Residential Treatment for Children & Youth

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wrtc20

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To cite this article: Linda Vaskinn , Anneli Mellblom , Pamela M. Waaler , Oda Skagseth , Cato Bjørkli & John Kjøbli (2020): Implementation in Residential Youth Care: Providers Perspectives on Effective Leadership Behavior, Residential Treatment for Children & Youth, DOI: 10.1080/0886571X.2020.1774464

To link to this article: https://doi.org/10.1080/0886571X.2020.1774464

Published online: 12 Jun 2020.

RESIDENTIAL TREATMENT FOR CHILDREN & YOUTH
https://doi.org/10.1080/0886571X.2020.1774464

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Implementation in Residential Youth Care: Providers Perspectives on Effective Leadership Behavior

Linda Vaskinn[a], Anneli Mellblom[a], Pamela M. Waaler[a], Oda Skagseth[b], Cato Bjørkli[c], and John Kjøbli[a]

[a]Research Group for Prevention and Treatment, Center for Child and Adolescent Mental Health, Eastern and Southern Norway, Oslo, Norway; [b]Section for Service Support and Training Courses, Center for Child and Adolescent Mental Health, Eastern and Southern Norway, Oslo, Norway; [c]Department of Psychology, University of Oslo, Oslo, Norway

ABSTRACT

Considering the high prevalence of mental health challenges among the residential youth care (RYC) population, it is imperative that research-informed interventions are implemented in this setting. However, little research is available regarding RYC implementation practices. Leadership is a vital influencer of implementation success. Therefore, the aim of this study was to further the knowledge base concerning effective implementation in RYC by investigating implementation leadership behavior. Utilizing qualitative methods, RYC providers were asked about effective implementation leadership behaviors, with an emphasis on similarities and variations in behavior enacted by different leadership levels within the organization. The results indicate that relations-oriented and task-oriented leadership behavior are more important than change-oriented implementation leadership behavior among the providers interviewed. The reported behaviors differed in terms of leadership level. The top executive leadership was more involved in task-oriented leadership behavior (i.e., monitoring activities, resource procurement), while the facility management was more involved with relations-oriented behaviors (i.e., providing support, facilitating cooperation). Finally, the results are discussed in light of RYC characteristics and implementation stages.

KEYWORDS

Residential youth care; implementation; leadership; leadership behavior; child-welfare services

Introduction

Youth living in residential care settings have been removed from their primary caregivers, and many have undergone several prior out-of-home placements. Young individuals placed in out-of-home care often have a disrupted past with incidence of abuse, neglect, and exposure to violence (Briggs et al., 2012; Hussey & Guo, 2002). In one study, researchers observed that 76% of 541 adolescents living in residential youth care (RYC), met diagnostic criteria for one or more mental health disorders (Jozefiak et al., 2016). Youth who enter RYC have higher rates of emotional and behavioral problems, substance abuse,

CONTACT Linda Vaskinn linda.vaskinn@r-bup.no Department of Prevention and Treatment, Centre for Child and Adolescent Mental Health, Oslo, Norway

and criminal activity, as well as low quality of life compared to youth in general and youth involved in other mental health services (Jozefiak et al., 2016; Leloux-Opmeer et al., 2016). These challenges significantly impact short and long-term outcomes for youth placed in out-of-home care. A crucial step in improving the outcomes for this vulnerable group is to implement effective treatment models and interventions targeting mental health and behavior problems. Several implementation frameworks emphasize leadership as an important component in intervention implementation and sustainment for children and youth (see Albers et al., 2017). In this qualitative study, the perspectives of RYC professionals regarding effective leadership behavior in the implementation of an evidence-informed cognitive behavioral intervention, was investigated.

Implementation in RYC

Child welfare system professionals are increasingly encouraged to utilize interventions and practices that promote well-being and reduce mental health and behavioral challenges (Barth, 2008). To address the complex needs of youth in RYC, an effort to disseminate and implement high quality services meeting those needs is essential. In recent decades, the research foci have been primarily on family and community-based interventions, which may have slowed and even hindered the development of effective treatment options for residential care (Whittaker et al., 2016). Therefore, it is pertinent to ensure that the best RYC practice is delivered. Due to the growing knowledge of the severity of RYC youth mental health problems, there is an urgency to implement effective strategies and interventions to care for these youth in an appropriate and competent manner. In addition, because high costs are associated with residential placements, residential services are encouraged to demonstrate the efficiency and effectiveness of the interventions they provide (Harrington et al., 2014). These reasons combined press the notion that RYCs must adopt and implement interventions that increase their effectiveness and benefit the mental health of youth placed in residential care.

Although professionals are encouraged to deliver high quality and evidence-informed treatments, little information on how to adopt and implement such interventions exists (James et al., 2017). In order to ensure effective and long-lasting RYC practice change, the processes involved in adoption, implementation, and sustainment of such changes needs to be investigated. As noted by James (2015), "while the emergent field of Implementation Science has been flourishing, there are no implementation models that have been tested for residential care" (p. 152). Still, various implementation frameworks have been applied in children, youth, and family services (Albers et al., 2017; Hanson et al., 2016) that highlight relevant factors and processes in RYC implementation efforts.

A few studies have addressed implementation in RYC settings (e.g., Greenwald et al., 2012; Little et al., 2010; Lovelle, 2005; Sunseri, 2004). Several studies point to staff turnover and leadership, as well as budgetary issues, as important barriers to implementation in RYC (see James, Alemi, & Zepeda, et 2013 for review). In one study where Aggression Replacement Training (ART) was implemented at a treatment center for youth with behavioral problems, the lack of continuity in group leadership due to shift work was highlighted as a specific implementation barrier (Coleman et al., 1992). These issues are a continuous challenge in residential settings, and implementation strategies countering these issues should be developed and tested in RYC. In a systematic review, Bryson et al. (2017) reviewed effective strategies for implementation of trauma-informed care in RYC. The results yielded five factors essential for implementation: senior leadership commitment, sufficient staff support, amplifying the voices of patients and their families, aligning policy and programming with trauma-informed principles, and using data to help motivate change (Bryson et al., 2017). In addition, across the initiatives included in the review, staff understood that implementation was a priority according to the way their leaders behaved.

Implementation Leadership

Many scholars emphasize the role of leadership within the organizational context as an important influencer in the implementation process (Aarons, Ehrhart, Farahnak et al., 2014; Aarons et al., 2016; Fixsen et al., 2009; Gifford et al., 2007). Implementation generates major changes in practice, structure, and workforce. Therefore, managing change is a critical and challenging responsibility for leaders as it involves guiding, encouraging, and facilitating the collective efforts of subordinates to adapt and persevere through an often unstable and stressful period (Yukl, 2013). Leadership behaviors and strategies are important inner-organizational factors that may profoundly impact the success of implementation efforts. A recent review highlighted the importance of leadership commitment to change in the implementation of trauma-informed care in residential and inpatient psychiatric treatment settings (Bryson et al., 2017). By demonstrating commitment to change, leaders can address resistance to change and negative attitudes toward new practice. Leaders can positively or negatively influence the capacity to foster change and innovation, and therefore, are essential in facilitating a positive climate for innovation during implementation processes (e.g., Damanpour & Schneider, 2006).

Transformational leadership is likely to be an effective leadership style in unstable and uncertain processes (i.e., implementation) (Bass & Riggio, 2006). Transformational leadership involves leaders that motivate, display individual consideration, and stimulate their subordinates intellectually to achieve the

goals of the organization (Bass, 1999). Research has shown the importance of transformational leadership in the development of innovation and positive attitudes toward Evidence-Based Practice (EBP) in large-scale implementation efforts (Aarons & Sommerfeld, 2012). Moreover, Aarons (2006) observed associations between transformational leadership and more positive clinician attitudes toward adopting EBPs.

Although leadership plays a critical role in implementation, research efforts have not highlighted the specific behaviors that leaders may enact to deliberately influence subordinates to support the larger aim of successful implementation. Leaders at the organizational level are often responsible for the decisions regarding implementation of a new practice model and how to execute these changes.

The Ottawa Model of Implementation

Efforts have been made to further the knowledge base on effective leadership during implementation processes. The Ottawa Model of Implementation Leadership (O-MILe) is a theoretical model based on leadership theory and empirical research. It was developed in a qualitative grounded theory study where leadership for successful implementation involved the following: 1) facilitating staff to achieve shared goals, 2) creating a positive climate, and 3) influencing organizational structures and processes (Gifford et al., 2006). These results combined with behavioral leadership theories and planned behavior theories resulted in a refined model with three meta-categories for effective leadership in implementation processes:1) change-oriented, 2) relations-oriented, and 3) task-oriented leadership behavior.

Change-oriented behaviors revolve around integrating a vision, demonstrating commitment to change, building coalitions to support change, and creating a sense of need. Change-oriented behavior intends to increase innovation, collective learning, and adaption to the external environment (Ekvall & Arvonen, 1991; Yukl, 2012). Relations-oriented behavior aims to increase the quality of human resources and relations, and includes supporting, developing skills, and facilitating cooperation and commitment to a unit and organization. Task-oriented leadership behaviors include planning, clarifying roles, monitoring operations and performance, and efficiently using resources in order to execute tasks in an efficient and stable manner (Yukl, 2013). Hence, the O-MILe highlights specific implementation leadership behaviors and corresponds for instance, with the Implementation Leadership Scale (Aarons, Ehrhart, Farahnak et al., 2014), an empirically validated scale that measures unit-level leadership for EBP implementation (Gifford et al., 2017).

Effective implementation and sustainment involve different leadership behaviors from leaders at different levels. For instance, middle-managers

and unit managers may exert more influence on care providers than top leadership since they function as a tie between upper management and regular employees (Engle et al., 2017; Zjadewicz et al., 2016). In one study, nurse unit managers were significantly related to unit implementation climates for EBPs through their leadership behavior (Shuman et al., 2018). However, additional research regarding the evaluation and identification of specific leadership behaviors enacted by leaders at different levels should be emphasized in the empirical literature. It is plausible that effective middle management behaviors differ from effective top leadership behaviors. Thus, different leadership levels may have both common and unique behaviors required for successful implementation (Aarons, et al., 2014).

Study Aims

The knowledge base for effective implementation is greater for community and clinic settings compared to RYC. However, the need for the implementation of effective treatment models in RYC is just as important. Residential youth care is a particularly challenging setting to implement and sustain new treatment models as they are often characterized by high turnover rates and reliance on shift staff that lack appropriate training (Colton & Roberts, 2007). Another key challenge is that scant literature exists on the perspectives of RYC professionals regarding EBP implementation. Investigating and understanding factors that facilitate or inhibit implementation is crucial as a means to reduce the science to service gap in residential care.

The current study aims to: a) investigate specific leadership behaviors that are important to successful program adoption and implementation in residential care settings (i.e. change-oriented leadership behavior, relations-oriented leadership behavior, and task-oriented leadership behavior), and b) examine whether residential care providers prefer different types of leadership behaviors dependent on the leader's management position (i.e., facility management vs regional leaders).

Method

Context

This study utilizes a qualitative approach with interview data from providers at eight different RYC facilities. These facilities constitute out-of-home care organized under the state-run child welfare services in Norway, and placements are made under the provisions of the Child Welfare Act. The top executive leadership is situated at the regional level and is responsible for the overall strategy and performance of the region's facilities, while each facility has a facility management which is responsible for the day-to-day operations.

The top executives provide guidelines to the facility management on how to conduct their work with youth, performance level, and documentation demands. The facilities vary in their capacity, ranging from serving four to ten youth. The average stay at these facilities is nine months.

Each facility has implemented a Milieu-Based Cognitive Behavior Therapy (MB-CBT) model and developed a systematic screening for mental health symptoms and trauma in order to effectively target the facility's vulnerable youth and their mental health concerns (i.e., depression, trauma, aggression). Cognitive Behavioral Therapy (CBT) is an effective treatment approach for child and adolescent emotional problems and is considered a research-informed intervention (Butler et al., 2006; Chambless & Ollendick, 2001; Compton et al., 2004; James et al., 2013). The authors define a research-informed intervention as an intervention based on methods proven efficient in research efforts, however, not necessarily complying to the rigorous, integrative process associated with evidence-based interventions (APA Presidential Task Force on Evidence-Based Pratice, 2006).

The MB-CBT intervention uses individual sessions and group activities in the milieu to understand and change the triggering and sustaining factors involved in the current problem areas the youth and their families experience (Matre & Jensen, 2012). In addition, RYC professionals systematically screen youth for mental health issues and trauma in order to identify problem areas when the youth are first admitted to the facility. This screening enables therapists to work purposefully with these concerns during the youth's stay. Continuous screening during the stay is conducted for progress monitoring and treatment approach adjustments.

Sample

A diverse sample of providers who differed in age, gender, seniority, and education level was desired. However, due to a limited sampling pool, experience with the model was given more consideration than the attributes listed above. Therefore, the invited providers had to have worked at least one year with the new practice model and/or completed training and received certification in milieu-based cognitive behavior therapy in order to participate.

An implementation coordinator asked the facility management to provide lists of providers eligible for participation, keeping in mind that a heterogenous group in terms of age, gender, seniority, and education level was desirable. The coordinator randomly chose two or three providers from each facility and emailed them information sheets. For those interested in participating, an interview was scheduled, and the interview guide was forwarded. If neither of the invited providers were willing to participate, subsequent e-mails were sent to additional eligible providers.

Data Collection

The interviews were conducted over a four-week period by the first author (LV). The interview guide was designed as a semi-structured interview based on the SWOT-paradigm where the informant is encouraged to reflect on strengths, weaknesses, opportunities, and threats (Dyson, 2004; Hoff et al., 2009). The intention with the interview guide was to allow the informants to elaborate and focus on issues important to them concerning MB-CBT implementation and sustainability along three dimensions: positive-negative, past-future, and external-internal. The interview guide was designed to elucidate the providers' experiences with the implementation process. After the open SWOT-based questions were presented, emphasis was given to leadership behavior both at the facility and at the regional level, which were the questions relevant for this study. The questions concerned with implementation leadership include: "What are the strengths with the new practice?", "How does the facility management facilitate the implementation?", "How does your closest leader facilitate the implementation?", and "How does the regional leadership facilitate the implementation?" Thus, the informants provided subjective perspectives on facilitative implementation leadership behavior. Interview duration was approximately 45 minutes.

Ethical Considerations

The project was approved by the Norwegian Center for Research Data (NSD). Participants were sent information sheets prior to the interviews and written consent forms were obtained from each participant.

Data Management and Data Analysis

The interviews were digitally recorded and transcribed verbatim. After transcription, the empirical information in the interviews was unitized. Unitizing refers to the identification of segments of relevant information in accordance with the aim of the study (Campbell et al., 2013; Krippendorrff et al., 2016). A segment was defined as the smallest meaningful unit that expressed a coherent and consistent perspective that was relevant for implementation. Such segments vary in size and could either be a part of a sentence, a whole sentence, or even a paragraph. The segments were pulled out of the original transcripts; thus, the coders did not know to which question the segment arose from, or which informant provided the segment. However, in the unitizing process a special emphasis was given to include as much information in the segment so that the narrative or meaning was not lost.

Template analysis was used for the qualitative analysis of the extracted units. Template analysis is a thematic approach that allows for a priori

themes where the coding structure is developed based on interests and initial interaction with the data and then applied to the full data set (Brooks et al., 2015; King, 2004). The template approach is flexible in terms of allowing the a priori themes to be influenced by theoretical concepts or perspectives that informed the aims of the study. In this study, the leadership behaviors derived from the O-MILe served as the initial themes, and concurrent with the template approach, these were tentative and open for revisions during the analysis.

Data Analysis

The analysis conducted in the current study follows the techniques and recommendations for executing a template analysis provided by Brooks with colleagues and King (Brooks et al., 2015; King, 2004), p. 1) define a priori themes (i.e., O-MILe meta-categories), 2) extract analysis units, 3) code on a relevant theme(s), modify a preliminary theme(s), or construct new theme-(s), 4) produce the initial template, 5) develop and modify the template, and (6) interpret the final template. Each time the template was revised, the preceding units were reanalyzed according to the modified template. In this study, the a priori themes derived from the O-MILe model were applicable for the data material and remained so throughout the analytic process. However, the specific behavior categories were developed and revised during the data analysis. There is no formal norm for determining the amount of information needed to comprise a theme. Still, it is important to avoid generating too narrow thematic structures and becoming too concerned with fine distinctions at the lower levels in the coding hierarchy. Doing so is not useful during the organizing and interpretation of the data (King, 2004).

The number of units and participants emphasizing a particular behavior will be presented numerically and textually. The use of numbers in qualitative research is controversial. However, there are advantages for applying numbers in qualitative results. By displaying information numerically, the patterns and diversity of perceptions will appear more transparent (Maxwell, 2010). Also, the inclusion of numbers allows the reader to assess whether the themes identified, are in fact typical or characteristic for the group of individuals as a whole.

Integrity Measures

Measures were taken in order to increase the rigor of the research process. The first author (LV) conducted the interviews and was responsible for the coding process. A second coder (PW) reviewed and coded 25% of the units to detect potential coding bias. A small number of theme labels were modified (i.e. behavior categories) based on discussions between both coders during the quality assurance process, however, this did not affect the units comprising the theme.

An iterative review process was undertaken during the analysis to ensure that the richness and integrity of the data was maintained. This review process was also used as a means to ensure the consistency (i.e., trustworthiness) of the study and its results (Gupa, 1981). This study strived to create truthful representation (i.e., truth value) by presenting accurate and credible quotes from the participants themselves (Kefting, 1991). The transferability of the study is emphasized by the utilization of purposeful sampling in order to obtain a representative sample. Information about the sampling procedure and the sample itself is presented above.

The first author kept a reflexive journal, starting from the interview phase and until the manuscript production in order to better evaluate the potential influence of researcher's background, expectations, and motivations on the data collection, analysis and interpretation of the results.

The guidelines for authors and reviewers of qualitative studies provided by Malterud (2001) have guided the study and manuscript.

Results

Participants

The sample consisted of 16 RYC professionals, ten (62.5%) females, and six (37.5%) males between 31 and 50 years old. The gender balance is representative for the population of group care providers in the specific region. Most of the participants had a three-year education in social work or in child welfare services. There was a wide range in seniority within the facilities in this sample; some of the participants had recently started the certification process and were quite new to the organization, whereas others had been working at the facility for over 10 years. The facilities are generally characterized by high turnover rates. However, some of the included facilities have had a stable workforce for a number of years. The sample did not consist of middle-managers, facility leaders, or regional leaders, only providers working directly with the youth.

Main Findings

Three primary themes related to the providers' perspectives on important implementation leadership behaviors were apparent in the study: change-oriented behavior, relations-oriented behavior, and task-oriented behavior (see Table 1 for examples and supporting quotes). The three primary themes all corresponded with the a priori themes derived from the O-MILe. All participants mentioned different types of important leadership behaviors, however, task-oriented leadership behavior (42.7 %) was the largest theme reported in terms of corresponding units. Change-oriented leadership behavior was the least mentioned behavior category (19.3 %), while 32.0% of the

Table 1. Supporting Quotes from Providers' Perspectives on Implementation Leadership Behavior in the O-MILe Template.

Theme	Leadership behaviors	K	% (K)	N	%(N)	Definition	Example
Change-oriented behavior		29	19.3	8	50	Change-oriented behavior involves integrating a vision, demonstrating commitment, building coalitions to support change, and creating a sense of need.	
	Demonstrates commitment to change	11		4		Leadership behavior that directly or indirectly involves demonstrating commitment to the implementation.	"The fact that our unit leader has taken the CBT-training module is good."
	Understand and act on difficulties with change	4		2		Leadership behavior involving reacting and addressing issues regarding the implementation.	"We've tried to reduce the resistance to change and our leader knows this and work continuously to reduce the negative attitudes"
	Reinforce vision and goals for change	14		5		Carries on and reinforces the vision and goals for the implementation over time and through the ups and down of the change process.	"Management exhibits great devotion and it is obvious that this is what we are focusing on and how we are going to work"
Relations-oriented behavior		52	32	16	100	Relations-oriented behaviors involve supporting, developing, and recognizing others, thereby increasing trust, cooperation and commitment amongst members of the organization.	
	Communicate with providers about practice	21		7		Leadership behavior concerning communication with the providers regarding practice and their use of it. It also involves answering questions about the practice and being disposable to the providers.	"My leaders are knowledgeable about CBT, so it's easy to talk to them about it"
	Exhibit support	16		8		Leadership behavior involving exhibiting support to the providers and acknowledging their contributions to the implementation. This relates to both emotional and instrumental support.	"The most important thing in implementing CBT, is having support from my leader here at the facility"
	Facilitate cooperation between providers	15		9		Leadership behavior concerned with promoting cooperation and openness about experiences with the intervention between the providers.	"The leaders set up theme meetings where we discuss CBT"
Task-oriented behavior		64	42.7	15	93.8	Task-oriented behavior includes clarifying roles, monitoring performance and outcomes, and using resources efficiently.	
	Clarify responsibilities	21		7		Leadership behavior that involves making the providers aware of their roles and responsibilities in the implementation and use of the intervention.	"We have treatment meetings where the therapists are expected to prepare something related to CBT"

(*Continued*)

Table 1. (Continued).

Theme	Leadership behaviors	K	% (K)	N	%(N)	Definition	Example
	Monitoring	18		11		Leadership behavior related to monitoring operations and assessing the performance of providers.	"If we have supervision, we have to register it online. We register group supervision, individual supervision, so the regional leaders can keep track"
	Acquire resources	25		14		Leadership behavior concerned with the procurement of resources and distributing them efficiently.	"They have invested money in this, so they educate therapists, educate supervisors, and then it's followed"

Note. K refers to number of units. N refers to number of informants providing statements corresponding to a theme.

units were coded as relations-oriented leadership behavior. In terms of the specific leadership behaviors, all behaviors correspond to those identified in the O-MILe model. However, some of the labels have been deciphered to represent the data in an appropriate manner. In this study, the labels have been altered to merely portray the participants' perspectives, and therefore, the leadership behavior labels may not directly correspond to the labels in the O-MILe model. For instance, the O-MILe includes "support change visibly and symbolically," while the corresponding theme is labeled "exhibit support" in this study.

Change-Oriented Leadership Behavior

Change-oriented behavior involves integrating a vision, demonstrating commitment, building coalitions to support change, and creating a sense of need. Change-oriented leadership behavior was the least mentioned of the primary leadership behavior themes. Half (50%) of the informants mentioned behaviors characterized as change-oriented leadership behavior. Eight informants (50%) provided statements regarding change-oriented behaviors enacted by their facility management, while five informants (31.3%) talked about change-oriented leadership behavior with regards to the top executives in their organization.

Change-oriented leadership behaviors involved leaders reinforcing the visions and goals for change. Participants recurrently reported on the importance of clarity and certainty in leaders' messages and actions. For example, one participant stated " … I think that my leader has been very clear on the fact that this is what we do now." Another said, "they [top executives] are definite and explicit in that this is what we do now and it's a devotion to it … It's a very clear message." The second most mentioned change-oriented behavior was commitment to the change process. There were several leadership behaviors mentioned in the interviews which directly or indirectly involved leaders demonstrating commitment to change. For the most part these accounts involve leaders " … following up what they have put forward" and the continuously endorsing the change.

Relations-Oriented Leadership Behavior

The relations-oriented behaviors that were identified in interview data include: 1) communicate with providers about practice, 2) exhibit support, and 3) facilitate cooperation between providers. Several statements (32%) concerned relations-oriented leadership behavior, and this type of leadership behavior was the only behavior category mentioned by all informants. In general, the leadership level involved with relations-oriented behavior was facility managers or departments managers, as mentioned by 68.8% of the

informants. Four (25%) informants mentioned relations-oriented leadership behavior performed by the top executives. The remaining informants listed relations-oriented leadership behaviors; however, it was not possible to identify the leadership level enacting those behaviors.

Many of the participants emphasized the importance of communication with their leaders regarding the new practice. The informants mentioned that their leaders were available for questions, and it was easy for them to talk to their leaders about the new practice model. For example, one participant said, "my leaders are knowledgeable about CBT, so it's easy to talk to them about it", another said, "I really appreciate that the facility leadership is receptive to recommendations and opinions from us."

Support is an important dimension of relations-oriented leadership behavior. According to the informants, leaders exhibited both instrumental and emotional support. It appears important to the providers that leaders visibly support the providers, for instance, by attending training sessions; one informant stated "they are not just sitting in their offices and saying do this and that, but they are experiencing this with us first-hand, what this is. So, I think that sends positive signals to us, that this is important, not just what they're seeing, but what we do." Some informants mentioned their leader's ability to recognize efforts to change as an important part of support, "they [facility leadership] are good at complimenting and recognizing me and my co-supervisor's work". Another said, "he [leader at the facility] applauds us and appreciates our efforts."

Task-Oriented Leadership Behavior

Task-oriented leadership behavior was the largest primary theme in the material as 42.7% of the leadership-related statements were coded into the task-behavior category and included the following behaviors 1) clarifying roles and responsibilities, 2) monitoring, and 3) acquiring and distributing resources. Fifteen informants (93.8%) discussed the importance of task-oriented leadership behavior. In general, the task-oriented leadership behavior was related to the top executives, whereas 13 (81.3%) of the informants brought up different types of task-oriented behaviors enacted by the leaders at the regional level. In addition, 43.8% mentioned task-oriented behaviors as the most important behavior their facility management executes to support them in the implementation of new practice.

The two most prevalent task-oriented behavior categories were clarifying responsibilities and acquiring resources. Participants' statements concerning leadership behaviors involved in role and responsibility clarification were primarily associated with the top executives. At the time of the interviews, the regional leadership had set some expectations for the providers regarding their intervention performance, "they [top executives] have set

some guidelines for how we should conduct the assessment, a least minimum on what we have to administer," and another, "[top executives] have set explicit expectations … this is what we do now and these tools are the ones we use".

The perception of how leaders procured and distributed resources was regarded as crucial, however, participants discussed the importance of different types of resources. Training activities and supervision are two resources that were highly valued by the providers. For instance, providers mentioned how leaders facilitated training and education to promote competence development both before and during the implementation, "they [facility leaders] send people to take the certification. They are really focused on that. They want everyone to have it, which I appreciate." Another participant mentioned, "the most important the facility leaders do, is to send us on seminars and booster sessions".

Discussion

The aim of this study was to identify essential implementation leadership behaviors in residential care settings reported by residential care professionals. The residential care professionals discussed leadership behaviors that fall into three main categories of O-MILe leadership behavior: change-oriented leadership behavior, relations-oriented leadership behavior, and task-oriented leadership behavior. The three broad leadership behavior categories encompass implementation leadership behavior on different leadership levels.

The two most mentioned behavior categories were task-oriented (i.e., procure resources) and relations-oriented leadership behavior (i.e., encouragement, communication about practice, support); the facility management was most involved in the former, and the top executives in the latter. Only half of the informants discussed change-oriented leadership behavior.

Change-Oriented Leadership Behavior

Contrary to what one might expect during major practice change, only half of the informants discussed change-oriented behaviors. The literature on change-oriented behaviors and change-specific leadership has been sparse regarding whether change behavior is likely to be enacted by certain types or levels of leadership. In this study, eight (50%) informants acknowledged change-oriented behaviors as important at the micro-leadership level (i.e., facility management), while only slightly under one-third highlighted this importance of this type of leadership in regard to the top executives.

When leaders enact change-oriented behaviors they aim to increase innovation, collective learning, and adaptation to external changes. During practice change, any indications that the change is no longer essential for the leaders

could cause ripple effects that reduce the providers' performance and efforts, which again undermines the overall implementation (Yukl, 2013). Less emphasis on this type of leadership behavior does not necessarily undermine its importance, nor does it imply that the leaders do not enact such behaviors, rather, it may reflect intangibility. It may be that change-oriented behaviors are more difficult to grasp and may not be as salient for the providers as say training opportunities or encouragement. In general, change behaviors are more relevant for the top executives than for lower level leaders (Yukl, 2012), and therefore may not be apparent to the providers in their day-to-day practice.

Relations-Oriented Leadership Behavior

The intent with relations-oriented leadership behavior is to increase the quality of human resources and relations within the organization (Yukl, 2012). Relations-oriented behaviors are the only behavior category mentioned by every informant, which indicates that such behaviors were of particular importance to the providers in this study.

Leadership support, which is a facet of relations-oriented behaviors, is often highlighted as an essential facilitator of implementation success (Reichenpfader et al., 2015), and is a vital component of relation-oriented leadership. From this qualitative study, the results indicate that leadership support in RYCs take different forms at different leadership levels. While two thirds of the informants state some sort of emotional support as the most important behavior their facility leaders use in pursuing successful implementation, only four informants did the same with regards to the top executives. Rather, the top executives are more involved in behaviors that are characterized as instrumental support and task-oriented behaviors (i.e., acquire and distribute resources). In a mixed-method study, G. A. Aarons et al. (2016) found similar results as the outer context leadership (comparable to the top executives in this sample) was related to sustainment through funding and proactive planning, while the inner context leadership (comparable to the facility management in this sample) facilitated sustainment by being enthusiastic and engaging staff. Furthermore, studies from residential and inpatient settings have highlighted the importance of staff members feeling supported throughout the change process (Bryson et al., 2017).

Supervisory or leadership support has critical influence on important RYC outcomes such as, retention, job stress, and burnout (Del Valle et al., 2007; Smith, 2005). In addition, the implementation process often puts additional strain on the individuals and organization involved. When providers are expected to use new techniques and approaches in their work, they must dedicate time during their workday to read materials and attend training and supervision sessions. In RYCs, implementation efforts may require the

providers to work outside of the milieu in which they primarily engage with the youth, which again may evoke time constraints with regards to their usual tasks. According to the providers in this study, an attentive, trusting, and supportive leader is essential in such situations. Moreover, the importance of leadership support and trust may be especially important for the RYC professionals as they usually do not receive the same appreciation as other members in the human service field (Seti, 2008).

Task-Oriented Leadership Behavior

Task-oriented leadership behaviors accounted for 42.7% of the statements provided by the RYC professionals who were interviewed. The main objective with task-oriented behaviors is to perform the work in an efficient and stable manner (Yukl, 2012). The task-oriented behaviors were primarily related to the top-executives. Thus, the top executives at the studied RYCs may be more involved in task-oriented behaviors than the facility management.

While the relations-oriented and change-oriented leadership behaviors correspond to transformational leadership, task behaviors correspond to transactional leadership. Transactional leadership is more practical with a focus on goal achievement and task completion (Bass, 1990), and is associated with the sustainment of EBPs (Aarons et al., 2016). In this study, the two most commonly mentioned task-oriented leadership behaviors were 1) clarifying responsibilities and 2) acquiring resources. In addition, these behaviors were primarily enacted by the top executives. Clarifying behaviors are thought to be especially important in situations and processes where there is substantial role ambiguity or role conflict (Yukl, 2013), and has been linked to increased job satisfaction and lower turnover rates (Hassan, 2013). Implementation processes are often ambiguous as professionals are expected to take on new methods and tasks while also continuing to perform their usual tasks. Thus, providers may be unsure about what is expected of them, what they should prioritize, and how to dispose their shift, which hinders their performance.

General Discussion

Researchers have observed positive effects of transformational leadership style in implementation processes (Aarons, 2006). An important characteristic of transformational leadership is individual consideration. This is often seen when leaders pay attention to the developmental needs of their employees through support and coaching (Bass, 1999). The relations-oriented leadership behaviors identified in this study correspond with the behaviors involved in individual consideration. Furthermore, the task-oriented behaviors specifically linked to the top executives may also correspond to individual consideration.

By providing learning and training opportunities, the top executives attend to the providers' needs and act accordingly. Such actions are associated with more positive attitudes toward EBPs and a climate for innovation in implementation efforts (Aarons & Sommerfeld, 2012).

As mentioned before, change-oriented leadership behavior was the least emphasized behavior category in this study. Some scholars have highlighted change behaviors as an essential factor in successful change efforts (Kotter, 1995). However, it appeared less relevant to the providers in this study. Similar results have been observed in other studies. For example, Herold et al. (2008) found that transformational leadership was related more to subordinates' change commitment than change-specific leadership behavior. Change commitment refers not only to positive attitudes toward a pending change, but also the intention to support it and to work toward its successful implementation (Herold et al., 2008). Furthermore, transformational leadership correlates positively with subordinates' motivation and job performance (Judge & Piccolo, 2004). Thus, the behaviors highlighted by the informants in this study may not only impact the implementation process, but also influence the providers' job motivation and performance.

While research on adoption and implementation has received much attention, research on sustainment (i.e., continued use over time with desired receiver-outcomes) has been sparse (Wiltsey Stirman et al., 2012). In this study, the initial training of providers began in 2011 and the facilities differed in their number of certified providers. Furthermore, it is difficult to classify which implementation stage the facilities were in at the time of the interviews due to the structural changes and turnovers that occurred in both the provider and management group prior to the interviews. Still, one might presuppose that the facilities were between the stages of implementation and sustainment. Sustainment leadership may involve less change-specific behaviors, but it may require more supportive and attentive leadership. If so, this reasoning may be used to explain the results of this study. In a recent study, Ehrhart et al. (2018) identified available leadership as a dimension of sustainment leadership, where leaders were available and accessible to the providers. The providers in this study were far more likely to report important behaviors enacted by their facility management. It could be hypothesized that if the facilities in the current study were transitioning into sustainment, the facility management's support and accessibility were more essential. The top executives usually are more involved in planning activities, advocating for change, as well as procurement of resources and policies, which may be of less importance in the sustainment phase. However, regarding the leadership behaviors across implementation stages and across leadership levels, more research is needed to be able to assist researchers and stakeholders in facilitating successful implementation and sustainment. Still, promising steps have been taken to design evidence-based leadership developments (e.g., Aarons et al., 2015). The

Leadership and Organizational Change for Implementation (LOCI) is a leadership capacity that aims to improve general and implementation leadership (Aarons et al., 2015, 2017). The LOCI incorporates implementation leadership behaviors that correspond to the behaviors identified in this study, such as supporting behaviors and proactive problem-solving Preliminary results have shown that LOCI is feasible and acceptable, useful and helpful in both day-to-day operations and in implementing EBP, and related to provider-rated change in leader behavior (Aarons et al., 2015). Such developments hold great promise in aiding leaders and their organizations in challenging implementation efforts and may facilitate sustained use of new interventions.

Limitations

This study aimed to increase the knowledge of implementation in residential care settings. It has several limitations that needs to be noted. First, the information from the interviews may be biased by selective memory for aspects of behavior consistent with the providers' stereotypes and implicit theories of effective leadership. If so, the behavior mentioned may not reflect the behavior most important to the providers during implementation, but rather may echo the behaviors the informants believe to be effective leadership. Secondly, the results may be influenced by the visibility of the leadership behaviors. Do the results reflect the behaviors considered most important by the providers, or do the informants highlight the behaviors that are more salient and tangible to them? Change behaviors may be less tangible, but they are still as important in effective implementation leadership, even though few providers mentioned this behavior category.

In this study, high turnover rates complicated the sampling process at some facilities, resulting in a narrow list of eligible providers who had at least one year work experience with the treatment model. A possible solution would have been to modify the inclusion criteria to ensure a larger sample. However, it was hypothesized that work experience was necessary to provide insightful perspectives on the implementation process.

The interview guide was not designed to elucidate barriers or unwanted leadership behavior. Thus, the informants were not asked about leadership behavior that hindered the implementation process. Furthermore, the informants in this study were not asked to rank the behaviors they mentioned, rather, the informants were asked to report on the most important behaviors enacted by their leaders in supporting and promoting the implementation. However, if a ranking procedure was used, the results would provide a clearer and more informative picture of important leadership behavior in RYC implementation.

Lastly, the leadership behaviors identified in this study are believed to be related to successful implementation in RYC. However, this study does not

address how successful the facilities actually were in implementing the MB-CBT intervention. Thus, the results are primarily reflections of the providers' perspectives on effective implementation leadership, rather than an objective evaluation of effective implementation in RYC.

Conclusions

The results of this study contribute to the understanding of factors that are involved in effective implementation in RYC. Moreover, these results can be used to guide researchers when testing effective leadership implementation strategies in residential care settings. From this study we cannot establish the mechanism in which the identified behaviors influence the effectiveness of the implementation. The leadership behaviors identified by the residential care professionals are the behaviors the professionals themselves consider important in facilitating implementation and sustaining the CBT milieu therapy intervention.

Acknowledgments

We wish to thank the RYC professionals who participated in this study.

Funding

The project was funded by the Research Council of Norway, award number 229158/H10.

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