” Means, standard deviations, and frequencies for the 9 variables are shown in Table 1 for the leaders and Table 2 for the staff. The means for assessing the main goals of the collaborative project are close to the means reported by Quinn and Cumblad (1994) in a study with community-based childcare (e.g., mental health, children and family services, juvenile probation, and the educational system) service providers (M = 2.28 to 4.23, and SD = 1.10 to 1.23, respectively).

Specially, the means and standard deviations found in this study were (M =3.90 to 3.97, and SD = 1.085 to .860, respectively) indicates that the leadership had no significant differences across the multiple service provider agencies on a 5-point scale (1 = strongly disagree, 5 = strongly agree). The items that received the most positive rating asked the respondents whether or not the major goal of the collaborative was to provide
tailored alcohol and drug treatment services to meet the individual needs of the clients and families being serviced. The responses were also indicative that the agents at both the leadership and staff levels are operating within the intended vision and goal of the collaborative project.

Table 1

Means and Standard Deviations for the Leader Indicators

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals of the collaborative project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide AOD to CWS clients</td>
<td>3.97</td>
<td>1.085</td>
</tr>
<tr>
<td>• Individualized treatment / service plans</td>
<td>3.90</td>
<td>.860</td>
</tr>
<tr>
<td>Communication Exchange</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Referral process</td>
<td>3.45</td>
<td>1.152</td>
</tr>
<tr>
<td>• Progress reports</td>
<td>3.90</td>
<td>.939</td>
</tr>
<tr>
<td>• Notification of change in CWS social worker</td>
<td>2.52</td>
<td>1.214</td>
</tr>
<tr>
<td>• Joint Planning / case conferences</td>
<td>4.14</td>
<td>.990</td>
</tr>
<tr>
<td>• Phone calls / emails</td>
<td>3.14</td>
<td>1.093</td>
</tr>
<tr>
<td>Coordinated case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Encourage &amp; support client with court-ordered case plan</td>
<td>4.59</td>
<td>.825</td>
</tr>
<tr>
<td>• Collaboration beneficial</td>
<td>4.55</td>
<td>1.093</td>
</tr>
</tbody>
</table>

*Note: AOD = Alcohol and Drugs; CWS = Child Welfare Services*
Table 2

Means and Standard Deviations for the Staff Indicators

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals of the collaborative project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide AOD to CWS clients</td>
<td>4.06</td>
<td>1.148</td>
</tr>
<tr>
<td>• Individualized treatment / service plans</td>
<td>4.21</td>
<td>.874</td>
</tr>
<tr>
<td>Communication Exchange</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Referral process</td>
<td>3.92</td>
<td>.966</td>
</tr>
<tr>
<td>• Progress reports</td>
<td>3.79</td>
<td>1.025</td>
</tr>
<tr>
<td>• Notification of change in CWS social worker</td>
<td>2.61</td>
<td>1.135</td>
</tr>
<tr>
<td>• Joint Planning / case conferences</td>
<td>4.01</td>
<td>.906</td>
</tr>
<tr>
<td>• Phone calls / emails</td>
<td>3.26</td>
<td>1.167</td>
</tr>
<tr>
<td>Coordinated case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Encourage &amp; support client with court-ordered case plan</td>
<td>4.52</td>
<td>.840</td>
</tr>
<tr>
<td>• Collaboration beneficial</td>
<td>4.21</td>
<td>.818</td>
</tr>
</tbody>
</table>

Note: AOD = Alcohol and Drugs; CWS = Child Welfare Services

Next, the diverse mean and standard deviation scores (e.g., M = 3.45, 3.90, 2.52, 4.14, and 3.14, SD = 1.152, .939, 1.214, .990, and 1.093) found among the 5 variables in this study to assess the communication exchange process are indicative that the treatment providers have mixed views when trying to engage the agents in child welfare services. For example, 34.1 % of the staff responses indicate that timely communication of shared information is not consistent, whereas the leadership responses indicate that interagency communication exchanges are appropriate. These results are comparable to the feedback found in the study by Nicholson, Artz, Armitage, and Fagan (2000). Treatment provider responses to the individual questions related to these variables are presented in Table 3.
Table 3

Treatment Providers’ Perceptions of Communication Exchange Questions by Frequency

<table>
<thead>
<tr>
<th>Opinions about Communication Process</th>
<th>“Strongly Disagree” or “Disagree”</th>
<th>“Strongly Agree” or “Agree”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Leader</td>
<td>Staff</td>
</tr>
<tr>
<td>Referral process</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Progress reports</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Notification of change in CWS social worker</td>
<td>17</td>
<td>42</td>
</tr>
<tr>
<td>Joint Planning / case conferences</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Phone calls / emails</td>
<td>12</td>
<td>29</td>
</tr>
</tbody>
</table>

The means assessing whether or not the collaboration is beneficial to the success of coordinated case management with child welfare services (M = 4.59 and 4.55 for leaders, 4.52 and 4.21 for staff) indicate that both leadership and staff perceived that their individual contributions add to the success of the overall stakeholder relationships. This analysis is corroborated by responses to individual questions in this section. For example, approximately 97% of the leader responses were 4 (agree) to 5 (strongly agree) ;91.8 % and 83.6% of the staff responses were positive as they related to these variables. Individual responses are presented in Table 4.
Table 4
Perceptions of Individual Contributions to Overall Collaboration Questions by Percentage

<table>
<thead>
<tr>
<th>Opinions about Communication Process</th>
<th>“Strongly Disagree” or “Disagree”</th>
<th>“Strongly Agree” or “Agree”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Leader</td>
<td>Staff</td>
</tr>
<tr>
<td>Encourage &amp; support client with court-ordered case plan</td>
<td>3.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Overall collaboration is beneficial</td>
<td>0%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Additional findings for this research question were data collected from follow up qualitative interviews with both staff and leaders of the treatment provider agencies. Responses to the interview question, “What facilitating factors contributed to the success of the collaboration?,” ranged from having case conferences, on site parenting classes and family visitations, open communication between the collaborative partners, understanding each other’s roles and agency’s culture, the referral system, leadership support and ensuring that case conferences are taking place to previous collaboration experiences, and the diverse services / programs being offered to clients and their families. Similar to Nicholson et al. (2000) study, the facilitating factors were protecting team meeting times, family/client involvement in collaboration, and being flexible and understanding others’ roles and contributions. When asked, “What ways do you involve your team in making decisions?” leaders’ responses ranged from joint decision making before implementing a policy change to having weekly meetings to get feedback. One
leader commented that he tries to empower his staff by allowing them to be creative in implementing new policies or procedure for joint planning activities. Another leader stated that he utilizes staff meetings as brainstorming sessions followed by testing periods to see how the suggestions worked before implementing new guidelines. Finally, one leader reflected,

We have a lot of weekly meetings, so I try to train my managers that they are here to advocate for their staff and staff needs. The clinical director has separate meetings for clinical supervision. I have a bottom up approach, but I obviously have directives that I need to pass down without choice. I have management to bring back things to their staff for program development to get feedback/recommendations. I encourage the team to bring a solution to the problem or let me know that they really thought about a solution, but are stuck and cannot come up with a solution.

Moreover, staff reflections were similar in that their responses ranged from the leader allowing the team to contribute to decisions via email or open dialogue at staff meetings to empowering staff to utilize creative ways to implement new policies and procedures. One respondent further elaborated:

In everything! That’s what is great about my supervisor. Prior to making a project, she will meet with who she needs to meet with and bring back to the team the information to let the team know what is going on. Here are the steps: How do you want to be involved? How do you guys think it ought to improve? She totally gives us every avenue to help make the collaboration and program better. She even asks us how do we want to change our jobs so that it will work better for us as individuals and the other teams we work with. All the way to how creative you can be to collaborate with your co-workers, families and other partners.

Overall, the face-to-face interviews gave detailed insights from the participants that suggest that interagency collaboration is interactional and developmental in nature; that is, there are many factors that contribute to the success (e.g., time, work and support) of interagency collaboration.
Research Question 2

What are the perceptions of leaders and staff regarding the challenges and solutions resulting from the collaborative process?

Findings from the data collected from survey questions 1 - 10 in section 3 were related to particular dimensions of interagency collaboration. These questions asked the treatment providers to rate the effects of leadership and communication as “positive” to “negative” perceptions based on the demographic variables of length of employment, position title, and level of education. In the majority of the chi-square analysis, population samples for leaders were too small and the assumptions for using inferential statistics were not met. For example, 15 cells (83.3%) have an expected count less than 5 and the minimum expected count is .03. The other phenomenon found in the data review from the 29 leader responses indicates that there were agreement of positive perceptions of leadership and communication across all demographic variables. Consequently, this results in a standard deviation of zero because there are no significant differences in their responses.

On the other hand, findings from the staff data collected from survey questions 1 - 10 in section 3 indicate that there were consistent agreements of positive perceptions across the level of education and possession of certification/license demographic variables for leadership in two leadership areas (e.g., being knowledgeable about the agency’s culture and perspectives of collaborative partners, and provides training in technical, programmatic, and relational areas). In addition, two communication dimensions (timely and frequent information sharing, conflict resolution, and effective communication process between the stakeholders) of interagency collaboration also had
positive perceptions. Although the staff population included 85 respondents, there were little variances in their responses.

Additional data was collected from survey questions 1 – 15 (barriers) in section 5, and the rankings from section 6 were also used to address this research question. Section 5 questions asked the treatment providers to rate their perceptions of the barriers to collaboration as “helpful” to “problematic.” T-tests were conducted to examine the equality of means and the prevailing barriers found in the data of leadership responses.

Responses to each item related that the leaders viewed some of the barriers as the most problematic (e.g., attitudes about the collaboration, vague interagency agreements / protocols, scarcity / insufficient level of resources, and high turn over in the workforce). Between 41 to 45 percent of the leaders also identified other barriers (e.g., policies and procedures at the county, state and federal level, different priorities among collaborative partners, differences in professional perspectives, and timely notification of case plan changes/modifications that impact treatment service interventions) to collaboration as problematic.

On the other hand, a review of the staff data found no prevailing barriers to the collaboration. The majority of the respondents marked the potential barriers as facilitating factors. This indicates that both survey instruments may have included too many questions which may have caused fatigue and incomplete responses; or the respondents may have misinterpreted the instructions. As a result, the data generated is presumed not to reflect the participants’ true perceptions of the construct being measured.

Interestingly, in section 6, only 86.2 percent of leaders (25) and 71.8 percent of staff (61) ranked the top five selections appropriately for the most needed additions or
changes to the current system of collaboration. The top five selections among the leaders and staff are presented in Table 5. However, note that two selections tied for the 5th position among the leaders and two tied for the 4th position among staff.

Table 5

Treatment Providers’ Perceptions of the Most Needed Additions or Changes to the Current System of Collaboration by the Top 5 Rankings

<table>
<thead>
<tr>
<th>Variable</th>
<th>Leaders</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent opportunities for open communication among and between staff and leaders (e.g. unit meetings, bureau meetings, multi-disciplinary meetings, telephone conference calls, etc.)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Logistical supports (e.g. workload relief) to assist stakeholders in attending meetings and/or case conferences</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Joint training opportunities on interagency collaboration practices</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Increased communication between policymakers and service providers</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Quarterly in-service training of the Child Welfare Services System of targeted program areas (e.g., Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement —a.k.a. Long Term Placement)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>An adequate level of resources for collaboration (e.g. financial, administrative and professional staff)</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Strong commitment from key leaders to be involved and committed to collaboration</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Cross-training of the similarities / differences between the organizational cultures (e.g. regulatory environment, values, structure and language) of the participating collaborative stakeholders.</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
Unlike the survey data collected, follow up interviews with staff participants revealed several barriers that inhibit the success of collaboration. These barriers ranged from lack of communication, scheduling conflicts, high caseloads, changing CWS social workers without notifying treatment provider to social workers’ lack of attendance at case conferences, and unrealistic court ordered case plans. Although leadership echoed similar barriers, they gave a little more insight into the barriers to collaboration. These barriers ranged from restrictive confidentiality policies that limit information sharing across agencies, adequate resources and funding, requirements and time limitations, to lack of understanding of the culture and language of Child Welfare Services, and social workers’ independence in making decisions. One leader further elaborated,

Social workers (SW) have too much independence to make whatever decision they choose regarding a parent and their children and I think that is completely irresponsible. From a leadership standpoint in the fact that it is allowed is difficult. I don’t have an answer to do it any other way, but I think leaving so much up to an individual. If that individual is not a great person, then that client is not going to get great service. For example I had a SW once say, “The client is smoking pot, and I know she is smoking pot.” The drug tests were negative, and the client was regularly testing 2 times or more per month and the SW was persistent that the client was getting around it and was in fact using. The SW wrote that information in the court report as fact. None was substantiated. I’ve also seen SW’s reports where the client says, “I’ve never met the SW,” or “The SW never completed a home visit.” So I call the SW. Some will say, “You know we don’t have time. We take the last court report and update it and keep it the same.” Now that’s irresponsible! See SW’s can go to court and say, no this person should not deserve to have their children back and yet what is that based on. How much in depth work have they really done to get to know the client and children especially when they have not contacted treatment providers or any one else? Yet they are making a stance that the parents should not have their children. I take this information up the leadership chain, but some of my staff are intimidated by CPS SW’s power and authority, so I encourage them to be advocates.

Nevertheless, respondents identified several solutions to enhance the existing collaborative project. These recommendations ranged from facilitating leadership,
improved social worker attendance at case conferences, implementing telephone
conferencing, identifying key characteristics of collaboration between the treatment
providers and CWS, strengthening interagency relationships to the referral process, job
shadowing, intensive training in drugs and alcohol, and coordinating case management.

Research Question 3

What are the factors affecting the benefits and limitations of interagency
collaboration?

Findings from the data collected from questions 1 – 15 (facilitating factors) in
section 5 were used to address this research question. Section 5 questions asked the
treatment providers to rate their perceptions of the facilitating factors to collaboration as
“helpful” to “problematic.” T-tests were conducted to examine the equality of means and
the prevailing facilitating factors found in the data of both leadership and staff responses.
Responses to each item revealed their views. Table 6 presents the treatment providers’
responses to the facilitating factors. However, note that item number four is not a
prevailing factor among the leader responses.
Table 6

Percentage of Treatment Providers’ Responses to the Most Prevailing Facilitating Factors

<table>
<thead>
<tr>
<th>Facilitating Factor</th>
<th>Leaders</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperative agency leadership</td>
<td>97%</td>
<td>93%</td>
</tr>
<tr>
<td>Cooperative county leadership</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>A combination of both cooperative agency and county leadership</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>Knowledge and understanding about the system of Child Welfare Services program areas (i.e., Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement—a.k.a. Long Term Placement)</td>
<td></td>
<td>83.5%</td>
</tr>
<tr>
<td>A clear view of the role of social work staff from Child Welfare Services</td>
<td>86%</td>
<td>83.5%</td>
</tr>
<tr>
<td>A clear view of the role of other professionals involved in the collaborative process</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Inclusive decision-making processes</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Positive attitudes towards collaboration</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Positive attitudes towards other stakeholders</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Diversity in leadership positions</td>
<td>90%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Additional findings for this research question were data collected from follow up interviews with both staff and leaders of the treatment provider agencies. Findings were arranged according to shared themes described by participants during the interviews and grouped into two categories with corresponding definitions. This was strategically created to show the variables under investigation in greater detail. Themes shared by the participants consisted of responses from the interview questions, what facilitating factors
contributed to the success of the collaboration? How would you describe the benefits of collaboration? The categories consisted of previous collaboration experience, effective leadership, shared vision and goals, trust, communication, case conferences, and financial benefits. Table 7 summarizes the shared themes expressed by the respondents.

Table 7

Contributing Factors for Successful Collaboration

<table>
<thead>
<tr>
<th>Categories</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Collaboration Experience</td>
<td>History of positive experiences and understanding the cultures of collaborating agencies</td>
</tr>
<tr>
<td>Effective Leadership</td>
<td>Support from management and supervisors</td>
</tr>
<tr>
<td>Shared Vision and Goals</td>
<td>Having solid agencies to serve same clients and interests with common goals to enhance services to families and children</td>
</tr>
<tr>
<td>Trust</td>
<td>Supporting and respecting each others’ expertise</td>
</tr>
<tr>
<td>Communication</td>
<td>Sharing of information, inclusive decision making, listening, and timely feedback</td>
</tr>
<tr>
<td>Case Conferences</td>
<td>Share information, stabilize family, and show solidarity. More sources of support when dealing with resistance families</td>
</tr>
<tr>
<td>Financial benefits</td>
<td>When communication is improved, client services are improved, increased family reunification rates, and shorten time children spend in foster care</td>
</tr>
</tbody>
</table>

Research Question 4

What is the relationship between a transformational leadership style of key leaders and the effective and efficient operation of interagency collaboration?
Findings from the data collected from survey questions 1 – 20 in section 4 were primarily used to address this question. However, several additional steps were taken to answer this question. First, the relationship between leaders' self rated transformational leadership style and the staff ratings were examined to determine if similarity of leadership behavior correlated to subordinates ratings of their leaders' success. The survey data showed that staff ratings of the highest score for leaders were in the area of idealized influence (behavior), followed by idealized motivation. The lowest score was in the area of individualized consideration. Similar to the staff ratings, the leaders rated themselves the highest in the area of idealized influence (behavior). However, idealized influence (attributes) rated the second highest followed by intellectual stimulation. Table 8 presents the descriptive statistics for the staff and Table 9 for the leaders.

Table 8

Descriptive Statistics for the Staff

<table>
<thead>
<tr>
<th></th>
<th>Idealized Motivation</th>
<th>Idealized Influence (Attributes)</th>
<th>Idealized Influence (Behavior)</th>
<th>Individualized Consideration</th>
<th>Intellectual Stimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>85</td>
<td>85</td>
<td>85</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Valid</td>
<td>85</td>
<td>85</td>
<td>85</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>2.6647</td>
<td>2.6382</td>
<td>2.7029</td>
<td>2.5600</td>
<td>2.5882</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>.46219</td>
<td>.47794</td>
<td>.41636</td>
<td>.43403</td>
<td>.48153</td>
</tr>
</tbody>
</table>
Table 9

Descriptive Statistics for the Leaders

<table>
<thead>
<tr>
<th></th>
<th>Idealized Motivation</th>
<th>Idealized Influence (Attributes)</th>
<th>Idealized Influence (Behavior)</th>
<th>Individualized Consideration</th>
<th>Intellectual Stimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>29</td>
<td>29</td>
<td>29</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>2.6552</td>
<td>2.7241</td>
<td>2.7845</td>
<td>2.7103</td>
<td>2.7126</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>.32330</td>
<td>.31584</td>
<td>.24752</td>
<td>.21103</td>
<td>.36432</td>
</tr>
</tbody>
</table>

Second, the within measure distinctions, confirmatory factor analysis of leadership and staff scales (based on mean scores) were examined. Nevertheless, the factor analysis did not confirm the factors due to the number of respondents and the consistency of their responses. Next, Pearson correlations were examined to determine the degree of correlation between the leaders and staff responses among the five dimensions (e.g. idealized motivation, idealized influence (attributes), idealized influence (behavior), individualized consideration, and intellectual stimulation). In examining the correlations to determine the degree of correlation between the leaders and staff responses among the five dimensions, responses revealed that the leaders rated their leadership style lower than what their subordinate’s perceptions of their leadership in the areas of idealized motivation, idealized influence (attributes), and idealized influence (behavior) within several of the participating agencies. However, there were statistically significant findings where staff rated the leaders lower than the leaders’ self assessment.
in the area of individualized consideration for one agency and in all five areas for a different agency. Figure 3 presents the overall degree of correlation between the leaders and staff for all agencies.

Figure 3 Leader and Staff Correlations for the Five Dimensions of Transformational Leadership

Finally, separate reliabilities for both leaders and staff inventories were calculated to determine the internal consistency of the multiple item scale. This level of analysis has been used widely by Bass & Avolio, 1990, Yammarino & Bass, 1990, Yammarino & Markham, 1992). Findings from the staff responses reveal that all five dimensions measuring transformational leadership had high Cronbach's alpha scores: Idealized Motivation = .885, Idealized Influence (Attributes) = .857, Idealized Influence (Behavior) = .840, Individualized Consideration = .815 and Intellectual Stimulation = .799. Most of these alphas suggest that there were perfect consistencies in the responses due to the presence of enough variability in the responses (e.g., everyone selecting different
answers). In contrast, the leader responses resulted in low alphas all five dimensions: Idealized Motivation = .605, Idealized Influence (Attributes) = .638, Idealized Influence (Behavior) = .399, Individualized Consideration = .282 and Intellectual Stimulation = .529. The reliability scores found among the leader results suggest that there were no consistencies in the responses due to the smaller numbers of participants or everyone choosing the same answers. The former may apply since the population sample for this study was 29 leaders.

Additional findings for this research question were data collected from follow up interviews with staff participants. The results revealed that the respondents were very clear of the vision and goals for their respective agencies and the overall collaborative partnership. Feedback from the participants also overwhelmingly revealed that having a leader who is approachable, knowledgeable, positive, supportive, and committed to the collaboration is critical to the success of interagency collaboration. Two respondents commented that it is also important to have a leader who is willing to share information and decision making as well as provide training and coaching. They view these qualities as invaluable assets to sustain collaborative efforts.

Summary

Leadership, case management, and interagency collaboration are essential components to the System of Care model to improve the quality of services and ensure timely treatment to help with the family preservation and reunification process to county residents in a Northern California County. Consequently, each of these different members in leadership of the interagency collaboration have differing professional cultures, values, and styles that can either restrict or facilitate cooperation with
professionals from other disciplines. Nevertheless, the style of leadership, interpersonal communication, and approaches to management yields the resulting factors that impact successful interagency collaboration.

In summary, the findings and conclusions from this study have enhanced the existing body of research related to this topic. For example, the study has filled the gaps in this research by providing both quantitative and qualitative data generated from alcohol and drug service providers. Finally, the information has provided current data that may be used to further study the factors that enhance successful coordinated case management and interagency collaboration with Child Welfare Services in the county studied as well as in other counties throughout California.
CHAPTER V
DISCUSSION, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

This chapter presents and summarizes the data analysis used to address the research questions established in the previous chapters. This chapter is divided into four sections. The first section presents a discussion of the findings related to each research question. The second section focuses on the study’s conclusions. The implications are discussed in the next section. In the fourth section, the recommendations for future research are reviewed.

Discussion of Findings

Research Question # 1

The first research question focused on the perceptions of leaders and staff regarding successful interagency collaboration. Previous research has been conducted on the perceptions of interagency collaboration and building collaborative capacity to facilitate inter-organization success (Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Craig, 2004; Foster-Fishman, Harley, Donnell, & Rainey, 2003; and Quinn & Cumblad, 1994). The studies found that building positive attitudes toward the value of collaboration, skill/knowledge sets (e.g., how to cooperate with, resolve conflict, communicate, and value member diversity), and supports to attend joint meetings are essential for working collaboratively with others.

Data collected for this study held similar findings. Questions from the survey items requested the treatment providers to assess the major goal of the collaborative project, the communication exchange process, and whether or not the collaboration is beneficial to the success of coordinated case management with child welfare services
(CWS). The responses revealed that the leadership had no significant differences across the multiple service provider agencies, but the staff had mixed views about engaging CWS social workers in the communication exchange process. However, the participants agreed that the benefit of teamwork, providing more comprehensive services, and tailoring services to the unique needs of individual consumers minimize the systemic challenges (e.g., high caseloads and attitudes).

*Research Question # 2*

The second research question focused on the perceptions of leaders and staff regarding the challenges and solutions resulting from the collaborative process. Literature suggested that the challenges that inhibit interagency collaboration range from lack of communication, limited resources, service mandates, and lack of joint training. Previous research attributed these barriers to the creation of a new relational community where members interact with other organizations to achieve desired outcomes. However, these partnerships often involve members who share a history of conflict or have little experience working collaboratively with others (Farmakopoilou, 2002; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; and Johnson, Zorn, Tam, LaMontague & Johnson, 2003).

Data from this study were similar to previous findings. Although the responses to the survey questions found no prevailing barriers to the collaboration, follow up interviews with key staff participants revealed that barriers did in fact exist. The data indicates that interagency collaboration with child welfare services (CWS) is dependent upon the interplay of a number of inter-organizational factors. The most prevailing inhibitory factors identified were lack of communication, lack of joint training,
unrealistic court mandated case plans for families, and high caseloads of CWS social workers. The reason for the lack of communication is directly related to social workers not including the clients in the development of the case plans, low or no attendance at case conferences, and lack of returning phone calls or emails to advise the treatment providers about the client’s status. For example, when asked about the barriers that inhibit the success of collaboration with child welfare services, one respondent reflected:

Not communicating. For example, CWS social workers are more powerful in their control of the client so they will make decisions without discussing them with me (the collaborative partner) and sometimes that may cause a problem in the way of treatment. When clients get their children removed from them, I am sometimes the last person to know. The client sometimes refuses to give permission for me to get and share information with CWS regarding their progress. So because of federal and state laws regarding confidentiality, CWS do not often communicate their plans or interventions with me.

The data suggests that treatment providers and social workers have different mandates, responsibilities, priorities, terminology, and perspectives. Although case conferences would minimize the confusion or uncertainties, organizational supports are apparently not in place to support the collaborative endeavors (e.g., case conferences, shared information, and joint training) thereby reducing caseloads and giving staff sufficient time to engage in collaborative activities. The perceptions of the staff suggest that collaboration is an added activity to the regular responsibilities of the CWS social workers’; therefore the energy it takes to nurture the relationship is not a priority due to competing priorities.

Additional data collected from survey questions in sections 3 and 6 highlighted the solutions for ensuring successful collaboration. The results were divided into two categories. The first was strong leadership that responds to feedback and changing conditions, involves the team in making decisions, knowledgeable about the agency’s
culture and perspectives of collaborative partners, and skilled in conflict resolution. The second category was frequent communication with the same definitions as outlined by the staff respondents previously mentioned above in the second paragraph. The perceptions of leaders suggest that although collaboration is hindered by conflicting expectations, strategic organizational support, coordination, and constant communication will produce the benefits for the collaboration.

*Research Question # 3*

The third research question focused on the factors affecting the benefits and limitations of interagency collaboration with child welfare services. Previous studies have been conducted on the complexity of interagency relationships and the factors that impact successful collaboration (Brown & Haggerty, 2002; Johnson, Zorn, Tam, LaMontagne & Johnson, 2003; and Thompson, Socolar, Nicholson, Artz, Armitage & Fagan, 2000). The diverse studies found that several factors contribute to the success of an interagency collaboration. The prevailing seven factors for success were: leadership, commitment, communication, and understanding the culture of collaborating agencies.

Data from this study corroborated the findings with some added insights. Questions included in this section asked the treatment providers to rate their perceptions of the facilitating factors to collaboration as “helpful” to problematic. Additional follow up open-ended interviews were conducted to obtain specific language and voices on the subject. The combined data revealed common themes shared by the respondents. The prevailing facilitating factors were cooperative leadership, trust, communication, a clear view of the culture of CWS system, the role of social workers and other professionals involved in the collaborative process.
The data from this study also indicates that when multiple agencies form a collaborative project, multiple objectives are established, with differing priorities which may cause some confusion and trust issues. Nevertheless, as noted by Johnson et al. (2003) it is important for stakeholders to understand the culture (e.g., rules, values, priorities, language, ways of doing business, etc.) of collaborating agencies. In using a cultural lens, the partners will find ways to understand the regulatory environment surrounding the issues of the collaborative effort (e.g., federal legislation dictating the timetable for removing or returning children home, the timetable for treatment recovery, and funding).

*Research Question # 4*

The final research question focused on examining the relationship between a transformational leadership style of key leaders and the effective and efficient operation of interagency collaboration. Research on the dimensions of transformational leadership examined the differential effects of transformational leadership (Arnold, Barling, & Kelloway, 2001; Carless, 1998 & 2001; Lim & Polyhart, 2004; and Tracey & Hinkin, 1998). However, in this study, the perceptions rather than the actual behaviors of leadership were examined. The analyses of the data revealed several trends and significant relationships. There were high similarities of leadership behaviors that correlated to subordinates’ perceptions of their leaders’ success. For example, this study found a high correlation between the staff perceptions (M=2.70) and leader perceptions (M=2.78) on one of the five dimensions of transformational leadership in the area of idealized influence (behavior). However, there were also statistically significant findings where subordinate’s perceptions of transformational leadership behavior were
rated lower in several areas than the leaders’ self-rated behaviors [e.g., idealized influence (attributes), idealized influence (behavior), and idealized motivation] within several of the participating agencies. These findings suggest that some of the leaders may lack the talent to communicate both the agency’s vision for providing treatment services and the follower’s role in the team to accomplish the vision.

Moreover, in follow up interviews respondents expressed that they value a leader who is willing to share information and decision making as well as provide training and coaching. They view these qualities as invaluable assets to sustain collaborative efforts. The results of this study suggest that promoting a culture of transformational leadership at all functional levels within organizations will benefit the process of interagency collaboration.

Conclusions

The purpose of this sequential mixed methods study was two-fold. The first was to examine the perceptions of leaders in providing leadership and case management services to facilitate successful interagency collaboration. The second purpose was to examine the perceptions of Treatment Providers regarding the process of interagency collaboration with Child Welfare Services as a whole and to determine if the direct-service providers from different agencies hold similar views about the collaboration. Participants in this study were 29 key leaders and 85 staff members from multiple alcohol and drug service providers in a Northern California county. The research questions in this study were explored through survey questionnaires and followed by face-to-face interviews with five key leaders and seven key staff members to obtain specific language and voices on the subject. The rationale for using the mixed methods strategy was to
explore the variables under investigation in greater detail and triangulate the findings using quantitative and qualitative data.

While all participating groups reported a variety of challenges associated with interagency collaboration, they also asserted that the benefits to the clients, the families, and the child welfare system outweigh the challenges. The reported benefits were teamwork, providing more comprehensive services, increase in the number of families reunifying, and reduced length of foster care placements. Among the identified challenges were the communication exchange process, high caseloads of CWS social workers, and high turnover in the workforce.

This study indicated that while interagency collaboration with child welfare services is essential, collaboration across disciplines with differing priorities poses challenges. Therefore, the commitment to collaboration rests with both the organization supporting collaborative endeavors and the agents “doing the work.” This requires the partners to take the time to communicate, learn the culture of the collaborating agencies, and value the input and participation of other stakeholders. In using a cultural lens, the partners will find ways to understand the regulatory environment surrounding the issues of the collaborative effort (e.g., federal legislation dictating the timetable for removing or returning children home, the timetable for treatment recovery, and funding).

A facilitative leadership style was also identified as positively contributing to the success of interagency collaboration. Transformational leadership was essentially the only leadership style measured in this study and scores on the five dimensions produced a single transformational leadership style. However, the findings have implications for the selection and training of leaders.
Implications

Data from this study may be beneficial to Alcohol and Drug Service (AOD) Providers, Child Welfare Services agencies, and trainers who train the leaders and staff in these agencies. The findings have a variety of implications. First, it would be of great value for senior level administrators in Child Welfare Services agencies to explore the perceptions that their leaders (e.g., middle management and direct line supervisors) and social workers have of interagency collaboration with treatment and other service providers. The significance of these perceptions should not be disregarded. If the findings in this study are correct, then creating an organizational environment to support the collaborative endeavors (e.g., case conferences, co-locating, and joint training) will enhance the success of the outcomes for the joint venture. In addition, reducing caseloads and giving staff sufficient time to engage in collaborative activities will allow the stakeholders to learn the culture of the collaborating agencies, and help to build positive attitudes towards the value of collaboration.

This study can also assist senior administrators, treatment providers, and diverse personnel in child welfare services to identify which factors impact interagency collaboration and take the necessary actions to facilitate successful outcomes. Specifically, the senior leaders in these agencies should spend time with the middle managers, supervisors, and line staff to effectively communicate the value of this collaboration, attentively listen to their feedback, and provide the necessary resources and on-going training to support successful collaborative endeavors. Moreover, findings from this study suggest that leaders must be cognizant of the particular dimensions of
leadership in use at their individual agencies to foster internal relationships thereby affecting external relationships for improved collaborative outcomes.

Recommendations for Future Research

Interagency collaboration is an essential component of the family preservation and reunification process for Child Welfare Services. However, like any study, this research involved some limitations, but has highlighted some questions worth exploring in future research. The methodology used in this study proved an effective means for understanding collaborative practice from the perspectives of the alcohol and drug service providers, but did not provide an independent understanding from the CWS social workers or the client effects. Studies that compare the aforementioned CWS agents’ perceptions of this topic could develop new and relevant findings. Further explorations of the process of collaboration with communication in group meetings, case conferences, and collaboration amongst individuals who are co-located (e.g., share the same physical space) will yield invaluable insights from the CWS perspectives. Finally, further research is needed to address the value of the transformational leader to the process of interagency collaboration.

Recommendations for the Profession

Although this study addressed some of the gaps in the relevant research, it also provides a recommendation for the human services profession. Despite the information lacking in the areas noted above, the results of this study will inform government agencies and community based organizations of how they can better employ strategies to support and strengthen effective engagement and facilitation practices for successful interagency collaboration. Findings from this research may have policy implications for
budgetary expenditures, inter-professional relationships, cultural competency education and training for practitioners in the human services profession. For example, designing and implementing training programs at each professional level in the areas of engaging in the process of collaboration, engaging non-voluntary clients, leadership practices, and developing culturally sensitive case / treatment plans for children and families would be more beneficial to staff development than a one-time training on collaboration. The benefits will provide the stakeholders in the partnership the ability to work effectively with other collaborative ventures. Additional benefits would allow the stakeholders to recognize and understand the differences in communication approaches to problem solving, agency culture, the necessary organizational supports for success, and the importance of facilitative leadership roles in a collaborative environment.

Concluding Thoughts

The researcher’s personal background combined with professional experiences facilitated this exploratory study on interagency collaboration. Service providers’ perceptions of interagency collaborations with Child Welfare Services are important to understand even if they are misperceptions. In fact, perceptions of organizational contexts also influence leadership behaviors. Nevertheless, in seeking more knowledge of transformational leadership approaches as well as factors that both impede and promote successful collaboration, the participants’ perceptions in this study provided me with valuable inside knowledge. This knowledge enlightened me with a greater understanding of how interorganizational coordination can be more beneficial than the cumulative efforts of individual agencies working separately. Although the dynamics of building trust, developing a common language, and facilitating case management and
effective communication in a collaborative partnership can be challenging, it can also produce successful outcomes. That being the case, the findings of this research process added to the field of organizational leadership studies by proving valuable results supporting interagency collaborative partnerships and facilitative leadership development.
REFERENCES


APPENDIX A

-----Original Message-----
From: irbphs@usfca.edu
To: sassyvlm@aol.com
Cc: mitchell@usfca.edu
Sent: Mon, 5 Feb 2007 5:02 PM
Subject: IRB Application # 07-002 - Application Approved

February 5, 2007

Dear Ms. Moore:

The Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco (USF) has reviewed your request for human subjects approval regarding your study.

Your application has been approved by the committee (IRBPHS #07-002). Please note the following:

1. Approval expires twelve (12) months from the dated noted above. At that time, if you are still in collecting data from human subjects, you must file a renewal application.

2. Any modifications to the research protocol or changes in instrumentation (including wording of items) must be communicated to the IRBPHS. Re-submission of an application may be required at that time.

3. Any adverse reactions or complications on the part of participants must be reported (in writing) to the IRBPHS within ten (10) working days.

If you have any questions, please contact the IRBPHS at (415) 422-6091.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Terence Patterson, EdD, ABPP
Chair, Institutional Review Board for the Protection of Human Subjects
IRBPHS University of San Francisco
Counseling Psychology Department
Education Building - 017
2130 Fulton Street
San Francisco, CA 94117-1080
(415) 422-6091 (Message)
(415) 422-5528 (Fax)
irbphs@usfca.edu
http://www.usfca.edu/humansubjects/
APPENDIX B

January 22, 2007

Institutional Review Board for the Protection of Human Subjects
University of San Francisco
Counseling Psychology Department
Education Building - Room 017
2130 Fulton Street
San Francisco, CA 94117-1080

Dear Members of the Committee:

On behalf of the Recovery Institute, I am writing to formally indicate our awareness of the research proposed by Ms. Verronda Moore, a student at USF. We are aware that Ms. Moore intends to conduct her research by conducting oral interviews and administering a written survey to our employees and contracted "Treatment Providers."

I am the Alcohol and Drug Administrator for the Recovery Institute. I give Ms. Moore permission to conduct her research in the Recovery Institute.

If you have any questions or concerns, please feel free to contact my office at (800) 555-2055.

Sincerely,

Jane Doe,
Alcohol and Drug Administrator
Recovery Institute
APPENDIX C

February 9, 2007

Institutional Review Board for the Protection of Human Subjects
University of San Francisco
Counseling Psychology Department
Education Building - Room 017
2130 Fulton Street
San Francisco, CA 94117-1080

Dear Members of the Committee:

On behalf of the ABC Treatment Center, I am writing to formally indicate our awareness of the research proposed by Ms. Verronda Moore, a student at USF. We are aware that Ms. Moore intends to conduct her research by conducting oral interviews and administering a written survey to our employees.

I am the Agency Administrator for ABC Treatment Center. I give Ms. Moore permission to conduct her research in my organization.

If you have any questions or concerns, please feel free to contact my office at (800) 555-1212.

Sincerely,

John Doe, Executive Director
ABC Treatment Center
APPENDIX D

E-Mail Sent to Recovery Institute Requesting Email Distribution List of Contracted Treatment Providers

Moore, Verronda

From: verronda@comcast.net
To: Recovery Institute
Subject: Email Addresses for Contracted Treatment Providers
Date: Fri, 23 Feb 2007 23:41:13 +0000

Hello Mary Doe – I would like to send a follow up email to each contracted Treatment Providers identified on your master list. I have identified that there are \textbf{26} Treatment Providers (including the 3 programs under the Recovery Institute that meets the targeted audience to participate in my research project. Do you have a list of email addresses that you can share with me?

\textbf{Reply From: Mary Doe < Recovery Institute>}

To: verronda@comcast.net
Subject: Email Addresses for Contracted Treatment Providers
Date: Mon, 26 Feb 2007 10:00:30 +0000

Hi, Verronda: We have a distribution list with e-mail addresses, however, I do not have it. If you'd like, we can send out an attachment to the providers. The resource list should have on top listed the providers as outpatient, residential, detox and prevention. Send me the information you'd like distributed and I'll have it sent out. Although, to have more of a response you will probably have to call each agency individually.
APPENDIX D Continued

E-Mail Sent to Potential Participants

Moore, Verronda

From: verronda@comcast.net
To: Recovery Institute
Subject: Email Addresses for Contracted Treatment Providers
Date: Mon, 26 Feb 2007 11:30:15 +0000

Thanks Mary Doe. I have been calling the TP’s and getting a better response. I would also like to come the next monthly TP meeting to briefly advertise my research project again. The following language below is what I would like for you to send out (blind copy to keep the targeted audience confidential via mass email to the contracted Treatment Providers. Thanks and have a great weekend.

**********************************************
Hello Treatment Providers – I am sending this email to follow up with the letter I mailed to you on Saturday, February 10, 2007. I would like your permission to invite your agency employees (i.e. leaders and staff) to participate in my research study entitled, "Alcohol and Drug Service Providers’ Perceptions of Interagency Collaboration with Child Welfare Services." I have been going to Treatment Provider’s staff meetings for other participating agencies and the participants have averaged anywhere from 10 - 15 minutes to complete the surveys. However, as the administrator, you may choose to have the researcher (me) pick up the completed surveys from your respective agencies or simply return the surveys via U.S. mail to: Verronda Moore - P.O. BOX 580731, Elk Grove, CA 95758.

Your respective agencies come highly recommended from the Recovery Institute / AOD Division and the researcher does not want to leave out any valued community partner’s perceptions / views of interagency collaboration. Therefore, the researcher is anxiously awaiting consent and feedback. Also, for your convenience, I have attached the "agency permission letter" for you to copy onto your agency’s letterhead, sign, and return to me.

The researcher is available if you need to ask any follow up clarifying questions at the phone number and email address listed below.

Thanking you in advance for your assistance,

Verronda Moore, MSW
Doctoral Candidate in Leadership Studies
University of San Francisco
(916) 261-0735
Email: Verronda@comcast.net
Hello John Doe - I am writing to follow up with the letter I mailed to you on Saturday, February 10, 2007 requesting your permission to invite agency employees (i.e. leaders and staff) to participate in my research study entitled, “Alcohol and Drug Service Providers Perceptions' of Interagency Collaboration with Child Welfare Services.” (I have attached the letter and flyer again for your reference.) FYI: I have been going to staff meetings for other participating agencies, and the staff has averaged anywhere from 8 - 15 minutes to complete the surveys. However, as the administrator, you may choose to have me pick up the completed surveys from your agency.

Your agencies (i.e. ABC Treatment Provider & Healing Institute) come highly recommended from the Recovery Institute / AOD Division. **I need at least 6 more agencies to participate in my research study** as I do not want to leave out any valued community partner’s perceptions / views of interagency collaboration. I am available if you need to ask any follow up clarifying questions. I can be reached at the phone number and email address listed below.

Thanking you in advance for your assistance,

Verronda Moore, MSW  
Doctoral Candidate in Leadership Studies  
University of San Francisco  
(916) 261-0735  
Email: Verronda@comcast.net
## APPENDIX E

### Breakdown of Research Participants by Agency

<table>
<thead>
<tr>
<th>Code Name for Treatment Provider</th>
<th># Leaders</th>
<th># Staff</th>
<th># Leaders Returned Surveys</th>
<th># Staff Returned Surveys</th>
<th>% Leader</th>
<th>% Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>1</td>
<td>11</td>
<td>1</td>
<td>9</td>
<td>100 %</td>
<td>81.8%</td>
</tr>
<tr>
<td>B.</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>C.</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>D.</td>
<td>2</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>50 %</td>
<td>40 %</td>
</tr>
<tr>
<td>E.</td>
<td>4</td>
<td>19</td>
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<td>17</td>
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<td>73.7 %</td>
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<tr>
<td>F.</td>
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<td>20</td>
<td>6</td>
<td>7</td>
<td>50 %</td>
<td>30 %</td>
</tr>
<tr>
<td>G.</td>
<td>2</td>
<td>15</td>
<td>2</td>
<td>6</td>
<td>100 %</td>
<td>33.3 %</td>
</tr>
<tr>
<td>H.</td>
<td>3</td>
<td>11</td>
<td>3</td>
<td>8</td>
<td>100 %</td>
<td>54.5 %</td>
</tr>
<tr>
<td>I.</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>J.</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>K.</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>L.</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>M.</td>
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<td>7</td>
<td>1</td>
<td>5</td>
<td>100 %</td>
<td>43 %</td>
</tr>
<tr>
<td>N.</td>
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<td>5</td>
<td>1</td>
<td>4</td>
<td>100 %</td>
<td>80 %</td>
</tr>
<tr>
<td>O.</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>P.</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>100 %</td>
<td>75 %</td>
</tr>
<tr>
<td>Q.</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>4</td>
<td>100 %</td>
<td>40 %</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>37</strong></td>
<td><strong>139</strong></td>
<td><strong>29</strong></td>
<td><strong>94 – 9 = 85</strong></td>
<td><strong>78.4 %</strong></td>
<td><strong>61.2 %</strong></td>
</tr>
</tbody>
</table>
APPENDIX F

February 23, 2007

Research Participant
ABC Treatment Center
Anytown, Ca 12345

Dear Research Participant:

My name is Verronda Moore and I am a doctoral student majoring in Organization and Leadership at the University of San Francisco. My dissertation research will focus on examining the “Alcohol and Drug Service Providers’ Perceptions of Interagency Collaboration with Child Welfare Services.” I am interested in learning both the facilitating factors and barriers to successful collaboration. Furthermore, I am also interested in determining if the Treatment Providers from different agencies hold similar views about the collaboration. Your agency’s administrator has given approval to me to conduct this research.

You are being asked to participate in this research study because you are either in a position of leadership in your agency in that you directly or indirectly supervise the case managers (i.e. Counselors, Therapists, Recovery Specialists, etc.) or you are directly responsible for case management, treatment, and communicating with both leaders and social workers from Child Welfare Services. If you agree to be in this study, you will participate in completing an oral interview encompassing issues related to your individual or leader’s leadership style and particular dimensions (i.e. coordinated case management, communication, facilitating factors or barriers) of interagency collaboration. The survey questionnaire will take approximately 15 – 20 minutes to complete (note: some agencies have been averaging 8 – 15 minutes to complete). The surveys will be distributed at your staff meeting or given to you individually to complete.

Although unlikely, if any of the questions make you feel uncomfortable, you are free to decline to answer any of them or to discontinue participation at any time. Although pseudonyms will be used in any published material pertaining to this study, participation in research can pose a minimal risk in confidentiality. All possible effort will be made to maintain study records in as confidential manner as possible. All research information will be coded and kept in locked files at all times with only study personnel having access to these files. Any results specific to your input will not be shared with personnel from your company.

While there will be no direct benefit to you from participating in this study, this research is expected to provide a clearer understanding of how collaborative projects can better employ strategies to support and strengthen effective engagement and facilitation practices for successful interagency collaboration.
There will be no cost to you as a result of participation in this study, nor will you be compensated for your participation.

If you have any questions concerning this research, you may contact me at (916) 261-0735 or the IRBPHS at the University of San Francisco, which is the Institutional Review Board for the Protection of Human Subjects concerned with protecting volunteers in research projects. You may reach the IRBPHS office by calling (415) 422-6091 or e-mailing IRBPHS@uscfa.edu or by writing to the IRBPHS, Department of Psychology, University of San Francisco, 2130 Fulton Street, San Francisco, CA. 94117-1080.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. The Effort is aware of this study, but does not require that you participate in this research. Your decision as to whether or not to participate will have no influence on your present or future status as an employee with ABC Treatment Center.

Thank you for your attention.

Sincerely,

Verronda Moore
Doctoral Student
University of San Francisco
INFORMED CONSENT FORM

March 7, 2007

Research Participant
ABC Treatment Center

Dear Research Participant:

Ms. Verronda Moore, a doctoral student in the School of Education at the University of San Francisco is doing a study on examining the “Alcohol and Drug Service Providers’ Perceptions of Interagency Collaboration with Child Welfare Services.” The researcher is interested in learning both the facilitating factors and barriers to successful collaboration as well as determining if the Treatment Providers (a.k.a. Alcohol and Drug Service Providers) from different agencies hold similar views about the collaboration.

I am being asked to participate because I am either in leadership position or I am directly responsible for case management, treatment, and communicating with both leaders and social workers from Child Welfare Services.

Procedures

If I agree to be a participant in this study, the following procedures will happen:

1. I will either complete a written survey that asks general demographic questions about my educational background and length of employment. The other questions are designed to get their opinions about particular dimensions (i.e. coordinated case management, communication, facilitating factors or barriers) of interagency collaboration. I understand that the survey will take approximately 15 – 20 minutes to complete. – OR –

2. I will participate in a face-to-face interview with the researcher, during which I will be asked about my educational background, length of employment, leadership style, and particular dimensions (i.e. coordinated case management, communication, facilitating factors or barriers) of interagency collaboration. I understand that the interviews will be 20 – 30 minutes in length to complete. The interviews be audio taped and will take place at my office location or an agreed upon alternative location.

3. I will complete the surveys and/or participate in the interview at my agency’s office or an agreed upon alternative location.
Risks and/or Discomforts

1. It is possible that some of the questions on the dimensions (i.e. leadership, communication, coordinated case management, facilitating factors or barriers) of interagency collaboration may make me feel uncomfortable, but I am free to decline to answer any questions or to stop participation at any time.

2. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only study personnel will have access to the files.

3. Because the time required for my participation may be up to 20 minutes for the survey or 30 minutes for the interview, I may become tired or bored. In this case, I may take a short break then resume the survey or interview process.

Benefits

There will be no direct benefit to me from participating in this study. The anticipated benefit of this study is to inform government agencies and community based organizations of how they can better employ strategies to support and strengthen effective engagement and facilitation practices for successful interagency collaboration.

Costs/Financial Considerations

There will be no financial costs to me as a result of taking part in this study.

Payment/Reimbursement

I will not be financially or otherwise compensated for my participation in this study.

Questions

I have talked to Ms. Moore about this study and have had my questions answered. If I have further questions about the study, I may call her at (916) 261-0735 or email her at Verronda@comcast.net.

If I have any questions or comments about participation in this study, I should first talk with the researcher. If for some reason I do not wish to do this, I may contact the IRBPHS, which is concerned with protection of volunteers in research projects. I may reach the IRBPHS office by calling (415) 422-6091 and leaving a voicemail message, by e-mailing IRBPHS@usfca.edu, or by writing to the IRBPHS, Department of Psychology, University of San Francisco, 2130 Fulton Street, San Francisco, CA 94117-1080.
Consent

I have been given a copy of the "Research Subject's Bill of Rights" and I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as employee of ABC Treatment Center.

My signature below indicates that I agree to participate in this study.

__________________________________________
Subject's Signature                      Date of Signature

__________________________________________
Signature of Person Obtaining Consent    Date of Signature
APPENDIX G  Profile of Survey Validation Experts

1. The first expert is an Associate Professor at the University of San Francisco (USF), School of Education in the Department of Leadership Studies: The Associate Professor has been teaching at USF for the past 28 years. This expert’s research interests and areas of expertise are as follows: Organizational development; leadership styles; management issues; women's issues; K-12 administration; K-12 teaching; language development; and literacy.

2. The second expert is an Adjunct Professor at the University of San Francisco (USF) whose areas of expertise are in research methods, statistics, technology and education, and informational systems. This expert is also an Adjunct Professor at Argosy University where he teaches master’s level research methods and technology courses.

3. The third expert is a new Program Planner, but former Mental Health Program Coordinator for the past two years monitoring the contracts of Treatment Providers for the County of Sacramento, Department of Health and Human Services, Alcohol and Drug Services (AOD) Division. Prior to the expert’s tenure in the AOD Division, she was employed in the Child Protective Services Division for eighteen years serving as a field social worker, supervisor and program specialist. This expert holds a masters’ degree in social work from CSUS and a Bachelor of Arts degree in behavioral sciences from CSU-San Jose.

4. The fourth expert is a Registered Dietitian (RD) and a Licensed Marriage and Family Therapist (LMFT). This expert has over 20 years of experience with Sacramento County Department of Health and Human Services; fifteen years working for Child Protective Services as a social worker, supervisor, and program specialist and five years for Alcohol and Drug Services as an evaluation specialist and program coordinator. Currently, this expert is the liaison between all collaborative groups involved with the Dependency Drug Court. This expert is the co-chair for the work group and oversight committee, and assists in the development and maintenance of the Dependency Drug Court policy and procedures. Finally, this expert earned a Bachelor of Science degree from Colorado State University in Food Science and Nutrition and a Master of Science degree in Counseling Education from CSUS.

5. The fifth expert is an Associate Clinical Social worker working towards licensure as a LCSW. This expert has over 10 years of experience in Child Welfare Services. He is currently a supervisor in the Emergency Response Program with previous experience as a social worker in both the Emergency Response and Family Reunification Programs. This expert serves as a liaison for local School Attendance Review Boards and Youth & Gang Violence Prevention. This expert is a part time counselor for the juvenile sexual offenders group home and for recovering and drug addicts at the Sacramento Area Housing Program. Finally,
this expert earned a Bachelor of Science in Criminal Justice and a Masters’ degree in Social Work from California State University, Sacramento.

6. The sixth expert is a Program Planner and Training Coordinator for the County of Sacramento, Department of Health and Human Services in the Alcohol and Drug Services (AOD) Division. This expert has worked in the AOD program for 9 years (4 years as a supervisor and 5 years as a planner). This expert is responsible for coordinating, facilitating and writing training curricula on both the local and statewide levels. She develops and monitors the fiscal training budget and serves as the public relations officer for the division. The areas of expertise also extend to higher education in that this expert is an adjunct professor of both graduate and undergraduate students at the California State University, Sacramento (CSUS), College of Health and Human Services in the Division of Social Work. This expert teaches in the subject areas of multicultural practices in social work, domestic violence, child abuse, mental health, and alcohol and drug treatment services. This expert is also an instructor in the Continuing Education Program at CSUS and the University of California Davis Northern California Training Academy. Finally, this expert is also a former special language skills and cultural social worker with 7 years of experience in the Child Protective Services Division.

7. The final expert has been employed for the past 6 years as a Recovery Specialist and Training Supervisor for the STARS (Specialized Treatment and Recovery Services) Program. This program is a contracted community treatment provider for the County of Sacramento. This expert has a California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation and a certificate from American River College in Human Services and Chemical Dependency. This expert is also a founding member of the Sacramento County’s Child Protective Services (CPS) “Shared Leadership Task Force.” This expert has educated and inspired hundreds of parents, social workers, service providers, politicians and community leaders by telling a personal story of addiction and recovery. During the past four years, this expert has demonstrated her deep commitment through hundreds of volunteer hours participating on committees to improve the quality and effectiveness of services provided by CPS to ensure families have every opportunity for success. This expert is always focused on the importance of the parent’s voice and participation in finding solutions to family issues. In addition to public speaking to increase community awareness and impacting CPS policies, procedures and agency culture, this expert actively recruits new parents who have recently reunited with their children and are in recovery to support them in developing leadership skills. This expert mentors and supports these new parents to help them find their “voice” and develop their leadership skills in the Task Force, influencing their local community and in their own homes. Finally, this expert also participates in parent leadership activities at both the state and local level and has been called upon to inspire parent leadership in other states around the nation.
APPENDIX H Interagency Collaboration Interview Profile & Questions for Key Leaders

Part I – Demographics (5 questions):

1. How long have you been employed with your agency?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [x] 11 years or more

2. What is your position title?
   - [ ] Agency Administrator
   - [ ] Executive Director
   - [ ] Assistant Director
   - [ ] Program Director
   - [ ] Supervisor
   - [ ] Mental Health Program Coordinator
   - [ ] Other (please specify __________________________)

3. How long have you been in the position of leadership?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11 years or more

4. Highest level of education:
   - [ ] High school diploma
   - [ ] GED
   - [ ] Some college
   - [ ] Associate Arts / Science (AA/AS)
   - [ ] Bachelor Degree
   - [ ] Master’s Degree
   - [ ] Doctorate Degree

5. Possession of certification / license (please check all that apply):
   - [ ] California Addiction Specialist Certification (CAS)
   - [ ] California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation
   - [ ] Licensed Clinical Social Worker (LCSW)
   - [ ] Marriage Family Therapist (MFT)
Part II – Interview Questions for Key Leadership (6 questions):

1. What is your understanding of the vision and goals for your program and how do you articulate this to your employees?

2. What facilitating factors contributed to the success of the collaboration?

3. How would you describe the benefits of collaboration?

4. What are the barriers (if any) that inhibit the success of collaboration?

5. In what ways do you involve your team in making decisions?

6. What changes (if any) would you recommend to the existing collaborative project?
Interagency Collaboration Interview Profile & Questions for Key Staff

Part I – Demographics (4 questions):

1. How long have you been employed with your agency?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11 years or more

2. What is your position title?
   - [ ] Case Manager
   - [ ] Recovery Specialist
   - [ ] Licensed Therapist
   - [ ] Certified Drug counselor
   - [ ] Senior Mental Health Counselor
   - [ ] Other (please specify ____________________)

3. Highest level of education:
   - [ ] High school diploma
   - [ ] GED
   - [ ] Some college
   - [ ] Associate Arts / Science (AA/AS)
   - [ ] Bachelor Degree
   - [ ] Master’s Degree
   - [ ] Doctorate Degree

4. Possession of certification / license (please check all that apply):
   - [ ] California Addiction Specialist Certification (CAS)
   - [ ] California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation
   - [ ] Licensed Clinical Social Worker (LCSW)
   - [ ] Marriage Family Therapist (MFT)
Part II – Interview Questions for Key Staff Members (6 questions):

1. What is your understanding of the vision and goals for your program and how does your leader articulate this to you?

2. What facilitating factors contributed to the success of the collaboration?

3. How would you describe the benefits of collaboration?

4. What are the barriers (if any) that inhibit the success of collaboration?

5. In what ways does your leader involve the team in making decisions?

6. What changes (if any) would you recommend to the existing collaborative project?
APPENDIX I

LEADER FORM

Interagency Collaboration Agency Leadership Survey Questionnaire

Section I – Demographics (5 questions):

1. How long have you been employed with your agency?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11 years or more

2. What is your position title?
   - [ ] Agency Administrator
   - [ ] Executive Director
   - [ ] Assistant Director
   - [ ] Program Director
   - [ ] Supervisor
   - [ ] Mental Health Program Coordinator
   - [ ] Other (please specify __________________________)

3. How long have you been in the position of leadership?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11 years or more

4. Highest level of education (please check all that apply):
   - [ ] High school diploma
   - [ ] GED
   - [ ] Some college
   - [ ] Associate Arts / Science (AA/AS)
   - [ ] Bachelor Degree
   - [ ] Master’s Degree
   - [ ] Doctorate Degree
5. Possession of certification / license (please check all that apply):

- California Addiction Specialist Certification (CAS)
- California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation
- Licensed Clinical Social Worker (LCSW)
- Marriage Family Therapist (MFT)

Section II – Opinions about Coordinated Case Management with Child Welfare

Services: Please select one (1) rating from the following selections (9 questions):

1. A major goal of this collaborative is to provide alcohol and drug treatment services to birth parents that have had their children removed from Child Welfare Services.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

2. Clients are referred to the appropriate treatment service provider without unnecessary delays.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree

3. Treatment / support service plans are tailored to meet the specific needs of the client /families.

- Strongly Disagree
- Disagree
- Unsure
- Agree
- Strongly Agree
4. Feedback of client’s progress is being sent to the case-carrying social worker at Child Welfare Services in a timely manner.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

5. A representative from Child Welfare Services informs the treatment provider in a timely manner when a new case-carrying social worker has been assigned.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

6. As the alcohol and drug treatment provider, I encourage and support the client to follow the court-ordered case plan from Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

7. The alcohol and drug treatment services in this collaborative create opportunities for joint planning / case conferences with Child Welfare Services when needed.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree
8. Phone calls / emails are returned in a timely manner from supervisors or other administrators from Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

9. The collaboration is beneficial to the success of coordinated case management with Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

Section III - Service Providers’ perceptions of particular dimensions of interagency collaboration with Child Welfare Services. Please select one (1) rating from the following selections (10 questions):

Leadership in Alcohol & Drug Treatment Agencies

1. Effective leadership

☐ Positive Perception
☐ Unsure
☐ Negative Perception

2. Effective in representing others to higher authority

☐ Positive Perception
☐ Unsure
☐ Negative Perception

3. Responds to feedback and changing conditions

☐ Positive Perception
☐ Unsure
☐ Negative Perception
4. Involves team in making decisions

- Positive Perception
- Unsure
- Negative Perception

5. Knowledgeable about the agency’s culture and perspectives of collaborative partners

- Positive Perception
- Unsure
- Negative Perception

6. Provides training in technical, programmatic and relational areas

- Positive Perception
- Unsure
- Negative Perception

7. Skilled in conflict negotiation and resolution

- Positive Perception
- Unsure
- Negative Perception

Communication

8. Effective communication process between your agency and other service providers

- Positive Perception
- Unsure
- Negative Perception

9. Timely and frequent information sharing, problem discussion and resolution

- Positive Perception
- Unsure
- Negative Perception
10. Effective communication process between your agency and Child Welfare Services

☐ Positive Perception  
☐ Unsure  
☐ Negative Perception

Section IV – Leaders’ Assessment of their Leadership Style in relation to the dimensions of transformational leadership. Please indicate how frequently you demonstrate the leadership behavior described (20 questions).

Inspirational Motivation

1. I communicate optimistically about the future

☐ Not at All  
☐ Somewhat Frequently  
☐ Most Frequently, If Not Always

2. I communicate enthusiastically about what needs to be accomplished.

☐ Not at All  
☐ Somewhat Frequently  
☐ Most Frequently, If Not Always

3. I articulate a realistic vision and goals related to improving the organization.

☐ Not at All  
☐ Somewhat Frequently  
☐ Most Frequently, If Not Always

4. I develop a communal plan of action for realizing the vision.

☐ Not at All  
☐ Somewhat Frequently  
☐ Most Frequently, If Not Always
Idealized Influence (Attributes)

5. I instill pride in others for being connected with my leadership.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

6. I go beyond self-interest for the good of the team.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

7. I act in ways that build others' respect for my leadership.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

8. I display a sense of non-threatening power and confidence.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

Idealized Influence (Behavior)

9. I emphasize the importance of having a collective sense of mission.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

10. I consider the moral and ethical consequences of decisions.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

11. I communicate about my most important values and beliefs
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always
12. I facilitate positive internal and external relations

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

**Individual Consideration**

13. I spend time teaching and coaching.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

14. I provide training in technical, programmatic and relational areas.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

15. I treat others as individuals rather than a member of a group.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

16. I value the diversity of member competencies (i.e. skills / knowledge).

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

17. I consider an individual as having different needs, abilities, and aspirations from others.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always
Intellectual Stimulation

18. I re-examine critical assumptions to question whether they are appropriate.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

19. I value and seek diverse perspectives when solving problems.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

20. I encourage others to look at problems from many different angles.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

Section V - Potential facilitators and barriers to collaboration. Please rate from helpful to problematic (30 questions)

Facilitating factors

1. Cooperative Agency leadership
   - [ ] Helpful
   - [ ] Problematic

2. Cooperative County leadership
   - [ ] Helpful
   - [ ] Problematic

3. A combination of both cooperative Agency and County leadership
   - [ ] Helpful
   - [ ] Problematic

4. History of the relationship between the collaborating agencies
   - [ ] Helpful
   - [ ] Problematic
5. Knowledge and understanding about the system of Child Welfare Services
   program areas (i.e. Family Maintenance /Informal Supervision, Court Services,
   Family Reunification, and Permanent Placement—a.k.a. Long Term Placement)
   □ Helpful
   □ Problematic

6. A clear view of the role of social work staff from Child Welfare Services
   □ Helpful
   □ Problematic

7. A clear view of the role of other professionals involved in the collaborative
   process
   □ Helpful
   □ Problematic

8. Inclusive decision-making processes
   □ Helpful
   □ Problematic

9. Positive attitudes about collaboration
   □ Helpful
   □ Problematic

10. Power sharing
    □ Helpful
    □ Problematic

11. Trusting other stakeholders
    □ Helpful
    □ Problematic

12. Positive attitudes about other stakeholders
    □ Helpful
    □ Problematic
13. Abundant / adequate level of resources (i.e. financial, administrative and professional staff)
- Helpful
- Problematic

14. Physical proximity (i.e. shared office space) of collaborative partners
- Helpful
- Problematic

15. Diversity in leadership positions
- Helpful
- Problematic

**Barriers**

1. Policies and procedures at the local agency level
- Helpful
- Problematic

2. Policies and procedures at the county level
- Helpful
- Problematic

3. Policies and procedures at the state / federal level
- Helpful
- Problematic

4. Communication between treatment providers and social workers
- Helpful
- Problematic

5. Different priorities among collaborative partners
- Helpful
- Problematic
6. Confidentiality of information sharing between social workers from Child Welfare Services and treatment providers

☐ Helpful
☐ Problematic

7. Differences in professional perspectives

☐ Helpful
☐ Problematic

8. Negative attitudes about collaboration

☐ Helpful
☐ Problematic

9. Openness /Flexibility to change among agency partners

☐ Helpful
☐ Problematic

10. Vague interagency agreements / protocols for interagency collaboration

☐ Helpful
☐ Problematic

11. Availability of joint training opportunities on interagency collaboration practices

☐ Helpful
☐ Problematic

12. Scarcity/ insufficient level of resources (i.e. financial, administrative and professional staff)

☐ Helpful
☐ Problematic

13. Record keeping

☐ Helpful
☐ Problematic
14. Timely notification of case plan changes/modifications that impact treatment service interventions

☐ Helpful
☐ Problematic

15. High turnover in workforce

☐ Helpful
☐ Problematic

Section VI – please identify five (5) of the eight (8) suggested items that are most needed additions or changes to the current system of collaboration. Please assign a ranking order from 1 – 5 next to your selections. A ranking of 1 represents the most needed item. (8 selections)

___ Provide frequent opportunities for open communication among and between staff and leaders (e.g. unit meetings, bureau meetings, multi-disciplinary meetings, telephone conference calls, etc.)

___ Logistical supports (e.g. workload relief) to assist stakeholders in attending meetings and/or case conferences

___ Provide joint training opportunities on interagency collaboration practices

___ Increased communication between policymakers and service providers

___ Quarterly in-service training of the Child Welfare Services System of targeted program areas (e.g. Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement —a.k.a. Long Term Placement)

___ Providing adequate level of resources for collaboration (e.g. financial, administrative and professional staff)

___ Strong commitment from key leaders to be involved and committed to collaboration.

___ Cross-training of the similarities / differences between the organizational cultures (e.g. regulatory environment, values, structure and language) of the participating collaborative stakeholders.
APPENDIX J

STAFF FORM

Interagency Collaboration Agency Staff Survey Questionnaire
(I.e. Case Managers, Recovery Specialists, Counselors, Therapists, etc.)

Section I – Demographics (4 questions):

1. How long have you been employed with your agency?
   - □ 2 years or less
   - □ 3 – 5 years
   - □ 6 – 10 years
   - □ 11 years or more

2. What is your position title?
   - □ Case Manager
   - □ Recovery Specialist
   - □ Licensed Therapist
   - □ Certified Drug counselor
   - □ Senior Mental Health Counselor
   - □ Other (please specify ____________________)

3. Highest level of education (please check all that apply):
   - □ High school diploma
   - □ GED
   - □ Some college
   - □ Associate Arts / Science (AA/AS)
   - □ Bachelor Degree
   - □ Master’s Degree
   - □ Doctorate Degree

4. Possession of certification / license (please check all that apply):
   - □ California Addiction Specialist Certification (CAS)
   - □ California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation
   - □ Licensed Clinical Social Worker (LCSW)
   - □ Marriage Family Therapist (MFT)
Section II – Opinions about Coordinated Case Management with Child Welfare

Services: Please select one (1) rating from the following selections (9 questions):

1. A major goal of this collaborative is to provide alcohol and drug treatment services to birth parents that have had their children removed from Child Welfare Services.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

2. Clients are referred to the appropriate treatment service provider without unnecessary delays.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

3. Treatment / support service plans are tailored to meet the specific needs of the client /families.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

4. Feedback of client’s progress is being sent to the case-carrying social worker at Child Welfare Services in a timely manner.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree
5. A representative from Child Welfare Services informs the treatment provider in a
timely manner when a new case-carrying social worker has been assigned.

☐ Strongly Disagree  ☐ Disagree  ☐ Unsure  ☐ Agree  ☐ Strongly Agree

6. As the alcohol and drug treatment provider, I encourage and support the client to
follow the court-ordered case plan from Child Welfare Services.

☐ Strongly Disagree  ☐ Disagree  ☐ Unsure  ☐ Agree  ☐ Strongly Agree

7. The alcohol and drug treatment services in this collaborative create opportunities
for joint planning / case conferences with Child Welfare Services when needed.

☐ Strongly Disagree  ☐ Disagree  ☐ Unsure  ☐ Agree  ☐ Strongly Agree

8. Phone calls / emails are returned in a timely manner from supervisors or other
administrators from Child Welfare Services.

☐ Strongly Disagree  ☐ Disagree  ☐ Unsure  ☐ Agree  ☐ Strongly Agree
9. The collaboration is beneficial to the success of coordinated case management with Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

**Section III - Service Providers’ perceptions of particular dimensions of interagency collaboration with Child Welfare Services.** Please select one (1) rating from the following selections (10 questions):

**Leadership in Alcohol & Drug Treatment Agencies**

1. Effective leadership

☐ Positive Perception
☐ Unsure
☐ Negative Perception

2. Effective in representing others to higher authority

☐ Positive Perception
☐ Unsure
☐ Negative Perception

3. Responds to feedback and changing conditions

☐ Positive Perception
☐ Unsure
☐ Negative Perception

4. Involves team in making decisions

☐ Positive Perception
☐ Unsure
☐ Negative Perception
5. Knowledgeable about the agency’s culture and perspectives of collaborative partners
   - Positive Perception
   - Unsure
   - Negative Perception

6. Provides training in technical, programmatic and relational areas
   - Positive Perception
   - Unsure
   - Negative Perception

7. Skilled in conflict negotiation and resolution
   - Positive Perception
   - Unsure
   - Negative Perception

Communication

8. Effective communication process between your agency and other service providers
   - Positive Perception
   - Unsure
   - Negative Perception

9. Timely and frequent information sharing, problem discussion and resolution
   - Positive Perception
   - Unsure
   - Negative Perception

11. Effective communication process between your agency and Child Welfare Services
    - Positive Perception
    - Unsure
    - Negative Perception
Section IV – Staff Assessment of their Leaders’ Style in relation to the dimensions of transformational leadership. Please indicate how frequently your immediate supervisor demonstrates the leadership behavior described (20 questions):

**Inspirational Motivation**

1. Communicate optimistically about the future.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

2. Communicate enthusiastically about what needs to be accomplished.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

3. Articulate a realistic vision and goals related to improving the organization.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

4. Develop a communal (shared) plan of action for realizing the vision.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

**Idealized Influence (Attributes)**

5. Instill pride in others for being connected with their leadership.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

6. Go beyond self-interest for the good of the team.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always
7. Act in ways that build others' respect for their leadership.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

8. Display a sense of non-threatening power and confidence.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

**Idealized Influence (Behavior)**

9. Emphasize the importance of having a collective sense of mission.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

10. Consider the moral and ethical consequences of decisions.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

11. Communicate about their most important values and beliefs.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

12. Facilitate positive internal and external relations.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

**Individual Consideration**

13. Spend time teaching and coaching.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always
14. Provide training in technical, programmatic and relational areas.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

15. Treat others as individuals rather than a member of a group.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

16. Value the diversity of members’ competencies (i.e. skills / knowledge).

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

17. Consider an individual as having different needs, abilities, and aspirations from others.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

Intellectual Stimulation

18. Re-examine critical assumptions to question whether they are appropriate.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

19. Value and seek diverse perspectives when solving problems.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

20. Encourage others to look at problems from many different angles.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always
Section V - Potential facilitators and barriers to collaboration. Please rate from helpful to problematic (30 questions)

Facilitating factors

1. Cooperative Agency leadership
   □ Helpful
   □ Problematic

2. Cooperative County leadership
   □ Helpful
   □ Problematic

3. A combination of both cooperative Agency and County leadership
   □ Helpful
   □ Problematic

4. History of the relationship between the collaborating agencies
   □ Helpful
   □ Problematic

5. Knowledge and understanding about the system of Child Welfare Services program areas (i.e. Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement—a.k.a. Long Term Placement)
   □ Helpful
   □ Problematic

6. A clear view of the role of social work staff from Child Welfare Services
   □ Helpful
   □ Problematic

7. A clear view of the role of other professionals involved in the collaborative process
   □ Helpful
   □ Problematic
8. Inclusive decision-making processes
   - Helpful
   - Problematic

9. Positive attitudes about collaboration
   - Helpful
   - Problematic

10. Power sharing
    - Helpful
    - Problematic

11. Trusting other stakeholders
    - Helpful
    - Problematic

12. Positive attitudes about other stakeholders
    - Helpful
    - Problematic

13. Abundant / adequate level of resources (i.e. financial, administrative and professional staff)
    - Helpful
    - Problematic

14. Physical proximity (i.e. shared office space) of collaborative partners
    - Helpful
    - Problematic

15. Diversity in leadership positions
    - Helpful
    - Problematic
Barriers

1. Policies and procedures at the local agency level
   - Helpful
   - Problematic

2. Policies and procedures at the county level
   - Helpful
   - Problematic

3. Policies and procedures at the state / federal level
   - Helpful
   - Problematic

4. Communication between treatment providers and social workers
   - Helpful
   - Problematic

5. Different priorities among collaborative partners
   - Helpful
   - Problematic

6. Confidentiality of information sharing between social workers from Child Welfare Services and treatment providers
   - Helpful
   - Problematic

7. Differences in professional perspectives
   - Helpful
   - Problematic

8. Negative attitudes about collaboration
   - Helpful
   - Problematic
9. Openness / Flexibility to change among agency partners

☐ Helpful
☐ Problematic

10. Vague interagency agreements / protocols for interagency collaboration

☐ Helpful
☐ Problematic

11. Availability of joint training opportunities on interagency collaboration practices

☐ Helpful
☐ Problematic

12. Scarcity/ insufficient level of resources (i.e. financial, administrative and professional staff)

☐ Helpful
☐ Problematic

13. Record keeping

☐ Helpful
☐ Problematic

14. Timely notification of case plan changes/modifications that impact treatment service interventions

☐ Helpful
☐ Problematic

15. High turn over in workforce

☐ Helpful
☐ Problematic
Section VI – please identify five (5) of the eight (8) suggested items that are most needed additions or changes to the current system of collaboration. Please assign a ranking order from 1 – 5 next to your selections. A ranking of 1 represents the most needed item. (8 selections)

___ Provide frequent opportunities for open communication among and between staff and leaders (e.g. unit meetings, bureau meetings, multi-disciplinary meetings, telephone conference calls, etc.)

___ Logistical supports (e.g. workload relief) to assist stakeholders in attending meetings and/or case conferences

___ Provide joint training opportunities on interagency collaboration practices

___ Increased communication between policymakers and service providers

___ Quarterly in-service training of the Child Welfare Services System of targeted program areas (e.g. Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement —a.k.a. Long Term Placement)

___ Providing adequate level of resources for collaboration (e.g. financial, administrative and professional staff)

___ Strong commitment from key leaders to be involved and committed to collaboration.

___ Cross-training of the similarities / differences between the organizational cultures (e.g. regulatory environment, values, structure and language) of the participating collaborative stakeholders.
Hello, my name is Verronda Moore. I will be conducting a research study examining the perceptions of substance abuse providers perceptions of interagency collaboration with child welfare services. The research design will be a two-stage study involving both a qualitative and quantitative methodology to assess both the facilitating factors and barriers to successful collaboration. The study will also serve as partial fulfillment of the requirements for my doctorate degree in education at the University of San Francisco School of Education, Department of Leadership Studies.

You are being asked to participate in this research study because you are in a leadership role in an Alcohol and Drugs Treatment Providers Agency. If you agree to participate, your involvement will entail an interview encompassing issues related to your own leadership style and particular dimensions (i.e. coordinated case management, communication, facilitating factors or barriers) of interagency collaboration. The in-depth interview questions will be aimed at gaining accurate insight in this regard and should not last any longer than 1 hour.

Although unlikely, if any of the questions make you feel uncomfortable, you are free to decline to answer any of them or to discontinue participation at any time. Although pseudonyms will be used in any published material pertaining to this study, participation in research can pose a minimal risk in confidentiality. All possible effort will be made to maintain study records in as confidential manner as possible. All research information will be coded and kept in locked files at all times with only study personnel having access to these files. Any results specific to your input will not be shared with personnel from your company.

While there will be no direct benefit to you from participating in this study, this research is expected to provide a clearer understanding of how collaborative projects can better employ strategies to support and strengthen effective engagement and facilitation practices for successful interagency collaboration.

There will be no cost to you as a result of participation in this study, nor will you be compensated for your participation.

If you have any questions concerning this research, you may contact me at (916) 261-0735 or the IRBPHS at the University of San Francisco, which is the Institutional Review Board for the Protection of Human Subjects concerned with protecting volunteers in research projects. You may reach the IRBPHS office by calling (415) 422-6091 or e-mailing IRBPHS@uscfa.edu or by writing to the IRBPHS, Department of Psychology, University of San Francisco, 2130 Fulton Street, San Francisco, CA. 94117-1080.

Would you be willing to participate?
APPENDIX L

Coming to your Agency Soon!

A RESEARCH PROJECT EXAMINING 
"ALCOHOL AND DRUG SERVICE PROVIDERS’ 
PERCEPTIONS OF INTERAGENCY COLLABORATION 
WITH CHILD WELFARE SERVICES"

**Targeted Participants:** Agency employees who are in leadership positions and those (i.e. Drug Counselors, Therapists, Recovery Specialists, etc.) directly responsible for case management and communicating with both leaders and social workers from Child Welfare Services.

**Research Method:** Survey instruments (i.e. Interagency Collaboration Agency Leadership Survey Questionnaire & the Interagency Collaboration Agency Staff Survey Questionnaire) are designed to learn both the facilitating factors and barriers to successful collaboration. The survey results will also yield data to determine if the Treatment Providers from different agencies hold similar views about the collaboration.

**An informed consent letter explaining the research will be provided to all participants.**

**Time Commitment:** Each survey will take approximately 15 - 20 minutes to complete.

**Special Note:** The Sacramento County Department of Health & Human Services, Acting Alcohol & Drug Division Administrator has given approval to conduct this research. The researcher will also solicit Agency Administrators for their consent to allow their employees to voluntarily participate in the study.

*Researcher: Verronda Moore, Doctoral Student at the University of San Francisco*  
*Major: Organization and Leadership*  
*Contact Information: (916) 261-0735 & Email: Verronda@comcast.net*
APPENDIX M

LEADER FORM – PILOT STUDY QUESTIONNAIRE

Interagency Collaboration Agency Leadership Survey Questionnaire

Section I – Demographics (5 questions):

1. How long have you been employed with your agency?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11 years or more

2. What is your position title?
   - [ ] Agency Administrator
   - [ ] Executive Director
   - [ ] Assistant Director
   - [ ] Program Director
   - [ ] Supervisor
   - [ ] Mental Health Program Coordinator
   - [ ] Other (please specify __________________________)

3. How long have you been in the position of leadership?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11 years or more

4. Highest level of education:
   - [ ] High school diploma
   - [ ] GED
   - [ ] Some college
   - [ ] Associate Arts / Science (AA/AS)
   - [ ] Bachelor Degree
   - [ ] Master’s Degree
   - [ ] Doctorate Degree
5. Possession of certification / license (please check all that apply):

☐ California Addiction Specialist Certification (CAS)
☐ California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation
☐ Licensed Clinical Social Worker (LCSW)
☐ Marriage Family Therapist (MFT)

Section II – Opinions about Coordinated Case Management with Child Welfare

Services: Please select one (1) rating from the following selections (9 questions):

1. A major goal of this collaborative is to provide alcohol and drug treatment services to birth parents that have had their children removed from Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

2. Clients are referred to the appropriate treatment service provider without unnecessary delays.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

3. Treatment / support service plans are tailored to meet the specific needs of the client /families.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree
4. Feedback of client’s progress is being sent to the case-carrying social worker at Child Welfare Services in a timely manner.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

5. A representative from Child Welfare Services informs the treatment provider in a timely manner when a new case-carrying social worker has been assigned.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

6. As the alcohol and drug treatment provider, I encourage and support the client to follow the court-ordered case plan from Child Welfare Services.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

7. The alcohol and drug treatment services in this collaborative create opportunities for joint planning / case conferences with Child Welfare Services when needed.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree
8. Phone calls / emails are returned in a timely manner from supervisors or other administrators from Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

9. The collaboration is beneficial to the success of coordinated case management with Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

Section III - Service Providers’ perceptions of particular dimensions of interagency collaboration with Child Welfare Services. Please select one (1) rating from the following selections (10 questions):

Leadership in Alcohol & Drug Treatment Agencies

1. Effective leadership

☐ Positive Perception
☐ Unsure
☐ Negative Perception

2. Effective in representing others to higher authority

☐ Positive Perception
☐ Unsure
☐ Negative Perception

3. Responds to feedback and changing conditions

☐ Positive Perception
☐ Unsure
☐ Negative Perception
4. Involves team in making decisions

☐ Positive Perception
☐ Unsure
☐ Negative Perception

5. Knowledgeable about the agency’s culture and perspectives of collaborative partners

☐ Positive Perception
☐ Unsure
☐ Negative Perception

6. Provides training in technical, programmatic and relational areas

☐ Positive Perception
☐ Unsure
☐ Negative Perception

7. Skilled in conflict negotiation and resolution

☐ Positive Perception
☐ Unsure
☐ Negative Perception

Communication

8. Effective communication process between your agency and other service providers

☐ Positive Perception
☐ Unsure
☐ Negative Perception

9. Timely and frequent information sharing, problem discussion and resolution

☐ Positive Perception
☐ Unsure
☐ Negative Perception
Section IV – Leaders’ Assessment of their Leadership Style in relation to the dimensions of transformational leadership. Please indicate how frequently you demonstrate the leadership behavior described (20 questions).

**Inspirational Motivation**

1. I communicate optimistically about the future
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

2. I communicate enthusiastically about what needs to be accomplished.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

3. I articulate a realistic vision and goals related to improving the organization.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

4. I develop a communal plan of action for realizing the vision.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

**Idealized Influence (Attributes)**

5. I instill pride in others for being connected with my leadership.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always

6. I go beyond self-interest for the good of the team.
   - [ ] Not at All
   - [ ] Somewhat Frequently
   - [ ] Most Frequently, If Not Always
7. I act in ways that build others' respect for my leadership.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

8. I display a sense of non-threatening power and confidence.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

Idealized Influence (Behavior)

9. I emphasize the importance of having a collective sense of mission.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

10. I consider the moral and ethical consequences of decisions.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

11. I communicate about my most important values and beliefs

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

12. I facilitate positive internal and external relations

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always

Individual Consideration

13. I spend time teaching and coaching.

[ ] Not at All
[ ] Somewhat Frequently
[ ] Most Frequently, If Not Always
14. I provide training in technical, programmatic and relational areas.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

15. I treat others as individuals rather than a member of a group.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

16. I value the diversity of member competencies (i.e. skills / knowledge).

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

17. I consider an individual as having different needs, abilities, and aspirations from others.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

Intellectual Stimulation

18. I re-examine critical assumptions to question whether they are appropriate.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

19. I value and seek diverse perspectives when solving problems.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

20. I encourage others to look at problems from many different angles.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always
Section V - Potential facilitators and barriers to collaboration. Please rate from helpful to problematic (30 questions)

Facilitating factors

1. Cooperative Agency leadership
   - Helpful
   - Problematic

2. Cooperative County leadership
   - Helpful
   - Problematic

3. A combination of both cooperative Agency and County leadership
   - Helpful
   - Problematic

4. History of the relationship between the collaborating agencies
   - Helpful
   - Problematic

5. Knowledge and understanding about the system of Child Welfare Services program areas (i.e. Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement—a.k.a. Long Term Placement)
   - Helpful
   - Problematic

6. A clear view of the role of social work staff from Child Welfare Services
   - Helpful
   - Problematic

7. A clear view of the role of other professionals involved in the collaborative process
   - Helpful
   - Problematic
8. Inclusive decision-making processes
   - Helpful
   - Problematic

9. Positive attitudes about collaboration
   - Helpful
   - Problematic

10. Power sharing
    - Helpful
    - Problematic

11. Trusting other stakeholders
    - Helpful
    - Problematic

12. Positive attitudes about other stakeholders
    - Helpful
    - Problematic

13. Abundant / adequate level of resources (i.e. financial, administrative and professional staff)
    - Helpful
    - Problematic

14. Physical proximity (i.e. shared office space) of collaborative partners
    - Helpful
    - Problematic

15. Diversity in leadership positions
    - Helpful
    - Problematic
Barriers

1. Policies and procedures at the local agency level
   □ Helpful
   □ Problematic

2. Policies and procedures at the county level
   □ Helpful
   □ Problematic

3. Policies and procedures at the state / federal level
   □ Helpful
   □ Problematic

4. Communication between treatment providers and social workers
   □ Helpful
   □ Problematic

5. Different priorities among collaborative partners
   □ Helpful
   □ Problematic

6. Confidentiality of information sharing between social workers from Child Welfare Services and treatment providers
   □ Helpful
   □ Problematic

7. Differences in professional perspectives
   □ Helpful
   □ Problematic

8. Negative attitudes about collaboration
   □ Helpful
   □ Problematic
9. Openness / Flexibility to change among agency partners

☐ Helpful
☐ Problematic

10. Vague interagency agreements / protocols for interagency collaboration

☐ Helpful
☐ Problematic

11. Availability of joint training opportunities on interagency collaboration practices

☐ Helpful
☐ Problematic

12. Scarcity/ insufficient level of resources (i.e. financial, administrative and professional staff)

☐ Helpful
☐ Problematic

13. Record keeping

☐ Helpful
☐ Problematic

14. Timely notification of case plan changes/modifications that impact treatment service interventions

☐ Helpful
☐ Problematic

15. High turn over in workforce

☐ Helpful
☐ Problematic
Section VI – please identify four (4) of the eight (8) suggested items that are most needed additions or changes to the current system of collaboration. Please assign a ranking order from 1 – 5 next to your selections. A ranking of 1 represents the most needed item. (8 selections)

___  Provide frequent opportunities for open communication among and between staff and leaders (e.g. unit meetings, bureau meetings, multi-disciplinary meetings, telephone conference calls, etc.)

___  Logistical supports (e.g. workload relief) to assist stakeholders in attending meetings and/or case conferences

___  Provide joint training opportunities on interagency collaboration practices

___  Increased communication between policymakers and service providers

___  Quarterly in-service training of the Child Welfare Services System of targeted program areas (e.g. Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement —a.k.a. Long Term Placement)

___  Providing adequate level of resources for collaboration (e.g. financial, administrative and professional staff)

___  Strong commitment from key leaders to be involved and committed to collaboration.

___  Cross-training of the similarities / differences between the organizational cultures (e.g. regulatory environment, values, structure and language) of the participating collaborative stakeholders.
APPENDIX N

STAFF FORM – PILOT STUDY QUESTIONNAIRE

Interagency Collaboration Agency Staff Survey Questionnaire
(I.e. Case Managers, Recovery Specialists, Counselors, Therapists, etc.)

Section I – Demographics (4 questions):

1. How long have you been employed with your agency?
   - [ ] 2 years or less
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11 years or more

2. What is your position title?
   - [ ] Case Manager
   - [ ] Recovery Specialist
   - [ ] Licensed Therapist
   - [ ] Certified Drug counselor
   - [ ] Senior Mental Health Counselor
   - [ ] Other (please specify ____________________)

3. Highest level of education (please check all that apply):
   - [ ] High school diploma
   - [ ] GED
   - [ ] Some college
   - [ ] Associate Arts / Science (AA/AS)
   - [ ] Bachelor Degree
   - [ ] Master’s Degree
   - [ ] Doctorate Degree

4. Possession of certification / license (please check all that apply):
   - [ ] California Addiction Specialist Certification (CAS)
   - [ ] California Association of Alcoholism and Drug Abuse Counselors (CAADAC) Accreditation
   - [ ] Licensed Clinical Social Worker (LCSW)
   - [ ] Marriage Family Therapist (MFT)
Section II – Opinions about Coordinated Case Management with Child Welfare Services:

Please select one (1) rating from the following selections (9 questions):

1. A major goal of this collaborative is to provide alcohol and drug treatment services to birth parents that have had their children removed from Child Welfare Services.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

2. Clients are referred to the appropriate treatment service provider without unnecessary delays.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

3. Treatment / support service plans are tailored to meet the specific needs of the client /families.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree

4. Feedback of client’s progress is being sent to the case-carrying social worker at Child Welfare Services in a timely manner.

   - [ ] Strongly Disagree
   - [ ] Disagree
   - [ ] Unsure
   - [ ] Agree
   - [ ] Strongly Agree
5. A representative from Child Welfare Services informs the treatment provider in a timely manner when a new case-carrying social worker has been assigned.

- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Unsure
- [ ] Agree
- [ ] Strongly Agree

6. As the alcohol and drug treatment provider, I encourage and support the client to follow the court-ordered case plan from Child Welfare Services.

- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Unsure
- [ ] Agree
- [ ] Strongly Agree

7. The alcohol and drug treatment services in this collaborative create opportunities for joint planning / case conferences with Child Welfare Services when needed.

- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Unsure
- [ ] Agree
- [ ] Strongly Agree

8. Phone calls / emails are returned in a timely manner from supervisors or other administrators from Child Welfare Services.

- [ ] Strongly Disagree
- [ ] Disagree
- [ ] Unsure
- [ ] Agree
- [ ] Strongly Agree
9. The collaboration is beneficial to the success of coordinated case management with Child Welfare Services.

☐ Strongly Disagree
☐ Disagree
☐ Unsure
☐ Agree
☐ Strongly Agree

Section III - Service Providers’ perceptions of particular dimensions of interagency collaboration with Child Welfare Services. Please select one (1) rating from the following selections (10 questions):

Leadership in Alcohol & Drug Treatment Agencies

1. Effective leadership
   ☐ Positive Perception
   ☐ Unsure
   ☐ Negative Perception

2. Effective in representing others to higher authority
   ☐ Positive Perception
   ☐ Unsure
   ☐ Negative Perception

3. Responds to feedback and changing conditions
   ☐ Positive Perception
   ☐ Unsure
   ☐ Negative Perception

4. Involves team in making decisions
   ☐ Positive Perception
   ☐ Unsure
   ☐ Negative Perception
5. Knowledgeable about the agency’s culture and perspectives of collaborative partners

☐ Positive Perception  
☐ Unsure  
☐ Negative Perception

6. Provides training in technical, programmatic and relational areas

☐ Positive Perception  
☐ Unsure  
☐ Negative Perception

7. Skilled in conflict negotiation and resolution

☐ Positive Perception  
☐ Unsure  
☐ Negative Perception

Communication

8. Effective communication process between your agency and other service providers

☐ Positive Perception  
☐ Unsure  
☐ Negative Perception

9. Timely and frequent information sharing, problem discussion and resolution

☐ Positive Perception  
☐ Unsure  
☐ Negative Perception

Section IV – Staff Assessment of their Leaders’ Style in relation to the dimensions of transformational leadership. Please indicate how frequently your immediate supervisor demonstrates the leadership behavior described (20 questions):

Inspirational Motivation
1. Communicate optimistically about the future.

☐ Not at All  
☐ Somewhat Frequently  
☐ Most Frequently, If Not Always
2. Communicate enthusiastically about what needs to be accomplished.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

3. Articulate a realistic vision and goals related to improving the organization.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

4. Develop a communal (shared) plan of action for realizing the vision.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

Idealized Influence (Attributes)

5. Instill pride in others for being connected with their leadership.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

6. Go beyond self-interest for the good of the team.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

7. Act in ways that build others' respect for their leadership.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

8. Display a sense of non-threatening power and confidence.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always
Idealized Influence (Behavior)

9. Emphasize the importance of having a collective sense of mission.
   - Not at All
   - Somewhat Frequently
   - Most Frequently, If Not Always

10. Consider the moral and ethical consequences of decisions.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

11. Communicate about their most important values and beliefs.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

12. Facilitate positive internal and external relations.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

Individual Consideration

13. Spend time teaching and coaching.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

14. Provide training in technical, programmatic and relational areas.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always

15. Treat others as individuals rather than a member of a group.
    - Not at All
    - Somewhat Frequently
    - Most Frequently, If Not Always
16. Value the diversity of members’ competencies (i.e. skills / knowledge).

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

17. Consider an individual as having different needs, abilities, and aspirations from others.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

Intellectual Stimulation

18. Re-examine critical assumptions to question whether they are appropriate.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

19. Value and seek diverse perspectives when solving problems.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

20. Encourage others to look at problems from many different angles.

☐ Not at All
☐ Somewhat Frequently
☐ Most Frequently, If Not Always

Section V - Potential facilitators and barriers to collaboration. Please rate from helpful to problematic (30 questions)

Facilitating factors

1. Cooperative Agency leadership

☐ Helpful
☐ Problematic
2. Cooperative County leadership
   - Helpful
   - Problematic

3. A combination of both cooperative Agency and County leadership
   - Helpful
   - Problematic

4. History of the relationship between the collaborating agencies
   - Helpful
   - Problematic

5. Knowledge and understanding about the system of Child Welfare Services program areas (i.e. Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement—a.k.a. Long Term Placement)
   - Helpful
   - Problematic

6. A clear view of the role of social work staff from Child Welfare Services
   - Helpful
   - Problematic

7. A clear view of the role of other professionals involved in the collaborative process
   - Helpful
   - Problematic

8. Inclusive decision-making processes
   - Helpful
   - Problematic

9. Positive attitudes about collaboration
   - Helpful
   - Problematic
10. Power sharing

☐ Helpful
☐ Problematic

11. Trusting other stakeholders

☐ Helpful
☐ Problematic

12. Positive attitudes about other stakeholders

☐ Helpful
☐ Problematic

13. Abundant / adequate level of resources (i.e. financial, administrative and professional staff)

☐ Helpful
☐ Problematic

14. Physical proximity (i.e. shared office space) of collaborative partners

☐ Helpful
☐ Problematic

15. Diversity in leadership positions

☐ Helpful
☐ Problematic

Barriers

1. Policies and procedures at the local agency level

☐ Helpful
☐ Problematic

2. Policies and procedures at the county level

☐ Helpful
☐ Problematic
3. Policies and procedures at the state / federal level
   
   [ ] Helpful
   [ ] Problematic

4. Communication between treatment providers and social workers
   
   [ ] Helpful
   [ ] Problematic

5. Different priorities among collaborative partners
   
   [ ] Helpful
   [ ] Problematic

6. Confidentiality of information sharing between social workers from Child Welfare Services and treatment providers
   
   [ ] Helpful
   [ ] Problematic

7. Differences in professional perspectives
   
   [ ] Helpful
   [ ] Problematic

8. Negative attitudes about collaboration
   
   [ ] Helpful
   [ ] Problematic

9. Openness / Flexibility to change among agency partners
   
   [ ] Helpful
   [ ] Problematic

10. Vague interagency agreements / protocols for interagency collaboration
    
    [ ] Helpful
    [ ] Problematic

11. Availability of joint training opportunities on interagency collaboration practices
    
    [ ] Helpful
    [ ] Problematic
12. Scarcity/insufficient level of resources (i.e. financial, administrative and professional staff)

☐ Helpful
☐ Problematic

13. Record keeping

☐ Helpful
☐ Problematic

14. Timely notification of case plan changes/modifications that impact treatment service interventions

☐ Helpful
☐ Problematic

15. High turnover in workforce

☐ Helpful
☐ Problematic

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___ Increased communication between policymakers and service providers
Quarterly in-service training of the Child Welfare Services System of targeted program areas (e.g. Family Maintenance /Informal Supervision, Court Services, Family Reunification, and Permanent Placement —a.k.a. Long Term Placement)

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