Published in final edited form as:

Hum Serv Organ Manag Leadersh Gov. 2020 ; 44(4): 332–342. doi:10.1080/23303131.2020.1767744.

Do Social Workers Lead Differently? Examining Associations with Leadership Style and Organizational Factors

Mimi Choy-Brown^a, Victoria Stanhope^b, Nancy Wackstein^c, Holly Delany Cole^d

^aSocial Work, University of Minnesota, St. Paul, Minnesota, USA

^bSilver School of Social Work, New York University, New York, New York, USA

^cSocial Work, Fordham University, New York, New York, USA

^dEvelyn and Walter Haas Junior Fund, San Francisco, California, USA

Abstract

What training leaders need to successfully shepherd high quality human service delivery remains less understood. This study aims to evaluate associations between social work training, leadership style, and organizational factors. Participants included leaders ($N=49$) and employees ($N=224$) working in 10 behavioral health organizations who completed a survey. Hierarchical linear models were used to analyze multilevel associations. Analyses indicated that leaders with social work training were rated higher in transformational leadership and organizational factors (e.g., lesser stress) on average within both samples. Findings begin an empirical argument for the value of social work leaders for the success of human service organizations.

Keywords

Social Work; Leadership; Organizational Context; Mental health recovery

Human service organizations (HSO) face considerable challenges in the current socio-political context in the United States. Over the last 40 years, social welfare and health service delivery have been shaped by policy that privileges the privatization of services and individual responsibility over progressive era approaches (Hasenfeld & Garrow, 2012). Post-welfare reform, HSO leaders have reported prioritization of productivity, efficiency, and cost reduction (Abramovitz, 2005) and incentives to be lean, efficient, and risk-averse (Lawler, 2007). In this context, service delivery models have shifted to a new public management model in which HSOs are required to innovate through market competition and demonstrate their impact through outcomes measurement (Mosley & Smith, 2018). In addition, HSOs are required to be agile to changing models for contract acquisition (e.g., coordinated care in health homes), billing for their work (e.g., value-based payment), and service delivery (e.g., evidence-based interventions) (Kerman et al., 2012; Authors, 2017). Further challenging HSOs, resources to support infrastructure and administrative functions are particularly scarce (Bugg-Levine & Ali, 2016). Limited administrative support and significant workforce

challenges (e.g., training and retention) have real consequences for the internal workings of an HSO such as how people collaborate, communicate, and practice (Hager et al., 2004; Woltmann et al., 2008), which further undermines HSOs' capacity to advance their missions.

Given this context, it remains an empirical question as to who are the best equipped to lead HSOs and respond effectively to the challenges currently facing them. What training, strengths, and values are needed at the helm of organizations with a primary mission to serve people and communities? In many social service fields (e.g., mental health services), social workers dominate the workforce employed in HSOs. However, a commensurate representation among HSO executive leaders has not been documented. Instead, people with general management degrees with marketed strengths in fiscal management or law degrees often populate these positions (Perlmutter 2006; Mosley and Smith 2018). This reflects a broader trend in non-profits and raises the question of whether it matters if a leader of an arts organization is not an artist or if the leader of an HSO has never practiced social work (SW) (Authors, 2016). Since 1980 and the erosion of the welfare state, SW leaders have become less visible (Brilliant, 1986; Perlmutter, 2006). The core SW curriculum prepares students to be competent in social welfare history, ecological systems theory, engagement of individuals, groups, and communities, and the technical application of interventions with consideration to the role of the environment (CSWE, 2015). What differential impact this SW training brings to the leadership of HSOs remains unknown. Knowledge of this critical gap has significant potential to advance our understanding of the unique contribution of SW leaders.

Organizational Factors

The organizational context within HSOs has been identified as a key domain that influences clinical practice in the implementation science literature (Damschroder et al. 2009). Among the key inner setting factors, organizational leadership and climate have been found to predict successful collective efforts to adapt organizational practice behavior (Weiner, 2009). In particular, a strong organizational climate for change has been operationalized as openness to change, mission clarity, cohesion and communication among staff, and manageable stress (Lehman, Greener, and Simpson, 2002), and has fostered the shared perception that a change is expected, supported, and rewarded (Weiner 2009). The HSO climate has impacted staff behavior, including organizations with more positive climates having lower staff turnover and higher success in changing practice (Aarons, Sommerfeld, & Willging 2011; Glisson et al., 2008).

While a positive organizational climate is necessary, it is not sufficient for the adoption of new practices. Klein & Sorra (1996) have argued that a values-fit between the context and the new practice must also be present for providers to successfully implement a new practice. Often these values can be shaped implicitly or explicitly through how an HSO relates to the people it serves, structures internal communication, and endorses overall value frameworks that shape service delivery. Within behavioral health care, one key values-based approach is mental health recovery, first articulated by people with lived experience of mental health recovery (Deegan, 1988; 1996) and now promoted in mainstream transformational efforts by state and federal policymakers (DHHS, 2003). With a recovery

orientation, the identified principles, including renewing hope, redefining self, assuming control, and living a meaningful life in the community, inform the logic of what and how services should be delivered (O'Connell et al., 2005). One way that values, such as those that undergird a recovery orientation, are communicated is through HSO leadership, which is another key inner setting factor.

A large body of research suggests that transformational leadership is associated with improved organizational climate for change efforts and is closely related to values-fit (Aarons & Sommerfeld, 2012). Transformational leadership is now among the most popular leadership theories (Dinh et al., 2014) and is characterized by inspiration, charisma, support, consideration, and intellectual stimulation (Bass & Avolio, 1990; Corrigan & Garman, 1999). The transformational leader energizes staff, models ethical behavior, encourages problem-solving and innovation, and develops staff to meet their potential. Specifically, transformational leadership has been found to have a positive relationship with team functioning and a negative relationship to staff burnout in mental health services (Corrigan et al., 2002; Gill, Flaschner, & Shachar, 2006). This leadership style also has a positive relationship with inclusive hiring and subsequent improvement in job performance (Kearney & Gebert, 2009; Liaw, Chi, & Chuang, 2010), intrinsic motivation, creative problem-solving, exploratory thinking, and sensitivity to client needs (Jung, Chow, & Wu, 2003), and job-related learning (Loon et al., 2012). This research suggests the transformational leadership style has great potential to improve workplace experiences and effectiveness, notably during change efforts. The negative relationship with burnout also suggests that transformational leadership can mitigate stressful workloads, improve recognition and support of staff, and foster cohesive team environments (Corrigan et al., 2002). In addition, individual's workload, agency tenure, and professional experience can be confounding factors for the assessment of an organization's climate or leadership (Green, Mill, & Aarons, 2013). For example, the larger the number of people that each provider is serving (i.e., caseload), the poorer their assessment of leadership (Broome, Knight, Edwards, & Flynn, 2009).

Social Work Leadership

Arguments for the importance of social work HSO leadership have been presented in the literature. Leaders make critical strategic choices as they balance external funding mandates with the mission and values of their agency (Lawler, 2007; Peters, 2017). Social workers have been found to use a systemic perspective to solve complex human service problems and a relational leadership style (Adams, 2018; Rank & Hutchison, 2000). In addition, arguments in support of SW leaders have stated that SW leaders bring to HSOs the necessary ethical, principled leadership style (Bliss, Pecukonis, & Snyder-Vogel, 2014), knowledge of direct practice that remains the bedrock of the profession (Brilliant, 1986), and commitment to social justice (Sullivan, 2016). Ethical leadership has been shown to translate to ethical practice (Mayer et al., 2009; Schaubroeck et al., 2012). Training anchored in social work values may prepare leaders to marry the values, interpersonal skills, and change management strategy necessary to foster a culture of effective service provision (Peters, 2017). In addition, recent research suggests that leaders with a business or management training background are more likely to run child welfare organizations like for-profit

businesses than leaders without that training (Robichau, Waters, & Wang, 2018). However, business and management skill sets have been considered desirable to “keep the doors open” and the lights on in a complex financing environment (Lawler 2007). In addition, ethical leadership is not exclusive to SW and has been found among leaders with business degrees.

While this literature has presented arguments for the value of SW leaders, the empirical basis for SW leadership remains very limited. There has been only one other study known to these authors that compared SW to other disciplines in ratings of leadership. Goldkind & Pardasani (2013) examined leaders’ ratings of their own leadership style and reported that participants with a SW degree self-assessed higher transformational leadership than those without a SW degree. Beyond this study, comparisons of leadership style from the perspective of subordinates or associations between discipline and any indicators of organizational effectiveness remain absent from the literature.

This study aims to take an initial step and is the first study to the authors’ knowledge to compare differences in organizational factors and leadership among SW and non-SW leaders from the perspectives of both leaders and their staff. In particular, this cross-sectional study aimed to identify differences in perceptions of leadership style, organizational climate, and values-based context 1) among SW and non-SW leaders and 2) among majority SW-led versus non-majority SW-led organizations. The study controlled for tenure within the agency, years of experience, and size of caseload as factors that have been found to influence provider perceptions of leaders and organizational climate (Green, Mill, Aarons, 2013; Broome et al., 2009) Multi-stakeholder perspectives were employed to guard against biases and limitations of self-assessments and critical insight into phenomena of interest (Aarons, Ehrhart, Farahnak, Sklar, & Horowitz, 2017).

Method

Data Source and Sample

This study draws from an electronic baseline survey administered to providers working in ten behavioral health organizations participating in a federally-funded, large-scale randomized controlled trial testing the effectiveness of Person-Centered Care Planning (PCCP), an emerging evidence-based practice (Authors 2015). The behavioral health organizations are located in two northeastern states and provide services to people diagnosed with serious mental illnesses. Private non-profit HSOs were selected by state leadership to participate if they had not received training in PCCP. Executive leaders of each organization then shared staff contact lists for the initial study recruitment. The baseline participant sample is comprised of leaders ($N=49$) and staff ($N=224$) who worked at a participating HSO. Leaders and staff received survey protocols with tailored item stems to their agency role (i.e., leaders were asked to self-assess and staff were asked to rate agency leaders). An introductory email from the leadership was sent to both encourage participation and emphasize that participation was voluntary. Participants received \$20 Amazon gift certificates for remuneration. The total response rate for the baseline survey was 89%. Two samples are used in this study. The first is comprised of executive-level leaders in the organizations ($N=49$) who each oversaw mental health services in their agency in some capacity and the second is comprised of staff participants ($N=224$) working in the

community mental health organizations participating in the trial. Staff participants are nested in 87 teams with one to three participants per team. Across the organizations, the number of leaders ranged from 1 to 10, number of staff participants ranged from 12 to 35, and the number of teams ranged from 2 to 13.

Measures

Outcomes.—Transformational leadership is measured using the Multifactor Leadership Questionnaire's transformational leadership subscale (Bass and Avolio 1990). Substantial research has examined transformational leadership theory and established the validity and reliability of the measurement (Judge & Piccolo, 2004). The subscale is comprised of 20 items (e.g., Leaders in my agency emphasize the importance of having a collective sense of mission, Leaders at my agency instill pride in me for being associated with him/her). Participants were asked to indicate the degree to which they felt the items reflected the executive leadership of their agency. Reliability with Cronbach's alpha ranging from .74 to .91 have been established in the literature (Aarons 2006). In these data, the Cronbach's alpha is .978. Organizational Climate is measured using the Organizational Readiness for Change's climate scale (Lehman, Greener, and Simpson 2002). This study uses 3 sub-scales: (a) stress and workload burden (e.g., you are under too many pressures to do your job effectively) with a Cronbach's alpha of .837 in these data; (b) staff cohesiveness (e.g., the staff here always work together as a team) with a Cronbach's alpha of .852 in these data; and (c) communication within the organization (e.g., the formal and informal communication channels here work very well) with a Cronbach's alpha of .852 in these data. Recovery-oriented context is measured using the Recovery Self-Assessment (RSA-provider version; O'Connell et al. 2005). The RSA-provider version is comprised of 36 items (e.g., Agency staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices) with a Cronbach's alpha of .933 in these data.

Predictors.—SW discipline is a dichotomous variable in which participants endorse their discipline from a list of 18 choices (i.e., addictions counseling, other counseling, education, psychiatric rehabilitation, criminal justice, psychology, SW, human services, physician assistant, occupational therapist, peer support services, medicine – primary care, medicine – psychiatry, medicine – other, nurse, nurse practitioner, administration, or other). The item prompted participants to check all disciplines/certifications that apply to them. If participants endorse SW, they are included in the SW category. Majority SW executive leadership is a dichotomous variable indicating that the majority (more than half) of the organization's leaders participating in the study endorse SW as a discipline. Of the 10 organizations, 3 have majority SW leadership with 75%, 66%, and 100% of their leadership participants endorsing SW. The other 7 organizations have 0 to 25% of their leadership endorsing SW with most often 1 of 5 endorsing SW. This does not include members of the leadership board in an organization.

Covariates.—Years of experience in service provision and years of tenure at the organization are measured by single items in the baseline survey. Caseload is measured as the average number of people served per staff member.

Analytic Strategy

Sample populations are characterized using descriptive statistics and frequencies. To answer the first research question among leaders' self-assessments, the outcome variables (transformational leadership, stress, cohesion, communication, and values-based context) were each modeled separately as a function of the SW discipline holding constant the covariates (years in mental health and years in the organization) at the individual level. In these analyses, two-level mixed effects regression models (hierarchical linear models) have random intercepts at the organizational level to account for the nesting of leaders in organizations. Caseload is not included because leaders do not carry caseloads. Analyses do not include teams because leaders are not nested in teams.

To answer the second research question among staff participants, the outcome variable (transformational leadership) was modeled as a function of majority SW leadership at the organizational level holding constant the covariates (years in mental health, years in the organization, and caseload) at the individual level. In these analyses, three-level mixed effects regression models (hierarchical linear models) have random intercepts at the organizational level to account for the nesting of provider observations (level 1) in teams (level 2) and in organizations (level 3). Third, the outcome variables (stress, cohesion, communication, values-based context) are modeled as a function of majority SW leadership at the organizational level holding constant the covariates (years in mental health, years in the organization, and caseload) at the individual level. In these analyses, three-level mixed effects regression models (hierarchical linear models) have random intercepts at the organizational level to account for the nesting of provider observations (level 1) in teams (level 2) and in organizations (level 3). In both sets of models, no random slopes were included and models are estimated using maximum likelihood. Cohen's *d* effect sizes were calculated for the SW predictor in each model. All analyses were conducted in SPSS.

Results

Participant Characteristics

The participant samples are comprised of leaders ($N=49$) and staff members ($N=224$) working in community mental health settings ($N=10$). SW is the discipline with the highest representation (38.1%) amongst the sample. Overall, the sample is an experienced group with an average of 10.12 years of experience in mental health services. In addition, 3 of the 10 organizations have majority SW leadership, which represents 66 of the 224 staff participants (29.46%), and 8 of the 49 leaders (16.32%) are working in a majority SW-led organization. Table 1 describes the demographics of the total sample by leadership and staff.

Table 2 shows significantly higher ratings of transformational leadership, recovery-oriented context, stress, and communication in the SW versus non-SW group as reported by leaders. SW leaders rate themselves higher in transformational leadership ($b=.48$, $SE=.19$, $p<.05$). SW leaders also rate their organizations' recovery orientation ($b=.39$, $SE=.13$, $p<.01$) and communication higher ($b=3.86$, $SE=1.85$, $p<.05$) and their stress lower ($b=-4.41$, $SE=1.93$, $p<.05$). SW leader ratings of the cohesiveness among staff ($b=-.149$, $SE=1.23$, $p=.90$) are not significantly different.

Table 3 shows that staff working in majority SW-led organizations rate the leadership as higher in transformational leadership style ($b=.66$, $SE=.28$, $p<.05$). In addition, staff in SW-led organizations rate their organizational context higher with regard to the recovery orientation ($b=.38$, $SE=.14$, $p<.05$), communication ($b=.545$, $SE=2.66$, $p<.05$), and staff cohesion ($b=.394$, $SE=1.55$, $p<.05$) on average. Staff in SW-led organizations also rate their stress as significantly lower on average ($b=-6.16$, $SE=2.63$, $p<.05$). The models have moderate effect sizes evidenced in the Cohen's d with the exception of staff cohesion that has a low effect size.

Discussion

These study findings provide initial support that social workers differ in their leadership as compared to non-SW leaders. Findings in both samples indicate that SW leaders had higher ratings of transformational leadership style than non-SW leaders with moderate effect sizes. Given the substantial evidence of the positive impacts of transformational leadership style on effectiveness and outcomes, this is a significant finding pointing to the contribution of SW leaders in HSOs (Dinh et al., 2014). This leadership style has also been associated with improved organizational climate, culture, and commitment (Aarons et al. 2011) and knowledge of evidence-based practices (Powell et al. 2017). Similarly, a study of SW leaders in health care found significant accomplishments, including a sense of optimism and creativity in how they support staff in a changing health care environment (Mizrahi & Berger, 2001). This finding may stem from SW competencies in engagement with individuals, groups, and organizations as well as how to apply a person-in-environment perspective that was developed through the integration of field and classroom learning experiences (CSWE, 2015).

In addition, findings indicated that SW leaders and their staff assessed their environments as being more reflective of recovery-oriented values than in non-SW led HSOs. In the context of community mental health, service user empowerment and the fundamental human rights of people diagnosed with a serious mental illness are core components of recovery-oriented practice, which has been both a U.S. policy and ethical imperative (Atterbury 2011). However, recovery-oriented reform has met significant challenges in implementation (Davidson et al., 2009). Leadership has been identified as a critical determinant of successful recovery-oriented practice implementation and findings here suggest that SW leaders may be making significant strides in overcoming implementation barriers (Piat & Lal, 2012). As a values-based profession, social workers are committed to ethical standards that are aligned with recovery-oriented practice (e.g., self-determination and competency in advancing human rights), which may contribute to their ability to foster a work environment and translate these priorities into organizational practice.

In addition, leaders and staff reported significantly less stress and higher openness of communication between staff and management. Stress and communication are key components of improved climates for learning and change (Aarons et al., 2011; Proctor et al. 2007). As such, SW leaders in this sample were fostering characteristics of learning organizations that are important for high quality services. These SW leaders may attend to the critical role and power of relational processes, which has been associated with stress

reduction and improvement of interpersonal communication with staff (Mor Barak et al., 2009). These competencies, combined with practice experience in engaging individuals in treatment among the majority of social workers, may provide SW leaders with the necessary ability and credibility to engage and inspire their direct practice workforce (CSWE, 2018). In addition, SW leaders may promote the value of the process of service delivery (e.g., *how* services are provided) and the idea that, for many people served, engagement with providers can be as valuable as achieving goals, which are often impeded by larger structural barriers. This has been identified as critical for HSOs to best serve people and communities in need (Heinrich 2002).

These findings must be understood within the context of the study's strengths and limitations. A strength of this study is the provision of multiple perspectives, including both leaders' self-assessments and staff ratings within the HSOs. However, the parent study trial sampling strategy potentially omitted relevant leaders that could have skewed the ratios of SW leaders and precluded examination of each leader individually. In addition, the perceptions of the transformational leadership style are exploratory in the context of potential limitations. Staff participants rated the leadership as a group rather than each leader individually, which presented potential threats to validity. However, this study contributes to the dearth of research on the unique contributions of SW leaders and presents the first findings that compare organizational factors and leadership between SW and non-SW leaders from multiple perspectives of staff and leaders. Taken together, the findings across multiple perspectives and indicators point to the clear potential for SW leaders' critical contributions to HSO leadership and the critical need for more research to further unpack the differential behavior, characteristics, and potential mechanisms of the influence of SW leaders as compared to leaders without grounding in SW ethics, values, and ecological systems theoretical orientation. Future multilevel research could examine relationships among SW leadership, key organizational inner-setting factors (e.g., culture, structural characteristics, networks & communications, tension for change, compatibility, relative priority, learning climate, readiness for implementation, goals & feedback, available resources, access to knowledge and information) as well as outer setting factors (e.g., susceptibility to peer pressure, cosmopolitanism, external policy & incentives) (Damschroder et al., 2009). These findings indicate the utility and importance of future studies to further our understanding of these complex relationships and examine hypothesized mechanisms of SW leadership from multiple perspectives will strengthen the case for the contributions of SW leaders, the educational needs of future SW leaders, and the broader organizational literature.

Conclusions

This study provides a starting point for building an empirical base for SW leadership of organizations that practice SW and the high potential of future research to replicate and expand our understanding of social work leadership and its contributions. SW competencies in engagement with individuals, groups, communities, and policy advocacy, demonstrating ethical professionalism, intervention, and evaluation are all essential aspects of HSO management (CSWE, 2015). This has implications for the candidates and the qualities board members and hiring committees consider critical for effective leadership of HSOs. While

SW has grappled with how to maintain true to its values and training while succeeding in an increasingly corporate environment, demonstrating the effectiveness of SW leaders empirically may make that balancing act less necessary – in that social workers can argue for their worth on their own terms. In addition, in a policy environment prioritizing the delivery of evidence-based practices, SW lead organizations may be more prepared to integrate efficacious interventions into routine mental health care. Within schools of SW, students do need more opportunities for advanced management and supervision-related course content, but it also may be true that SW educators can demonstrate the utility of applying the core SW competencies in the leadership context. Future studies need to build on these exploratory findings and further demonstrate the impact of SW leaders in organizations and communities.

References

- Adams DR (2018). Social Work's Role in Collaborative Community–Academic Partnerships: How Our Past Informs Our Future. *Social work*, 64(1), 19–28.
- Aarons GA (2006). Transformational and transactional leadership: association with attitudes toward evidence-based practice. *Psychiatric Services*, 57: 1162–1169. [PubMed: 16870968]
- Aarons GA & Sommerfeld DA (2012). Leadership, innovation climate, and attitudes toward evidence-based practice during a statewide implementation. *Journal of American Academy of Child and Adolescent Psychiatry*, 51 (4): 423–431.
- Aarons GA, Sommerfeld DA & Willging CE (2011). The soft underbelly of system change: The role of leadership and organizational climate in turnover during statewide behavioral health reform. *Psychological Services*, 8(4): 269–281. [PubMed: 22229021]
- Aarons GA, Ehrhart MG, Farahnak LR, Sklar M, & Horowitz J. (2017). Discrepancies in leader and follower ratings of transformational leadership: Relationship with organizational culture in mental health. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(4), 480–491. [PubMed: 26164567]
- Abramovitz M. (2005). The largely untold story of welfare reform and the human services. *Social Work*, 50(2): 175–86. [PubMed: 15853194]
- Atterbury K. (2011). Preserving the person: The ethical imperative of recovery-oriented practices. *American Journal of Orthopsychiatry*, 84(2): 182–189.
- Authors, 2015
- Authors, 2017
- Bass BM, & Avolio BJ (1990). Multifactor leadership questionnaire. Consulting Psychologist Press, Palo Alto, CA.
- Bliss DL, Pecukonis E. & Snyder-Vogel M. (2014). Principled leadership development model for aspiring social work managers and administrators: Development and application. *Human Service Organizations Management, Leadership & Governance*, 38 (1): 5–15. 10.1080/03643107.2013.853008.
- Brilliant EL (1986). Social work leadership: A missing ingredient? *Social Work*, 31(5): 325–31.
- Broome KM, Knight DK, Edwards JR, & Flynn PM (2009). Leadership, burnout, and job satisfaction in outpatient drug-free treatment programs. *Journal of Substance Abuse Treatment*, 37(2), 160–170. doi: 10.1016/j.jsat.2008.12.002 [PubMed: 19339143]
- Bugg-Levine A. & Ali, F. (2016). Grantmaking should be grounded in real costs. *Stanford Social Innovation Review*. https://ssir.org/up_for_debate/pay_what_it_takes_philanthropy/ali_bugg_levine (accessed January 9, 2018).
- Corrigan PW & Garman AN. (1999). Transformational and transactional leadership skills for mental health teams. *Community Mental Health Journal*, 35(4): 301–312. [PubMed: 10452698]
- Corrigan PW Diwan S. Campion J. & Rashid F. 2002 Transformational leadership and the mental health team. *Administration and Policy in Mental Health*, 30(2): 97–108. [PubMed: 12680615]

- Council on Social Work Education. (2018). 2017 annual survey of social work programs. Alexandria, VA: Author.
- Council on Social Work Education. (2015). Educational policy and accreditation standards for baccalaureate and master's social work programs. (Retrieved on January 10, 2018).
- Davidson L, O'Connell MJ, Tondora J, Styron T, & Kangas K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57(5), 640–645. [PubMed: 16675756]
- Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, & Lowery JC (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*, 4(1), 50. [PubMed: 19664226]
- Deegan PE (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11 (4): 11–19.
- Deegan PE (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19 (3): 91–97.
- Dinh JE, Lord RG, Gardner WL, Meuser JD, Liden RC, & Hu J. (2014). Leadership theory and research in the new millennium: Current theoretical trends and changing perspectives. *Leadership Quarterly*, 25 (1): 36–62.
- Glisson C, Landsverk J, Schoenwald S, Kelleher K, Hoagwood KE, Mayberg S. & Green P. (2008). Assessing the organizational social context (OSC) of mental health services: Implications for research and practice. *Administration and Policy in Mental Health*, 35: 98–113. [PubMed: 18085434]
- Goldkind L, & Pardasani M. (2013). Social workers as senior executives : Does academic training dictate leadership style? *Advances in Social Work*, 14 (2): 573–93.
- Hager MA, Pollak T, Wing K. & Rooney PM (2004). Getting what we pay for: Low overhead limits nonprofit effectiveness. Nonprofit Overhead Cost Project. <https://www.giarts.org/sites/default/files/Getting-What-We-Pay-For.pdf> (accessed January 9, 2018).
- Hasenfeld Y. & Garrow E. (2012). Nonprofit Human Service Organizations, Social Rights, and Advocacy in a Neoliberal Welfare State. *Social Service Review*, 86 (2): 295–322.
- Heinrich C. (2002). Outcomes-based performance management in the public sector: Implications for government accountability and effectiveness. *Public Administration Review*, 62(6): 712–725.
- Jung DI, Chow C. & Wu A. (2003). The role of transformational leadership in enhancing organizational innovation: Hypotheses and some preliminary findings. *The Leadership Quarterly*, 14: 525–544.
- Kearney E. & Gebert D. (2009). Managing diversity and enhancing team outcomes: The promise of transformational leadership. *Journal of Applied Psychology*, 94(1): 77–89. [PubMed: 19186897]
- Kerman B, Freundlich M, Lee JM, & Brenner E. (2012). Learning while doing in the human services: Becoming a learning organization through organizational change. *Administration in Social Work*, 36 (3): 234–257.
- Klein KJ & Sorra JS (1996). The Challenge of Innovation Implementation. *Academy of Management Review*, 21, 1055–1080.
- Lawler J. (2007). Leadership in social work: A case of caveat emptor? *British Journal of Social Work*, 37: 123–141.
- Lehman W, Greener EK, & Simpson DD (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, 22 (4): 197–209. [PubMed: 12072164]
- Liaw Y, Chi N, & Chuang A. (2010). Examining mechanisms linking transformational leadership, employee customer orientation, and service performance: The mediating roles of perceived supervisor and coworker Support. *Journal of Business Psychology*, 25: 477–492.
- Loon M, Yet M, Lee T, & Tam C. (2012). Transformational leadership and job-related learning. *Management Research Review*, 35 (3/4): 192–205.
- Mayer DM, Kuenzi M, Greenbaum R, Bardes M, & Salvador R. (2009). How low does ethical leadership flow? Test of a trickle-down model. *Organizational Behavior and Human Decision Processes*, 108: 1–13.

- Mizrahi T, & Berger CS (2001). Effect of a changing health care environment on social work leaders: Obstacles and opportunities in hospital social work. *Social Work*, 46(2), 170–182. [PubMed: 11329646]
- Mor Barak ME, Travis DJ, Pyun H, & Xie B. (2009). The impact of supervision on worker outcomes: A meta-analysis. *Social Service Review*, 83(1), 4–32. 10.1086/599028
- Mosley JE & Smith S. (2018). Human service agencies and the question of impact: Lessons for theory, policy, and practice. *Human Service Organizations Management, Leadership and Governance* 42 (2): 113–22. 10.1080/23303131.2018.1425953.
- O’Connell M, Tondora J, Croog G, Evans A, & Davidson L. (2005). From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, 28 (4): 378–386. [PubMed: 15895922]
- Perlmutter F. (2006). Ensuring social work administration. *Administration in Social Work*, 30 (2): 3–10.
- Peters SC (2017). Social work leadership: An analysis of historical and contemporary challenges. *Human Service Organizations Management, Leadership and Governance* 41 (4): 336–45. 10.1080/23303131.2017.1302375.
- Piat M, & Lal S. (2012). Service providers’ experiences and perspectives on recovery-oriented mental health system reform. *Psychiatric Rehabilitation Journal*, 35(4), 289–296. 10.2975/35.4.2012.289.296 [PubMed: 22491368]
- Powell BJ, Mandell DS, Hadley TR, ... Beidas R. (2017). Are general and strategic measures of organizational context and leadership associated with knowledge and attitudes toward evidence-based practices in public behavioral health settings? A cross-sectional observational study. *Implementation Science*, 12 (1): 64–74. [PubMed: 28499401]
- Department of Health and Human Services (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Publication Number SMA-03–3832. Rockville, MD: President’s New Freedom Commission on Mental Health.
- Proctor E, Knudsen KJ, Fedoravicius N, Hovmand P, Rosen A, & Perron B. (2007). Implementation of evidence-based practice in community behavioral health: Agency director perspectives. *Administration and Policy in Mental Health*, 34: 479–488. [PubMed: 17636378]
- Rank MG & Hutchison WH (2000). An analysis of leadership within the social work profession. *Journal of Social Work Education*, 36 (3): 487–502.
- Robichau RW & Wang L. (2018). Marketization strategies and the influence of business on the management of child welfare agencies. *Human Service Organizations Management, Leadership and Governance* 42(2): 146–65.
- Rothman J. (2013). Education for macro intervention: A survey of problems and prospects. Association for Community Organization and Social Administration Report. <https://www.acosa.org/joomla/pdf/RothmanReportRevisedJune2013.pdf> (accessed January 10, 2018).
- Schaubroeck JM, Hannah ST, Avolio BJ, ...Peng AC. (2012). Embedding ethical leadership within and across organization levels. *Academy of Management Journal*, 55(5): 1053–78.
- Sullivan WP (2016). Leadership in social work: Where are we? *Journal of Social Work Education*, 52(September): S51–61.
- Weiner B. (2009). A theory of organizational readiness for change. *Implementation Science*, 4(67): 1–9. [PubMed: 19123945]
- Woltmann EM, Whitley R, McHugo GJ, Brunette M. Torrey WC, Coots L. Lynde D. & Drake RE(2008). The role of staff turnover in the implementation of evidence-based practices in mental health care. *Psychiatric Services*, 59(7): 732–737. [PubMed: 18586989]

Practice Points

- Leaders with social work training are associated with transformational leadership style, which has a robust evidence-base supporting its impact on organizational effectiveness and success.
- Leaders with social work training are also associated with organizational factors (e.g., stress and cohesion) that have been associated with the effective translation of evidence-based practices.
- This study compares social work to non-social work leaders and points to the value of social work training for leading organizations that practice social work.

Table 1.

Sample Demographics

	Leaders (N=49)				Staff (N=224)			
	N	%	Mean	SD	N	%	Mean	SD
Discipline								
Social Work	12	24.5%			92	41.1%		
Non-Social Work	37	75.5%			132	58.9%		
Gender								
Male	18	36.7%			60	26.8%		
Female	31	63.3%			163	72.8%		
Race								
Other	3	6.1%			16	7.1%		
African American	2	4.1%			64	28.6%		
White	44	89.8%			136	60.7%		
Hispanic	1	2.0%			10	4.5%		
Education								
High School	3	6.1%			26	11.6%		
College	10	20.4%			82	36.6%		
Graduate	36	73.5%			117	52.2%		
Age in Years			53.10	10.48			40.26	11.51
Years in MH			24.08	10.02			11.64	8.67
Years at Agency			13.20	9.51			6.27	6.02
Caseload			-	-			28.50	54.35

MH=Mental Health Services

Table 2.

Mixed-Effects Regression Analyses of Leaders' Self-Ratings of Leadership and Organizational Context

Model Parameter	<u>Stress</u>			<u>Cohesion</u>			<u>Communication</u>			<u>Transformational Leadership</u>			<u>Recovery-Oriented Context</u>		
	<i>B</i>	<i>SE</i>	<i>d</i>	<i>B</i>	<i>SE</i>	<i>d</i>	<i>B</i>	<i>SE</i>	<i>d</i>	<i>b</i>	<i>SE</i>	<i>d</i>	<i>b</i>	<i>SE</i>	<i>d</i>
Fixed Effects															
Intercept	32.92**	2.34	.6 2	36.64**	1.58	.0 3	33.70**	2.19	.6 7	3.82**	0.23	.7 9	4.14**	0.15	.9 5
SW Disc.	-4.41*	1.93		-0.15	1.23		3.86*	1.85		0.48*	0.19		0.39*	0.13	
Tenure	-0.02	0.10		-0.10	0.06		0.04	0.09		0.01	0.01		0.01	0.01	
Years in MH	-0.08	0.09		0.13*	0.06		0.03	0.09		0.00	0.01		0.00	0.01	
Variance Components															
Within Leaders	28.40	6.55		10.47	2.42		27.86	7.11		0.32	0.06		0.14	0.03	
Organizations	3.91	5.49		4.22	3.52		1.34	5.52		0.00	0.00		0.00	0.00	

Note. SW Disc. = Social Work Discipline; MH = Mental Health;

**
p<.001*
p<.05

Table 3.

Mixed-Effects Regression Analyses of Staff Perceptions of Leadership and Organizational Context

Parameter	<u>Stress</u>			<u>Cohesion</u>			<u>Communication</u>			<u>Transformational Leadership</u>			<u>Recovery Oriented Context</u>		
	<i>B</i>	<i>SE</i>	<i>d</i>	<i>b</i>	<i>SE</i>	<i>d</i>	<i>B</i>	<i>SE</i>	<i>d</i>	<i>B</i>	<i>SE</i>	<i>d</i>	<i>b</i>	<i>SE</i>	<i>d</i>
Fixed Effects															
Intercept	33.95**	1.70	.62	35.36**	1.14	.48	33.73**	1.67	.60	3.41**	0.18	.66	4.07**	0.10	.64
SW led	-6.16*	2.63		3.94*	1.55		5.45*	2.66		0.66*	0.28		0.38*	0.14	
Caseload	0.00	0.01		0.01	0.01		0.00	0.01		0.00	0.00		0.00	0.00	
Tenure	-0.11	0.14		0.15	0.12		0.15	0.12		0.00	0.01		0.01	0.01	
Yrs in MH	0.10	0.09		-0.05	0.08		-0.13	0.08		0.00	0.01		-0.01	0.01	
Variance Components															
Providers	64.01	8.03		50.60	6.30		52.97	6.66		0.85	0.11		0.29	0.04	
Organizations	8.68	6.70		0.73	2.68		9.88	7.09		0.12	0.08		0.02	0.02	
Teams	18.24	8.07		13.65	6.26		15.84	6.90		0.00	0.07		0.02	0.02	

Note. SW Disc. = Social Work Discipline; MH = Mental Health; Yrs = Years;

**
p<.001*
p<.05