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The Experience of Children's Mental Health Leaders During Times of Constraint: A Narrative Study

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This dissertation, by Jody Levison-Johnson, has
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ABSTRACT

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CONSTRAINT: A NARRATIVE STUDY

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Across the United States, each state has a public mental health system that is designed to support children and youth with emotional and behavioral challenges. This is critically important as recent estimates show that one in six children in the United States has a diagnosed mental health condition (Whitney & Peterson, 2019). The design and structure of these systems vary by state, but consistent across them is the presence of a state-designated leader who is faced with an array of constraining factors that influence their behavior and shape the resulting system. This study describes the experience of leaders in children's mental health administration and how they define, interpret, and perceive their current environments; the constraining factors that impact them, such as decline, instability, risk, politics, policy, and random events; and the strategies they engage in to achieve their goals. Using narrative inquiry, this study captures the experiences of ten leaders engaged in state-level children's mental health system reform. These stories paint a rich picture of the complexity of leading change in public sector environments where there is dynamic interplay across people, politics, and policy and offer new insights into effecting change in complex systems. This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu/.

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Dedication

In memory of Matthew Patrick Lane, whose death illuminated the systemic failures that serve as the foundation for this work and my mission.

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CHAPTER I: INTRODUCTION

The current environment in children's mental health is complex, with a long history of actors and factors testing the system's abilities to adequately meet the needs of children and youth with mental health needs. For over 50 years, there has been some degree of attention to the challenges faced in developing children's mental health systems across the country. Extensive literature documents the prevalence of children's mental health conditions in the general population as well as the inadequacy of services and systems for these young people and their families. A fair amount of literature on specific direct service (micro-level) interventions that have been created to address mental health needs in children exists. Less information is available on the broader systemic approaches that leaders in children's mental health administration have put in place to meet the diverse needs in their communities. While the systems designed to support children with mental health needs vary across the country, consistent across them are an array of constraining influences that impact leader's behaviors and activities when attempting to meet the needs of this vulnerable population. This study is situated within this context.

Background

The prevalence of mental health challenges in children and youth is well documented. Recent estimates show that one in six youth will be affected by a mental health disorder and nearly 50% of those who have a mental health disorder do not receive proper treatment (Whitney & Peterson, 2019). It has been noted that "the prevalence of severe emotional and behavior disorders is even higher than the most frequent physical conditions in adolescence, including asthma, or diabetes, which have received widespread public health attention" (Merikangas et al., 2010, p. 987).

Despite the magnitude of this issue, the resources devoted to address children's mental health are inadequate. According to the Cummings Graduate Institute for Behavioral Health Studies (2020), there have been $5 billion in state cuts to mental health services between 2009 and 2012. A report from the Urban Institute reflects that "access to [mental health] services is lower than it should be for all children, regardless of income and insurance status" (Howell, 2004, p. 7). In a review of 53 studies, McMorrow and Howell (2010) found high costs, disparate use, and variable access and utilization of children's mental health services.

In addition to the inadequacy of resources dedicated to children's mental health, leaders charged with oversight of these systems are faced with a variety of other complicating factors which shape their behavior and may require or result in retrenchment. These leaders operate in highly politicized environments that are impacted by changes in government administrations, changes in policy and regulation, financial hardships, and a host of other factors that can constrain the options available to them and ultimately their behavior.

The Literature

Within the scientific literature extensive research focuses on the specific interventions that can be delivered to children with mental health challenges, including a range of information on evidence-based treatments. Far scarcer is literature that helps to articulate the complexity of the children's mental health system and the approaches to leadership within these environments. While some literature is specific to leadership during periods of decline (Behn, 1988; Bunker & Wakefield, 2010; Carmeli & Sheaffer, 2009; Walsh & Glynn, 2008) and some specific to leadership in the public sector (Hummel, 1991; Luton, 2010), very little literature addresses approaches used by leaders in children's mental health during times of constraint. Countless articles note the lack of research devoted to the constructs of retrenchment and leading in periods

of decline (Bishop, 2004; Carmeli & Sheaffer, 2009; Whetten, 1980). As powerfully articulated by Hannah et al. (2009), "…leadership in extreme contexts may be one of the least researched areas in the leadership field" (p. 897). Others concur: "Research and analysis on the decline and recovery of public organizations is sparse" (Honoré et al., 2012, p. 364), and "Unfortunately, like research on leadership in general, empirical studies examining the cognition of strategic leaders in challenging leadership situations have appeared only sporadically" (Musteen et al., 2011, p. 926). This void is what my study has attempted to address.

The Study

Leaders in children's mental health are charged with making decisions in a dynamic environment that is impacted by a variety of constraining factors that can include, but are not limited to: funding inadequacy and reductions; political changes; policy changes at the federal, state, and local levels; media scrutiny; legal actions; and natural or manmade disasters. How the leader approaches this work is uniquely their story and where this study has surfaced learning that contributes to the field.

This study describes the experience of leaders in children's mental health administration and how they define, interpret, and perceive their current environments; the constraining factors that impact them, such as decline, instability, risk, politics, policy, and random events; and the strategies they engage in to achieve their goals. The purpose was to better understand how children's mental health leaders worked to accomplish system improvement amidst the many constraints that they face. The specific research question to be answered is, "How do leaders in children's mental health attempt to improve their systems, and ultimately access to and availability of services and supports, in an environment of constraint?"

The study employed narrative inquiry to understand the stories of how leaders approach their work, their successes, and their failures. Through these stories, the picture of a rich and interconnected field emerged that offers future leaders invaluable lessons about leadership in complex systems that are often riddled with a variety of constraints. While several qualitative approaches may have been used to conduct this study, the four turns of narrative inquiry—from objective to relational; from numbers to words; from general to specific or particular; and from facts and singular ways of knowing to multiple ways of knowing (Pinnegar & Daynes, 2012)—which are further explored in Chapter II, are congruent with the field of children's mental health. Further, story has credibility within the mental health field as both a therapeutic intervention (White & Epston, 1990) and as a pillar of the recovery movement where the use of lived experience is primary in the treatment of those facing mental health challenges (Thornhill et al., 2004).

Data collection for the study began following approval of an application to Antioch University's Institutional Review Board. Participants were sought through the National Association of State Mental Health Program Directors (NASMHPD) Children, Youth, and Family Division (CYFD) which is a member association consisting of each United States state/territory designated leader for children's mental health. Ten interviews were conducted with participants who represented regional geographic distribution across the country. Data was collected through one-to-one video-conference interviews conducted via the Zoom meeting platform using the following prompt: "I am interested in hearing stories from your career that help me understand how you managed to lead during or under specific constraints or constraining circumstances." Interviews were transcribed following the completion of each interview. Data was analyzed using a categorical-content (thematic) approach. From the stories, I

identified the broad categories of constraint that these leaders faced and the strategies they have used in the face of these constraints to effect change in their jurisdictions. Specific leader attributes also emerged from the data analysis. The delimitations of the study were intentionally broad. The sample was pulled from those designated as children's mental health leaders across the continental United States. While the notion of constraint was initially conceptualized to provide some context or frame of reference for the participants, each participant had the opportunity to share their own perceived constraints and how they responded. The limitations of the study are largely a result of the chosen methodology, i.e., that the use of qualitative approaches does not allow for determination of causal relationships or generalizability across the entire population. A further limitation was my own positionality which is further discussed below.

Researcher Positionality

My interest in studying, in some rigorous way, the experiences of leaders in children's mental health during times of constraint comes from my own experience. I have worked in the field of children's mental health my entire professional career. I have served as a public sector leader in both a county and state system and have led change under a variety of circumstances. I have shared these experiences, through story, with many who have expressed an interest or desire to learn from them. Narrative inquiry is a method that allows for and respects the researcher's own experience. While it is important to hear the stories of the research participants and not see them through the lens of my story, having my own story is not seen as a drawback or problem. As Creswell et al. (2007) state, "Within the participants' stories may also be an interwoven story of the researcher as she or he gains insight into herself or himself" (p. 245). Further, my training as a clinical social worker and therapist has allowed me to work, tenaciously, on being focused

on not projecting my own story or experiences onto those of my clients. When I was engaged in direct practice, many sessions with my supervisor and actually with my supervisees when I was the supervisor, focused on the notion of countertransference and recognizing when you were potentially tangling your own "stuff" with that of your clients. This experience is tied to the narrative turn from objective to relational within the research context and is further described in Chapter II. These related experiences will provide what Gadamer (1989) refers to as enabling bias. Enabling bias is understood as having particular views or perspectives that have been informed and shaped by one's own deep experiences. This is distinguished from disabling bias which can play out as confirmation bias, where the researcher collects and analyzes data in a manner congruent with their own beliefs. Given that the intent of my study is to learn about children's mental health leaders' experience and not to prove that a specific set of strategies or techniques is successful, potential for disabling bias is mitigated. Awareness of this potential was critical during data analysis.

It is also important to note that my positionality is also tied to the methodology I selected. As a social worker and as a leader, I am energized by human experience. I see and understand the world through people, relationships, and interactions. I am pragmatic and prefer to offer clear guidance and do not feel fulfilled simply offering theory or supposition. I tend to focus on providing practical application of information. I believe that reality is constructed through the actions of people, by capturing those experiences, and by retelling those experiences.

I learn and teach through story. I am able to understand and illustrate concepts when they are tied to action. I can deeply embed something in my brain by doing it. I continue to embed it by talking about it and sharing the experience with others. If I am not actually doing the "it" myself, then hearing others talk about how they did it also helps me to more truly understand and

integrate new information. I often find myself saying, "It's a metaphor for [insert whatever I am discussing here]" Story to me represents a way to bring things to life, to concretize it through application. This is a longstanding preference.

Narrative inquiry is also a method that is aligned with my leadership preferences for authentic (Luthans & Avolio, 2003), relational (Uhl-Bien, 2006), and inclusive (Booysen, 2014) interactions. This study created a context where leaders from a variety of places and cultures (inclusive) felt comfortable (relational) sharing their personal experiences (authentic).

Key Terms

Definitions for key terms used in this dissertation are offered here.

- *Children/youth/young person* are used interchangeably to refer to a person at or under the age of 21.

- *Children's mental health* refers to emotional and behavioral conditions that impact the well-being of children, it is not intended to include only specific diagnostic conditions.

- *Children's mental health leader or administrator* refers to the person, designated by statute, law, regulation, or state/county leadership, who is responsible for the oversight and administration of the children's mental health system in a particular jurisdiction. This is generally not a person engaged in direct provision of services.

- *Children's mental health system* refers to the overarching structure of services and supports that are offered in a particular jurisdiction to address mental health needs in children. It may include services and supports offered by various governmental entities and private providers.

- *Constraint or decline* refers to any environmental factor or condition that imposes some sort of restriction on the children's mental health leader or administrator. This can include but is not limited to funding reductions; political changes; policy changes at the federal, state, and local levels; media scrutiny; legal actions; and natural or manmade disasters.

- *Public sector* refers to the government setting.

- *Retrenchment* refers to both environmental conditions (economic scarcity, organizational decline, and political environments) and a range of responses that may be used in response to a period of decline or constraint. These responses are generally reflective of reductions or regression.

Outline of Chapters

Chapter II of this dissertation provides a thorough critical review of the research on the various concepts and constructs that are relevant for my research as introduced above. The chapter is organized into four main sections: an overview of the children's mental health field, understanding complexity in children's mental health systems, understanding constraint and decline including retrenchment, and understanding leadership and change strategies under these conditions.

Chapter III of this dissertation is devoted to discussing the use of narrative inquiry for my research. In this chapter the use of narrative inquiry to understand the strategies and approaches used by leaders in children's mental health to effect change and improve their systems is explored and explained. Literature specific to narrative inquiry is reviewed to demonstrate the utility of this methodology for research specific to children's mental health and highlight how the role of story has been pronounced in the mental health and public administration fields. The

chapter also includes more specific information about my sample, sample size, data collection methods, analytic approach, and ethics considerations.

Chapter IV of this dissertation presents the stories of the 10 participants who shared their experiences as state children's mental leaders with me. Each participant has been assigned a pseudonym to protect their identity.

Chapter V of the completed dissertation presents my findings. This section includes specific quotes from the stories of my participants to clearly identify themes that emerged from the analysis. To close the chapter, a grand narrative or composite narrative is presented to illustrate the commonalties found across the ten participants.

In Chapter VI, I summarize my approach to the research and offer my interpretation of the findings and what they mean for the field of leadership and change in children's mental health and more broadly. I also explore the implications for practice and policy by offering thoughts about how the findings could be used by other leaders, both in children's mental health and more broadly, who are facing similar constraining circumstances or environments. Lastly, I touch on the potential for further research based on the findings from this study.

CHAPTER II: REVIEW OF LITERATURE

Introduction

In the broad sphere of healthcare, children's mental health lies at the margin representing a smaller subset of the population, a discrete set of needs that are not as prominent or prevalent as certain physical health conditions, and an area that is highly stigmatized with those who are impacted by these challenges often being marginalized. Yet the needs of children faced with mental health challenges remain and the systems to serve them remain inadequate. In the face of these issues, the children's mental health field has continued to evolve and leaders within children's mental health have engaged in a variety of activities to attempt to address these needs. This study seeks to understand the experience of leaders in children's mental health administration and how they define, interpret, and perceive their current environments; the constraining factors that impact them, such as decline, instability, risk, politics, policy, and random events; their priority goals at this time; and the strategies they engage in to achieve their goals. Understanding the roles and activities of leaders in children's mental health is critically important. After all, children with mental health needs deserve no less than our best and our nation has not yet delivered.

This chapter first reviews the literature on the historical and current context surrounding the children's mental health field. Next, I discuss the complexity and dynamic nature of public sector children's mental health systems. Then I explore the literature specific to retrenchment, as retrenchment is a common response when faced with constraining environments. I then discuss the roles, traits, and possible activities of leaders in environments of decline. I then present the argument that retrenchment, while more researched, represents one *possible* response to constraining or declining environments, and that a void in the literature that explores more

adaptive responses to these environments exists. It is within this void that my study will be situated.

<div align="center">**The Challenge of Children's Mental Health**</div>

A Historical Challenge

As early as 1970 and 1978, commissions charged with exploring children's mental health within the U.S. identified that vast numbers of youth were not receiving the treatment that they needed (Joint Commission on Mental Health of Children, 1970; President's Commission on Mental Health, 1978). In a seminal study in the field, Knitzer and Olson (1982) identified that two-thirds of children and youth were not receiving the mental health care that they required, that the state agencies charged with oversight of mental health services for children provided minimal services, and that there was no central policy strategy to unify the nation's approach to mental health treatment for young people. In a study in 1999, it was found that children and youth who were receiving mental health treatment were most often admitted to costly out of home options (hospitals and residential treatment) and not receiving the home and community-based services that result in sustained positive outcomes (Burns et al., 1999).

An Ongoing Challenge

Prevalence

More recently, estimates have shown that severe mental health conditions occur more frequently in adolescents than common physical health disorders including asthma and diabetes (Merikangas et al., 2010). The Centers for Disease Control and Prevention (CDC; 2013) noted that up to one-fifth of the children in the United States have mental health conditions each year and that trends over the past 17 years show that prevalence is increasing. More recently, Whitney and Peterson (2019) found that that one in six youth will be affected by a mental health disorder

and nearly 50% of those who have a mental health disorder do not receive proper treatment. We know that nearly half of the United States' population has been affected by a mental health condition and that prevalence hovered just over 20% for the adolescent population (Merikangas et al., 2010). From this information, it is clear that many children and youth in this country have mental health needs.

High Cost and Inadequate Resources

While the number of children with mental health challenges is increasing and costs for healthcare continue to rise, the pool of resources being used for children's mental health remains low. The CDC (2013) has noted that children's mental health is "an important public health issue in the United States because of the[ir] prevalence, early onset, and impact on the child, family, and community, with an estimated annual cost of $247 billion" (p. 1). According to a recent report on children's utilization of Medicaid, less than 10% of Medicaid expenditures were for behavioral health services, which includes mental health and substance use services (Pires et al., 2013). Available services and supports are inadequate and overall mental health service utilization is below what is expected for children and youth across all socioeconomic statuses and health insurance types (Howell, 2004). According to the American Medical Association,

> Only 63% of U.S. counties have at least one mental health facility that provides outpatient treatment for children and adolescents and fewer than half of U.S. counties have a mental health facility with any special programs for youth with severe emotional disturbance. (Cummings et al., 2013, p. 553)

These reports reflect a system that is plagued by challenges.

In 2008, the Mental Health Parity and Addiction Equity Act was passed. This landmark legislation amended the Mental Health Parity Act of 1996 and

> requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no

more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. (USDOL, 2010, para. 2)

The passage and enforcement of parity were seen as a big win in the mental health field. While parity introduced the concept of equity between physical health benefits and mental health benefits, there remain varying policy interpretations by states on the definition and some advocates in the mental health field are concerned about the disparity between private and public insurance benefits: "A recent review of state parity laws indicates that while such legislation improves coverage, few laws call for either equal benefit design or equal access to appropriate care for mental illness" (Frank et al., 1997, p. 116). While federal policy was intended to have positive impact on the system, state interpretation and implementation may not result in these desired effects.

While children covered by Medicaid and private insurance continue to experience system inadequacies and inequities as noted above, state funds are often used to plug holes in service access for people with mental health challenges. Unfortunately, between fiscal year 2009 and 2012 state funding for mental health services was drastically reduced across the United States totaling reductions of more than $1.6 billion (Honberg et al., 2011). These same authors report that over half of the states and the District of Columbia (29 of 51) made reductions to their state funds for mental health services over this same time period. State funds represent only a portion of the total dollars allocated to cover mental health service costs. Medicaid is generally the largest payor of children's mental health services in the U.S. yet only 10% of children covered by Medicaid use mental health services (Pires et al., 2018), even after the inception of the Patient Protection and Affordable Care Act (ACA) and corresponding Medicaid expansion. Pires et al. (2018) note that "those [Medicaid] children account for over one-third of all costs for children in Medicaid—totaling over $30.2 billion" (p. 1). Despite this high spending, Medicaid coverage

does not always ensure access to services that are deemed best practice as certain evidence-based practices may not be eligible for Medicaid reimbursement and are variable from state to state (Cooper, 2008). These realities paint a grim picture of a system that is funded in a variety of ways, with variable evidence, and remains in trouble despite nearly five decades of attention to the inadequacy of the nation's response to children's mental health.

Given the consistently high rates of prevalence of mental health issues in young people, the significant amount of money being invested, the overall environment of reducing resources, and the continued challenges with service access and utilization, the field of children's mental health has been engaged in efforts to change and evolve for nearly a half-century. These change efforts have been geared toward improving the availability of and access to appropriate mental health services and supports for children and their families across a variety of settings and locations. Complicating change in children's mental health is the fact that the system(s) that serve youth with mental health needs is complex (Stroul & Friedman, 1986), structured differently in every locality, and comprised of a variety of partners and key actors (Knitzer & Olson, 1982). Children's mental health systems are clearly complex.

Children's Mental Health Systems as Complex Systems

In 2001, Plsek and Greenhalgh drew parallels between the healthcare system of the United Kingdom and a complex adaptive system. The authors note that in a complex adaptive system, boundaries are more fluid with membership changes over time, that members are often engaged in multiple systems and behave in alignment with an internalized set of rules, that both the members and the system itself are responsive and adaptive to the environment, and that systems are often embedded within broader systems. As a result, the actions of a complex adaptive system are often unpredictable, non-linear, and "emerge from the interaction among the

agents" (Plsek and Greenhalgh, 2001, p. 626). Similarly, Uhl-Bien and Arena (2017) suggest that "Complexity is about *rich interconnectivity* . . . when things interact, they change one another in unexpected and irreversible ways" (p. 9). Changing regulations, evolving fee and payment structures, emerging technologies, and variability in the doctor–patient relationship also contribute to an ongoing state of uncertainty and add to the complexity of healthcare environments (Uhl-Bien & Arena, 2017). Tan et al. (2005) further the notion of complex adaptive systems by reflecting on the multiple levels involved in the healthcare system suggesting that these systems "…display apparently complex behaviors that emerge as a result of often non-linear and unpredictable interactions among a large number of component systems at both the micro (human) and macro (organization and system) levels" (p. 44).

In 2010, Stelk and Slaton noted the complex and dynamic nature of children's mental health systems given the variety of entities that comprise the broader system and that activities across the entities and therefore the system "are fluid, potent, intrusive, and unpredictable" (p. 101). Similarly, Hodges et al. (2012) found in their qualitative study of children's mental health systems using the system of care approach that how systems were established and functioned was largely shaped by "individual choices and actions of stakeholders" (p. 534) reflecting the complexity and dynamic nature of systems that are made up of diverse actors or agents. These authors' views align with the notion that the children's mental health system in our nation is complex. Leaders are charged with making decisions in a dynamic and often constraining environment that is impacted by a variety of factors that can include retrenchment (changes in fiscal climate, reductions) and policy (at the federal, state, and local levels). This interplay—of leadership decisions and the influence of the dynamic environment on these decisions—has yet

to be systematically studied. What is clear is that leaders in children's mental health work in a complex environment which has an impact on what they do and how they do it.

The mental health needs of young people are addressed by many sectors, including schools, health care providers, child welfare and juvenile justice agencies, mental health treatment programs, and others. In 1986, the system of care concept and philosophy was developed in an attempt to bring together these various sectors (Stroul & Friedman). At that time, a system of care was defined as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network" (Stroul & Friedman, 1986, p. iv). The framework identified core components that include mental health, social, educational, health, vocational, recreational, and operational services. The authors noted that states and communities were more easily able to identify the necessary components for an effective system but that the challenge emerged during implementation. This reflects the complexity of transforming a system that is fragmented and inadequately funded into a cohesive and integrated approach.

Building on this work and experiences in the field since that time, in 2007 a research team at the University of South Florida expanded upon the Stroul and Friedman definition and defined a system of care as "an adaptive network of structures, processes and relationships" (Hodges et al., p. 1), reflecting that a true system of care is more than a conglomeration of coordinated services; it is an active undertaking that results in interdependencies between systems and actors to achieve the defining result of effectively meeting the mental health needs of young people. More specifically, the definition reflects the importance of established boundaries (structures), identified "methods of carrying out organizational activities" (processes; Hodges et al., 2007, p. 2) and the connections between the multiple actors involved in children's

mental health activities (relationships) and begins to address the complexity in establishing responsive and effective children's mental health systems.

From these definitions, a picture of what a children's mental health system *is* begins to emerge. While a high degree of variability by jurisdiction and region exists, a children's mental health system is the overarching system that encompasses a specific geographic area's network of services and supports aimed at addressing mental health needs in children and youth. It requires collaboration and coordination across a variety of child-serving systems and agencies (relationships), each with a specified role (structures) in a unified strategy for how services and supports will be organized and delivered (processes) to meet the needs of young people with mental health challenges. These systems are operating in environments where need remains high, and resources are inadequate and or dwindling. A variety of constraints are regularly faced by leaders in children's mental health—from changes in administration or policy to reductions in funding. Given the complex and constraining environment, solutions to effectively address these needs require leadership and an array of strategies that allow the leader to effectively shape the system in adaptive and responsive ways.

Common Constraint: Retrenchment

The literature specific to the construct of constraint is most often focused on the concept of retrenchment. Retrenchment was developed largely in the management and business literature. While not widely used in healthcare and the public sector, there has been increasing attention paid to this construct more recently given the current environment in both the United States and abroad. The term *retrenchment* has been used to describe both environmental conditions (economic scarcity, organizational decline, and political environments) and a range of responses to a period of decline or constraint. As has been noted above, over the past several decades the

children's mental health system has faced consistent inadequacy or reduction in devoted resources and changes in the surrounding environment that have necessitated a range of responses and could clearly be characterized as retrenchment.

Retrenchment as an Environmental Condition

Retrenchment as Economic Scarcity

Economic scarcity or the more layman's term of "tough times" is frequently cited in the literature surrounding retrenchment. In the 1970s, retrenchment was a common term in higher education (Culbertson, 1976; Rubin, 1979), and in the 1980s, the term was used to describe government or public sector settings. Behn (1988) noted that "in government, the contraction of resources is forcing retrenchment at all levels" (p. 348). In his chapter, Behn (1988) equates cutbacks with retrenchment and articulates that retrenchment is real if a decline in resources requires the manager to do more than just "cutting out the fat" (p. 348). Similarly, in discussing environmental education, Crohn and Birnbaum (2010) equate retrenchment with reduction in public sector jobs and declining budgets. Bishop (2004), in her discussion of a set of nonprofit organizations operating under a specific federal funding stream in the state of Missouri, refers to retrenchment as the expectation "to deliver more services with fewer funds" (p. 71). In this conceptualization, retrenchment is viewed as the requirement to do more with less, or at a minimum, to do the same with less. As the previous discussion of children's mental health reflects funding reductions are commonplace and economic scarcity a reality.

Retrenchment as Organizational Decline

At times, retrenchment is used synonymously with the term organizational decline. Interestingly, as early as 1980, Whetten noted that the concept of decline had not been adequately covered in the literature and that the focus on organizational research was more oriented to

increases or growth. Yet during this same time period the need for organizations to reassess and reduce their operations in order to sustain was common. Whetten (1980) called for researchers to "improve the conceptual clarity of organizational decline" (p. 582) and to better understand the management practices that are used in these situations.

Krantz (1985) presents two case studies specific to organizational decline and notes the alignment between this process and the grief process associated with a death. Krantz bases his approach on the work of the Tavistock Institute which applied psychoanalytic theory to organizational behavior. His framework attends to the levels of anxiety experienced by members of the organization and the impact that anxiety will have on the organization's ultimate outcome. He notes the challenges facing leaders during organizational decline include their own and their employees' anxiety which makes decision-making and planning more challenging.

Since that time, several conceptualizations of decline have been offered including those by Weitzel and Jonsson (1989) who explain decline both in terms of what may be going on inside an organization (a normal developmental process, a lack of modernization of a process or procedure) and external factors (things outside of an organization that impact the organization's ability to continue to remain viable). The authors further describe organizational decline as a staged process that includes a blinded stage where an organization is not even aware of the things that may be threatening the organization, an inaction stage where no responses are undertaken, a faulty action stage where the wrong responses are attempted, a crisis stage where an "organization reaches the critical point in its history, during which it must undergo major reorientation and revitalization or suffer certain failure" (Weitzel & Jonsson, 1989, p. 104), and finally a dissolution stage which results in the end of the organization and is not survivable. The authors note that intervention and potential turnaround varies across the stages introducing a

temporal consideration into the retrenchment literature. The children's mental health system in the United States has certainly faced periods of decline which have related to shifts in funding and policy at the national and state levels.

Retrenchment as a Political Construct

Jordan (2011) discusses welfare state retrenchment as an era in which "the welfare state has evolved into a policy institution that fundamentally alters the political and economic landscape" (p. 113). The author conceptualizes retrenchment as a period when political perspective and ideology are changed and a reduction in partisanship results. In this conceptualization, the underlying belief is that external factors result in a more intense focus on core beliefs and that this overshadows the more nuanced debate that characterizes times with less constraint or stress. To highlight this, the author notes convergence of thinking across political parties in both Britain and Canada about the importance of preserving nationalized healthcare while controlling spending. Similarly, Clayton and Pontusson (1998) argue that welfare-state retrenchment "yields a politics of blame avoidance in which cutbacks can take place only through incremental and surreptitious mechanisms or during moments of extraordinary fiscal stress and political consensus" (p. 68).

Looking at retrenchment through a more political lens, Smith (2010) looked at the field of youth justice where there was regression in thought that resulted in increasingly punitive approaches that were then integrated into policy and practice. In this conceptualization of retrenchment, the author equates retrenchment with backsliding or the return to policies and practices that are more constraining, harsh, and less aligned with emerging best practices. Interestingly, the author notes that this shift in policy and practice is incongruent with the concurrent emergence of the United Nations Convention on the Rights of the Child, an

international policy statement that articulated the need for nations to decriminalize youth justice and move away from institutionalization of offenders. These depictions of retrenchment are characterized as shifts in the political climate and are less related to the concepts of financial constraint and organizational decline that appear more frequently in the retrenchment literature. They do have applicability to the children's mental health field which has at times regressed toward more restrictive out of home care options (with limited evidence of efficacy) and elimination of a broader range of service types (with more evidence of efficacy) with bipartisan support during times of constraint.

The framing of retrenchment in the literature reflects a vision that retrenchment itself is an environmental condition. In this vein, the children's mental health system can be viewed as operating in an environment of retrenchment—having faced economic scarcity, organizational decline, and a range of political forces that shift the system with regularity. Also common in the literature is the view that retrenchment is a set of activities or responses to environmental conditions (periods of restraint and decline) that require strategic rethinking or redirecting of resources (Alexander, 1999; Barker & Barr, 2002; Behn, 1988; Biester et al., 1999; Bishop 2004; Crohn & Birnbaum, 2010; Honoré et al., 2012; Kaboolian, 1998; Karanikolos et al., 2013; Lee & Romano, 2013; O'Kane & Cunningham, 2012; Schmitt & Raisch, 2013; Tangpong et al., 2015).

Retrenchment Responses

Most prominent in the retrenchment literature is a focus on the options that can be taken to respond during times of constraint, known as retrenchment activities or responses. In this literature, the most commonly employed strategies included reductions, strategic reorientation and employing what has been referred to as "the new public management," and collaboration/partnerships. These responses are further explored below.

Reductions

Several authors note that one of the most common responses to periods of decline is making reductions. These reductions can be to people, dollars, or programs and services. In some ways, this is the simplest form of response. Deciding to eliminate something offers the opportunity for more immediate results and relief. Behn (1988), in his chapter that summarizes findings from a small community of scholars who have focused on the management of cutbacks, noted the nuanced decision-making required to make the right reductions is often a juggle of equity or efficiency. The difference here is whether cuts are dispersed equally across an organization (equity) or targeted and focused in a way that mitigates the impact to the entire organization (efficiency). O'Kane and Cunningham (2012), in their discussion of findings from the case studies they conducted, note that a common response in a decline scenario is about leadership and whether or not it is necessary to replace the top executive or members of the executive team.

Karanikolos et al. (2013), in their study of the impact of the European financial crisis on the health of the population in several nations, identified a range of reduction strategies used across varying countries including drastic funding cuts, austerity policies, staff reduction, program and service reduction, and decreased subsidies for healthcare costs (increased out of pocket expense) in several countries. Similarly, Schmitt and Raisch (2013) discuss cost and asset reductions as a key to successful turnaround. Tangpong et al. (2015) looked at the timing of specific retrenchment activities similar to those identified by Karanikolos and found that use of these retrenchment activities early in a firm's decline increases the likelihood of turnaround success, whereas delaying taking action reduced the likelihood of turnaround success. These findings support the notion that reductions, made swiftly, can help an organization to survive a

decline. Reductions are not uncommon in children's mental health, yet despite constraints some systems and leaders have approached constraint with redeployment (repurposing) of resources instead of outright reduction (Stroul & Manteuffel, 2007).

Strategic Reorientation and the "New Public Management"

As Schmitt and Raisch (2013) note, one possible retrenchment response is to engage in strategic thinking that shifts an organization or system's potential path. Organizations or systems that use the period of decline to reinvent themselves are fewer despite being a viable alternative to combat the challenge (D'Aveni, 1989; Whetten, 1980). Several authors have introduced the concept of the "new public management" to respond to declines in the nonprofit and public sectors. Simply put, new public management is the use of more business-oriented and for-profit strategies in the nonprofit and public sector arena. As Kaboolian (1998) relates, the new public management focuses on maximization of efficiencies and integrates strategies from business such as technology, performance-based contracting, and compensation incentives.

Citing the need for "evidence-based private sector turnaround strategies" (p. 364) or what could also be referred to as new public management, Honoré et al. (2012) suggest several financial and risk mitigation strategies, frequently employed in the business sector, as possible responses to decline in a public health agency. The authors also discuss the use of repositioning and reorganizing both staff and strategy as possible responses. Using these approaches, the health department they studied explored new funding sources, engaged in marketing activities to drive new consumers to use their services, reduced costs by updating equipment and re-selling their services to non-governmental entities, and engaged in strategic planning to chart a course for the future. This represents a more creative approach that begins to introduce the idea that retrenchment does not have to equate to reduction.

Barker and Barr (2002) attempted to understand whether an organization had undertaken strategic change by examining the relationship between the top manager's perception of the reason for decline and the subsequent response. The authors looked at internal attribution (something within the organization caused the decline) versus external attribution (something in the environment surrounding the organization is responsible for the decline) and found that "internal attributions are more likely to lead to change than external attributions" (Barker & Barr, 2002, p. 976). This is consistent with locus of control and self-determination literature which finds that when we believe we have control and self-determination over something (internal), we feel able to make change to respond and succeed, as opposed to when something is external, and we feel no ability to control the situation (Deci et al., 1989).

Alexander (1999) looked at nonprofit organizations serving children and youth in one county in Ohio to better understand the impact of the new public management for those who were dependent on government funding or whose contractual expectations were changing. Through focus groups and survey data, the author found that nonprofits were changing their management processes included marketing, fundraising, finance, and outcome measurement to sustain. She found that "more established nonprofits continued along a trajectory of business-oriented practices while community- and faith-based organizations struggled to adopt this new tack" (Alexander, 1999, p. 68). Hence, strategic reorientation and new public management may be effective to stave off decline but may be more effective for those nonprofit organizations that have stronger infrastructure already in place. The impact that these approaches have within the public sector remains largely untested.

Similar to the work by Alexander, Bishop (2004) explored the ability of a subset of largely federally funded nonprofits, known as community action agencies, in the state of

Missouri to adopt new public management strategies. Through her research she was able to discern that these agencies "have taken initiatives to find resources through planning, reorganization, competition, and alliance building" (Bishop, 2004, p. 91) and reduced cost, engaged in evaluation, strategic planning, increasing volunteers, and reorganization in order to survive. The research also suggested that smaller nonprofits can learn new public management strategies and succeed in this era of decline but that more mature organizations with clear missions are often more successful at strategic reorientation and the ability to survive decline.

Collaboration and Partnership

Another frequent response to environments of constraint and decline is the formation of partnerships. As noted above in Bishop's work, alliance building was cited as one of the more successful strategies employed by the community action agencies in her study. Behn (1988), in outlining the basic responsibilities of cutback management in governmental settings, notes the criticality of support from constituents and legislation. Similarly, when looking at environmental education in the public sector, Crohn and Birnbaum (2010) found public-private partnerships across the civic and public sectors to be an important strategy during a period of constraint.

The Editorial Board of the *Journal of the Society of Pediatric Nurses* conducted a readership survey in 1999 which identified concerns by their readership (pediatric nurses) about the constraints they were facing in their nursing practice, including "human and material resources; time management; more acute patients with shorter lengths of stay; and the stress imposed on staff, resulting in decreased morale" (Biester et al., 1999, p. 141). As a follow-up to these concerns, each author discusses how nurses contribute to quality in the face of these challenges. Each response offers a different lens, but several themes appear across each author's response. Specifically, "Creativity, innovation, leadership and collaboration are viewed as critical

components to achieving success in the future healthcare market" (Biester et al., 1999, p. 145).

Within nursing practice, this collaboration is viewed as interdisciplinary in nature, noting the

importance of all roles within a medical setting—doctors, nurses, social workers, patient

technicians, etc.—in effecting change that will result in efficiency. These ideas suggested a more

adaptive approach to environments of constraint.

Similar to collaboration and partnership is "deliberation" or the intentional engagement

of stakeholders and broader community representatives in determining responses to a particular

area of concern or decline. "Deliberation is part of a panoply of strategic options for

organizations of all sectors trying to manage political and economic challenges in a landscape of

limited resources and demanding stakeholders" (Lee & Romano, 2013, p. 734). In their

multi-site ethnographic study of the use of deliberation, the authors identify that financial

constraints have resulted in increased use of deliberation as a mitigation strategy against

potential public outcry over cuts. Sadly, according to these authors, this form of stakeholder

engagement has become a business for many consultants, is less genuine and authentic, and is

used to "force participants to realize that satisfying all of the different stakeholder demands made

on organizations is untenable and unreasonable" (Lee & Romano, 2013, p. 746). Regardless of

the intended outcome from the use of public deliberation, it is important to note that engaging

people in co-creation of solutions is viewed as a potentially beneficial strategy and one that has

been used in children's mental health.

Policy and Retrenchment

Clayton and Pontusson (1998) note that "by and large, the retrenchment literature tends to

ignore the question of changes in the delivery of social services or, in other words, the question

of how the public sector is organized" (p. 70). The authors recognize that conceptualizations of

retrenchment also have a place within the public sector which is a question of both politics and policy. Largely, the retrenchment literature focuses on the range of reduction strategies undertaken due to a changing fiscal climate. Policy is occasionally noted as a possible response, to a far lesser degree than activities such as layoffs and closures. Policy may be used as a retrenchment response or a shift in the political or policy environment may also serve as a catalyst for the constraining conditions that surround retrenchment and therefore be part of the cause. The literature in this area remains sparse with a continued lack of attention to the public sector policy implications.

Butz and Zuberi (2012) examine the impact of what they term as "social welfare retrenchment" (p. 359) or the changes in federal policy that reduced funding for an array of safety net services, on poverty in one progressive U.S. city. The authors found that "while local policies and programs can ameliorate some urban poverty impacts, national and macro-level socioeconomic and policy factors continue to shape poverty in even the most fortunate U.S. cities" (Butz & Zuberi, 2012, p. 365). In this way it seems that federal policy can in fact create the conditions that constitute retrenchment.

Hinkley (2017) explores the impact of fiscal stress in four U.S. cities. In her study she argues that local and national policy decisions have negatively impacted U.S. cities and their ability to manage a negative economy. Case studies of four cities found that policy focusing on reduction, restriction, and cuts were often framed as the sole option for survival. In their analysis of several European countries' response to financial crisis, Karanikolos et al. (2013) note the impact of a challenging fiscal environment on the health systems and protections available to citizens. While the range of responses varied across countries as noted previously, the authors noted that "Policy decisions about how to respond to economic crises have pronounced and

unintended effects on public health" (Karanikolos et al., 2013, p. 1323). Through these examples we see that policy can be both a cause of or response to a declining environment, however that is defined. What is clear is that policy plays an important role in establishing the context within which healthcare is delivered.

Retrenchment in Children's Mental Health

While there has been an overriding sense of resource inadequacy within the children's mental health system for several decades, there are several other challenges that leaders in children's mental health face on a regular basis. While funding reductions are common, these leaders are impacted by a variety of constraining factors. The retrenchment responses noted most commonly in the literature—reductions, strategic reorientation, and collaborations and partnerships—have been used by leaders in children's mental health. However, retrenchment frames the environment surrounding children's mental health as a technical problem or one that "can be resolved through the application of authoritative expertise and through the organization's current structures, procedures, and ways of doing things" (Heifetz et al., 2009, p. 19). The current environment reflects far more than this technical problem. Describing the overarching environment in which children's mental health leaders operate as solely retrenched is short-sighted and simplistic.

Within children's mental health systems, retrenchment is a technical response to environmental conditions that require more adaptive thinking. There are a range of other more adaptive alternatives and strategies that are being employed by leaders in children's mental health to respond to the changing and complex environment. These adaptive responses that consider the complexity of the children's mental health field and allow for "shedding certain entrenched ways, tolerating losses, and generating the new capacity to thrive anew" (Heifetz et

al., 2009, p. 19) must be better studied and understood in order to achieve long-term positive change within the field.

Leading Change in Complex Systems

Leaders in children's mental health operate in environments characterized by decline and constraint. This section explores the role and traits of leadership in environments characterized by decline. This is followed by a discussion of several dichotomous constructs that emerged through the review of literature that seem to have utility when considering leadership in children's mental health during times of constraint.

Leadership Roles in Environments of Decline

While the role of leadership in decline has been addressed, the literature is limited. Behn in his 1988 chapter on cutback management identifies "five fundamentals of retrenchment leadership" (p. 353). Included within these are the need for the leader to be honest and clear and explain any planned reduction activities and the consequences for not taking these actions. It is also suggested that leaders adopt a longer-term view noting that initial strategies often have minimal impact and it is only over time that benefits from reductions are realized. Related to the discussion above about strategic reorientation, Behn notes the role of the leader in developing a plan for the future and the importance of this activity on employee morale by adopting a future orientation and sharing the things that the organization will be doing in the future. Similar to some of the strategies subsumed under the concept of the new public management, Behn also suggests establishing performance metrics and incentivizing cooperation and participation. Walsh and Glynn (2008) discuss the role of leadership in organizational legacy identity and helping members to construct these identities. By offering context, realities, and explanations,

leaders are supporting staff through the period of decline, retrenchment, and in some cases, organizational demise.

Whether in decline or not, these concepts provide a useful frame to explore leadership in any complex environment characterized by change. These roles are also prominent in the broader leadership literature and have applicability to the children's mental health field.

Leadership Traits in Environments of Decline

While leaders can play a variety of roles in situations of decline, another critical aspect of leadership in these circumstances are the traits of the leaders themselves. Bunker and Wakefield (2010) discuss how leaders respond to "the 'dark side' of management—imposing layoffs, budget cuts, and other downsizing measures" (p. 15). In particular, the authors suggest the need to be authentic, positive, and communicative, and also balanced in terms of presenting as both competent and capable and concurrently vulnerable and approachable.

In their study of organizational decline, Carmeli and Sheaffer (2009) look at leadership risk-aversion and leadership self-centeredness as "key leadership characteristics [that are] potentially detrimental to organizational viability" (p. 366). Through a series of surveys assessing decline, self-centeredness, and risk aversion administered to two members of leadership teams from 85 organizations as well as data from these organizations to determine downsizing, the authors found that risk aversion and self-centeredness were positively related to decline. Related, O'Kane and Cunningham (2012) used a case study approach to better understand the need for a change in leadership during a period of decline. While their findings were inconclusive regarding whether CEO replacement is necessary for successful turnaround, their research indicated that stability and humility are useful when assessing success in a turnaround situation.

Norman et al. (2010), in their mixed methods study, looked at two leadership traits, positivity and communication transparency, in the context of downsizing. The authors hypothesized and demonstrated that leadership positivity and transparency is positively related to perceived trust and effectiveness and that those leaders who exhibit high levels of both will be perceived as more effective than those who are high in one of the two traits.

The literature cited above is specific to periods of decline. While constraint can encompass more than decline, constraint does require adaptation and change, both of which typically represent loss in some way to those involved. In this way constraint does have similarity to decline.

Leadership Activities in Environments of Decline

Policy

The role of policy in children's mental health systems change has been discussed by several authors. Evans et al. (2007) conducted a policy analysis case study using mixed methods to assess the degree to which policy was used as a vehicle for systems change (developing a children's mental health system of care) in 34 U.S. states. In this two-phased study, the authors used cluster analysis to group states by the approach they employed for their system change efforts. This resulted in five clusters that used a combination of different policy instruments and collaboration with varying partners to achieve their desired end state. The authors then conducted site visits to two states within each cluster to better understand the nature of their collaboration. The findings showed that a vast majority (82%) used legislation as a mechanism for leading change. Similarly, Armstrong and Evans (2010) found the role of policy to be important in effecting systems change and implementing a system of care. The authors' findings included that

collaboration is greater when supported by policy and that a variety of policy instruments are used to support the change.

Mulvale et al. (2015) conducted a case study to better understand the impact of a national policy framework on a local mental health system in Canada. The research team engaged in mapping between the national framework and one local system, conducted a thematic analysis between the literature, national framework, and local framework and also conducted interviews with key informants. The authors found that "national frameworks can play important roles at the program and strategic levels, saving time and money in developing local frameworks, strengthening rigor, and helping to build consensus among local policy-makers" (Mulvale et al., 2015, p. 111). This is similar to the system of care strategy used in the United States where the federal government has used a funding (grant) opportunity with a very specific framework as a vehicle to effect policy and system change in the children's mental health system at the state and local levels. The authors also note the value of a national framework in simplifying the work at the local level and serving as a "neutral point of reference" (Mulvale et al., 2015, p. 123) when there were differing opinions among key players.

From this review, a picture has begun to emerge that illustrates the complexity of the children's mental health environment. Leaders in children's mental health are faced with a multitude of influencing environmental factors, policy and those akin to retrenchment as primary examples, that contribute to how their respective systems are shaped. While these two areas have been a primary focus of this discussion, it is also important to note several other factors that shape the environment in which these leaders operate. According to Hernandez et al. (2017), other factors that can influence children's mental health systems include: the presence of a designated leader with authority for decision-making, leader knowledge and understanding of

children's mental health, adequate funding, service availability, workforce capacity, level of cross-system collaboration, and the presence and power of advocacy. Other influencing factors that have been noted in personal communications include the presence of manmade or natural disasters, the political environment, and the presence of lawsuits. This list is not meant to be exhaustive, but rather to serve as a way to portray the intricacy of children's mental health systems, the complexity that leaders in children's mental health face, and to frame leadership in children's mental health as an adaptive challenge that requires a range of varied responses.

Dichotomies in Change Leadership

Throughout the literature on retrenchment, decline, and complex systems, several dichotomies emerged which seem to have relevance to the study of leading change in children's mental health. These constructs and their potential utility are reflected below.

Incremental Versus Radical

In the literature on welfare state retrenchment, the notion of incremental adjustments and radical change are both noted as possible responses to decline (Clayton & Pontusson, 1998). The two are presented as a polarity, where less profound changes to address reductions are seen as incremental and, as Pierson (1996) states, a "complete overhaul of social policy" (p. 171), is viewed as more radical. In considering leadership within children's mental health, it is interesting to consider whether leaders use a carefully constructed, well-planned approach that is incremental in nature or if they are engaged in more reactive or sweeping radical responses. Understanding if certain environmental conditions result in incremental versus radical approaches could be an important distinction and learning for the field. Arguably, one might assume that radical responses may be more likely in situations where the environmental conditions are sudden or unplanned, e.g., in manmade or natural disasters and incremental

approaches may be used when efforts to make change are the result of careful planning and decision-making.

First Order Versus Second Order

Foster-Fishman et al. (2007) define system change as "an intentional process designed to alter the status quo by shifting and realigning the form and function of a targeted system" (p. 197). Similar to complex systems, the authors note "that most systems contain a complex web of interdependent parts" (Foster-Fishman et al., 2007, p. 199), and that change can only occur if shifts occur in all of the involved interdependent parts some of which may be hard to detect or understand. The authors note that, similar to Pierson (1996) and Clayton and Pontusson (1998), many system change efforts include both episodic or first-order change that is incremental in nature and also more radical, or second-order, change. Interestingly, the framing of these changes is not necessarily as a polarity, and the authors note the potential concurrence of both first and second order change. Given the range of possible environmental influences in children's mental health, these two types of activities occurring simultaneously seem likely and congruent with the view that constraint in children's mental health is an adaptive challenge that requires a range of adaptive solutions and not simply technical fixes.

Evolution Versus Revolution

Similar to the dichotomies noted above, two approaches to change, evolution and revolution, are explored by Corrigan and Boyle (2003) in their review of change within a psychiatric treatment setting. The authors contend that "effective systems change likely represents a blend of evolutionary and revolutionary approaches" (Corrigan & Boyle, 2003, p. 384) which is to say that successful change can include both more immediate and dramatic (revolutionary) efforts coupled with a more slow and deliberate process (evolutionary) which is

akin to the first and second order change concepts articulated by Foster-Fishman et al. (2007),

and the incremental and radical dichotomy raised by Pierson (1996) and Clayton and Pontusson

(1998). In considering the broad range of environmental factors influencing leaders within

children's mental health, it seems likely, as is noted above, that leaders will be engaged in both

evolutionary and revolutionary activities. While leading change in children's mental health in the

state of Louisiana, I personally engaged in both types of activities. A planned, evolutionary

transition into managed care, the result of a multi-year inclusionary planning process, was

underway for all behavioral health services in the state, when I was abruptly asked to make

significant reductions in the use of state funds for services for children and families. An

expedient response was required and resulted in an alteration to the available service array for

children and youth with minimal planning and little engagement of stakeholders and partners.

The evolutionary (adaptive) change continued, uninterrupted, while the revolutionary (technical)

change was immediately implemented.

Retrenchment Versus Recovery

An important distinction in the literature reviewed on retrenchment is the difference

between retrenchment and recovery. Musteen et al. (2011) look at the relationship between leader

attributes and their tendency to "initiate more far-reaching strategy changes" (e.g., recovery; p.

929) or "retrenchment activities such as layoffs, selling of assets, and cutting costs" (p. 929).

Similarly, Honoré et al. (2012) distinguish retrenchment from repositioning, the latter

representing a more recovery-oriented strategy. "Retrenchment is an efficiency strategy

characterized by reductions in size and scope of an organization . . . and the scaling back of

operations to gain efficiencies" (Honoré et al., 2012, p. 367), which is akin to the

characterization of technical responses (Heifetz et al., 2009), whereas "repositioning emphasizes

innovation and growth" (p. 368) more akin to adaptive response (Heifetz et al., 2009). Primarily, the difference seems to be one in which organizations or systems engage in reactive response to a decline situation as opposed to adopting a more strategic and long-term view. As is noted above, it is likely that leaders in children's mental health are engaged in retrenchment responses when environmental conditions warrant such activity (the Louisiana example offered above), while also looking at adaptive approaches that both allow them to sustain positive gains made and continue forward momentum.

These dichotomies create curiosities and queue up questions about how leaders in children's mental health engage in change, what strategies they use, and the degree of intentionality and planned purposefulness behind their approaches.

How it all Comes Together

Void in the Field

Children's mental health systems are complex. They are organized differently in almost every jurisdiction, are comprised of multiple players from a variety of systems, and are plagued by a range of environmental conditions that shape and constrain them. Surprisingly, little research on leading under conditions of constraint exists with the exception of the literature focused on retrenchment. Within this literature, retrenchment is defined as an ongoing environmental condition or a specific set of responses to decline. This body of knowledge, most prolific in the business and management sectors with minimal attention in the public sector, is generally focused on regression and reduction. It represents one possible technical response to environments facing constraint. Yet, every day across the United States, leaders in children's mental health are creating a range of possible responses to the constraining factors they face. These leaders recognize the adaptive challenge before them and are developing innovative and

creative ways to continue to improve their system in the face of challenging environmental influences. These adaptive approaches have allowed children's mental health systems across the country to continue to evolve and flourish. Using narrative inquiry to capture the stories of leaders in children's mental health operating in environments of constraint will uncover a host of strategies they have used to effectively tackle these adaptive challenges and position future leaders for increased success, a necessary and meaningful contribution to the literature and the field.

CHAPTER III: METHODOLOGY

Introduction

As reflected in Chapter II, children's mental health system leaders face a range of constraining environmental factors that impact their ability to effect change within their respective settings. Little research on leading under conditions of constraint exists with the exception of the literature focused on retrenchment. Retrenchment represents one possible response to constraining environmental factors and is largely associated with regression and reduction. While this represents the most frequently researched type of response, most of these studies do not address the public sector environment. Additionally, the literature does not reflect the richness of adaptive strategies a leader can use to address constraining factors beyond simply reduction or elimination (retrenchment responses). This study seeks to address this gap in the literature. Using narrative inquiry, the study elicited the stories of leaders in children's mental health as a catalyst to uncover the creative and innovative ways they continue to refine and improve their systems in the face of constraint.

This chapter begins by providing an overview of narrative inquiry. The utility of narrative inquiry for the study is then explored by reviewing the role of story in the field of mental health, the use of story in public sector (administration) settings, and the fit between narrative inquiry and my own world view. Within this discussion, my positionality is explored. The chapter then delineates the study design including the participant selection criteria, selection processes, data collection and analysis procedures, quality control activities, and ethical considerations.

Narrative Inquiry

Overview

It is said that stories date back as many as 300,000 years ago (Konner, 2010), and that "Human beings have lived out and told stories about that living for as long as we could talk" (Clandinin & Rosiek, 2012, p. 2). Stories help to capture the essence of experience throughout the ages and can provide a valuable tool to understand specific phenomena and experience. The longevity of storytelling attests to its importance to society. It is not surprising then that the study of story has become a way to learn and to teach. According to Lewis (2014),

> Narrative is the everyday practice of storytelling, the teller/speaker uses the basic story structure to organize events and/or experience to bring forward what is perceived as important and significant for the teller and the audience. Narrative research, then, is the exploration of the stories humans tell to make sense of lived experience. (p. 2)

Narrative inquiry is a qualitative methodology that contributes to the knowledge base by capturing the experiences of people and using these experiences to make sense of or understand aspects of specific phenomena.

The legitimacy of qualitative research, and narrative in particular, has long been a challenge in the scientific field. Historically, quantitative approaches that hold a positivistic world view have been seen as more rigorous and therefore more valid. Positivism and post-positivism focus on cause and effect and seek to establish a singular truth (Creswell, 2014). This type of research is aimed at supporting or refuting a specific hypothesis which is *the* universal explanation (Bruner, 1986). However, over time, these approaches have increasingly been found to be limited in their value to depict the depth and breadth of human experience.

In further elucidating the importance of narrative approaches in social science research, Bold (2013) suggests that people construct truth through their own lenses, which are subjective and impacted by their experiences, emotions, and reflections, and that this integration is

ultimately what results in truth for that person. Further, proponents of narrative inquiry note the importance of context when attempting to understand phenomena, that one cannot truly separate the actual event or experience from what surrounds it and that the environment actually shapes the phenomenon itself (Lewis, 2014). Narrative inquiry allows for the understanding and meaning making to be individualized. It does not establish universal truth, as in the eyes of narrative inquirers, there is no one truth.

The Narrative Turns

Several authors discuss what they describe as "the narrative turn" (Lewis, 2014; Ospina & Dodge, 2005; Pinnegar & Daynes, 2012; Riley & Hawe, 2005) or the shift from positivism to narrative research in the 1960s. Pinnegar and Daynes (2012) discuss four distinct components of the turn toward narrative that include: the researcher-researched relationship, the use of words as data, a focus on more specific and local experience, and a broader appreciation that variety of ways people can know. These four aspects are critical to understanding the emerging importance and acceptance of narrative inquiry in the scientific world.

Pinnegar and Daynes' (2012) first turn speaks to the notion of subjectivity and to the interplay between the researcher and those being researched. Similar to Bold (2013) and Lewis (2014), the authors acknowledge that there is a seldom a universal truth, particularly in the social sciences. In this view, context is viewed as critical to developing understanding and understanding is co-created. The authors note that this shift was most prominent in the 1960s through the 1980s, particularly as those in the therapeutic community found that the research resulting from quantitative approaches was less useful in understanding their realities. In this sense, quantitative approaches focused too myopically on the client's behavior or symptoms and failed to attend to the surrounding culture and context. This culture and context included the

powerful interplay between client and therapist, what each brought to the encounter through their own experiences, and the resulting experience which was borne from the dynamic interaction between the two.

Related to this shift is the next turn noted by Pinnegar and Daynes (2012) where the value of numbers as data is seen as limited and words are viewed as legitimate data points. As the turn above illustrates, researchers in this vein view themselves and their participants as deeply embedded within a context. The context is best represented and relayed in the words of the participants. Attempts to simply count things do not attend to the complexity and richness of the range of diverse human experiences and where deep learning can occur. In this sense, words are viewed as the means to best understand a particular phenomenon.

The authors go on to discuss the move toward more specificity in both what is sought to be understood and in what results. "When researchers make the turn toward a focus on the particular, it signals their understanding of the value of a particular experience, in a particular setting, involving particular people" (Pinnegar & Daynes, 2012, p. 22). In this sense, narrative inquirers are not seeking to uncover support for broad general constructs. Instead, they are looking to bring forth the depth and variety of experience to help paint a detailed portrait that respects the uniqueness of experience.

Historically, the Cold War and the rise of libertarianism with the resulting increased focus on the promise of equality for all helped to open the door for questioning of positivist approaches. Previously, the experience of marginalized populations was seen in broad terms—using quantitative data points to illustrate the magnitude of these issues. The civil rights and women's movement in the United States shifted the approach by using the voices of those impacted to shape the conversation. Powerful stories from racial minority groups and women

coupled with the previously exclusively relied upon quantitative data (salary data by gender, voter registration by race) painted a picture that could not be ignored. Large data sets are impersonal, detached, and do not evoke feelings for many people. They do not spark people into action. Tying data sets to faces combines the power of numbers and the power of words, makes the general more specific, touches people in more profound ways by making information less abstract and more human, and helps to legitimize and underscore the importance of the narrative approach.

The final turn was a shift in beliefs specific to epistemology. In shifting to a more relational stance, where words are viewed as legitimate sources of data and enhanced contextualization is occurring, there is also a recognition and acceptance that there are many ways to understand phenomena and as noted above, a distancing from the notion of one universal truth and from the enlightenment. Alisdair MacIntyre (1984), a moral philosopher, and Stanley Hauerwas (1980/2001), a Christian ethicist, point to the impossibility of decontextualization assumed by enlightenment and positivism. This turn was also supported by the work of sociologist Bruno Latour (1979) who demonstrated that the researcher's personal and professional history are inexplicably intertwined and cannot be separated from that which is being studied. Similarly, Ospina and Dodge (2005) make the distinction between what they refer to as explanatory and interpretive researchers. An explanatory researcher seeks to explain behavior and uncover universal truth through scientific methods like statistical analysis whereas interpretative researchers attempt to focus on the underlying aspects of a surfaced behavior, to bring meaning through the understanding of context. These arguments helped to distinguish qualitative methods from quantitative, to make the case that both approaches have value in the field of social sciences, and ultimately to weaken the stronghold of positivism that allowed for

narrative inquiry to emerge. As will be further discussed, these turns, and the narrative inquiry

approach in general are well-suited for explorations into leadership in children's mental health, a

complex system under constant fire.

The Utility of Narrative Inquiry for Children's Mental Health

Congruence with the Narrative Turns

Pinnegar and Daynes' (2012) four turns described above provide one compelling

rationale for the applicability of narrative inquiry to the social sciences, the study of people, and

therefore to the field of children's mental health. Children's mental health, whether at the macro

(system) level or the micro (individual) level, requires "the cultural and contextual tailoring

necessary to bridge the quality chasm confronted by families with very diverse needs" (Alegria

et al., 2010, p. 57).

Table 3.1 delineates each of the four turns and ties each construct to the field of children's

mental health.

Table 3.1

Connection between Pinnegar and Daynes (2012) Narrative Turns and Children's Mental Health

Narrative Turn	Children's Mental Health
From objective to relational	The field of mental health is dependent upon the interactions between people and between people and systems.
From numbers to words	Quantification of systemic change is challenging, particularly when it involves complex systems. Understanding the lived experiences of leaders charged with oversight of children's mental health systems is critical to sense-making.
From general to specific or particular	General constructs must be applied within the context of specific cultures—of the people, of the system, of the geographical area. These cultural factors are unique and therefore specific

Narrative Turn	Children's Mental Health
	to the environment in which they occur. Universal constructs need to be adapted to achieve fit and congruence across the variety of environments in children's mental health.
From facts and singular ways of knowing to multiple ways of knowing	People's experiences vary based on their culture and the culture of their environment. In children's mental health, there is no "one right way" as system design and interventions must be tailored to the environment and the consumers.

Beyond the clear correspondence between the narrative turns outlined above, the mental health field is rooted in story. With story as its foundation, the study of children's mental health lends itself to narrative inquiry as a methodology.

The Role of Story in Mental Health

Within the field of mental health, stories have long played an important role. Stories are the core of specific therapeutic interventions as well as to the consumer-driven movement in the field. These areas are explored briefly below.

Therapeutic Intervention

The use of personal narratives and lived experience is the nexus of the therapeutic encounter and as such, the crux of work in children's mental health at the service delivery or practitioner level. Creswell et al. (2007) note that parallels between narrative research and the therapeutic encounter. White and Epston (1990) based all of their therapeutic work in the stories of their clients and are viewed as the founders of narrative therapy, an approach that uses the process of storying and re-storying as the basis for the therapeutic encounter and process. An underlying premise in narrative family therapy is that multiple perceptions or stories are involved in every family problem, i.e., not one universal truth (Beels, 2009). The work of the therapist is to engage each family member in telling their story and work to create a new narrative that

blends these varying perspectives and alters the family's trajectory by shifting the original interpretations. Beels (2009) notes the parallels between the therapeutic model and the research approach by discussing the inversion of the power differential between therapist and patient and its similarity to the inversion or co-creation that occurs between the research and participant in narrative inquiry.

Recovery Movement

Storytelling also has strong connections to the recovery movement in mental health. The concept of "lived experience" and its role in both patient recovery from mental health issues (micro-level application) and in system design (macro-level application) has gained traction over the past several decades. Narrative inquiry builds on this foundation and broadens the role of patient voice as a means to a more rigorous understanding of both specific treatment interventions and systemic structures. Ridgway (2001) explores the role of what she refers to as "restorying" in patients with psychiatric disability. She contends:

> Autobiographical accounts serve as strong testaments to the existence of recovery and the inherent strengths of people who face the challenge of psychiatric disability . . . Recovery narratives intersect growing interest in narrative in mental health theory and practice. (Ridgway, 2001, p. 336)

Brown (2008) articulates the value of the patient or client perspective which emerges through narrative inquiry and paints a more detailed picture that allows for deeper understanding than researcher-driven research which tends to be very top-down, fails to honor participant perspective, and offers a view that is almost entirely shaped by the professional.

Thornhill et al. (2004) engaged people who had been diagnosed with psychosis in a process that used their stories to enlighten the field about possible approaches for recovery. In their study, 15 people who had experienced psychotic episodes and hospitalizations were invited to share their stories of hope, resilience, and recovery. From their work, the authors contend that,

"If the practice of mental health is to catch-up with academic theorizing, then multiple voices and multiple realities must be heard and allowed existence" (Thornhill et al., 2004, p. 195). The authors contend that a universal truth in understanding the experiences of those who are impacted by mental illness does not exist and that to effectively respond to those experiencing psychosis, we must not impose top-down, professional driven perspectives and solutions. This is consistent with the turns suggested by Pinnegar and Daynes (2012) who focus on the more subjective and particular nature of experience and how learning can occur by embracing the varied experiences of participants and of participants in relation to researcher. While the Thornhill et al. (2004) study is situated in the individual treatment (micro) context, it seems that this assertion is no less valid when seeking to best understand approaches to be used to effect broader systemic (macro) change in the mental health field.

As many leaders in children's mental health began their careers as direct care practitioners, the role of story is likely to have played a role in their professional lives. For this reason, the intended beneficiaries of my research (current and future children's mental health leaders in particular) will be comfortable with the methodology and view the approach and findings as appropriate and relevant.

The Role of Story in Public Administration

Given my interest in understanding leaders who face constraint in more systemic mental health settings (macro), broadening the lens to look at the role of story in public sector systems (public administration) is also important. As early as 1991, Hummel discussed knowledge acquisition and research in public sector settings and noted the challenges of positivist research in this environment, as those in the sector tend to refute purely scientific results as it is seen as very disconnected from their experience in the real world. The author goes on to note that in

public sector work, the involvement of these managers as either actors or players in the story helps to give it credence and meaning.

> Analytic science gives us events that are objective fragments of reality and leaves us detached from them; the story always gives us events that are intended to be coherent and meaningful *to* us, something that cannot happen unless we become involved with them. (Hummel, 1991, p. 36)

Luton (2010) discusses the utility of various qualitative methodologies in public sector settings. In discussing narrative inquiry, he suggests, "Because narratives weave linkages among actors, events, decisions, actions, and results, they are a particularly valuable resource for understanding the meaning(s) of many kinds of life experiences, including experiences in public administration" (Luton, 2010, p. 54). Public administrators are generally charged with the oversight of specific components of the public sector or systems. As such, they find their work situated at the macro-level which is comparable to a complex organization and that system (or complex organization) is the context that the participants in my sample will be operating within. According to Luton (2010), narrative inquiry offers the ability to explore the power and emotions of organizations from a variety of perspectives and allows one to engage in sense-making that is more broadly constructed.

In their work to understand leadership in public administration and nonprofit environments, Ospina and Dodge (2005) discuss the move toward narrative approaches in the sector. In their work on social-change leadership in the United States, the authors elected to use a narrative approach to understand the experiences of public sector leaders engaged in a development program. The primary intent was to deeply understand the experience of participation in the program and its impact on the involved individuals versus attempting to prove whether a specific component or approach was or was not effective. When considering the goals of my research, the intent is similar. This study sought to learn about the experiences of

children's mental health leaders and not to prove that a specific set of strategies or techniques result in success.

Related to the sharp criticism of difficulty with applicability of more causality driven approaches in the social and human services, Ospina and Dodge (2005) and Dodge et al. (2005) discuss the concept of relevance in narrative inquiry. Specifically, relevance relates to how applicable a finding might be to the field, or in other words, the connection between research and practice. Quantitative approaches are often seen as more antiseptic and devoid of connection to the reality of experience for practitioners. In contrast, narrative approaches overtly and directly raise the experience of practitioners as the findings.

The relevance of these assertions to the field of children's mental health is profound. For several decades, researchers and practitioners alike have voiced concern about the research-to-practice pipeline and the lack of adoption of research findings into practice settings in any sort of expeditious way. This holds true when looking at practice at the macro or system level as well. Stroul et al. (2010) discuss this challenge for children's mental health and noted that "the relationship between research and system change has been tenuous at best" (p. 125) and that "significant improvements in this relationship are essential to ensure that research will better inform policy and practice in the future" (p. 125). The authors go on to note that there is generally an absence of information obtained through research when constructing policy and a strong disconnect between research and system-level work. By capturing the stories of policy and system leaders themselves, this research is more readily translated to the system change audience and therefore has true potential for significant impact on the field.

Relatedly, Feldman et al. (2004) discuss the benefits of narrative inquiry in the field of public administration. The authors studied organizational change in five U.S. cities using the

stories of city managers in these cities. Through a rhetorical analysis of the city managers' stories they were able to understand how plans were translated into the reality of the work and how the political and social environments needed to be factored in when attempting implementation. Social and political relations have significant influence on children's mental health administrators who are functioning as part of a political system. Their actions will be influenced by these environments (and the constraints they face) and understanding their activities within this context can be achieved through hearing their stories.

Similarly, Maynard-Moody and Musheno (2000) discuss the value of narrative in public sector settings in their work to look at differing perceptions and experiences between local level direct care workers and state level bureaucrats. Here the authors share that, "Stories allow the simultaneous expression of multiple points of view because they sustain and suspend multiple voices and conflicting perspectives. They can also present highly textured depictions of practices and institutions" (Maynard-Moody & Musheno, 2000, p. 336). In healthcare in particular, there has been an increased emphasis to broaden the research base and integrate more qualitative approaches. These have more often found their home in the "softer" specialties of healthcare like mental health; however, there are efforts to make the value of qualitative work, and narrative in particular, more obvious in the medical community as well. Beginning in 1999, *Health Affairs* began publication of a column entitled, "Narrative Matters," with the intent to bring multiple voices and perspectives to important healthcare policy issues. By bringing narrative into the medical community, it offers further legitimization as physical health, and physicians in particular, are often viewed as more scientific than those in the mental health and human services arena. "It seemed to us that the personal narrative could bring a perspective to the quantitative

material traditionally in the journal that promote understanding and help focus policy deliberations" (Mullan et al., 2006, p. xiii).

The Potential Role of Story in Children's Mental Health

Children's mental health systems are quite simply, complex. Leaders in children's mental health face a variety of imposing factors, and the "rich interconnectivity" (Uhl-Bien & Arena, 2017, p. 9) of these factors shapes and forms a system. How the leader approaches this work is uniquely their story and where learning is surfaced. Understanding the stories of how leaders approach their work, their successes, and their failures, begins to paint the picture of a rich and interconnected field and offers future leaders invaluable lessons about leadership in complex systems that are often riddled with a variety of constraints. Given this focus, narrative inquiry, or "the exploration of the stories humans tell to make sense of lived experience" (Lewis, 2014, p. 2), was a good fit for this research.

The Utility of Narrative Inquiry for Me

The fit between narrative inquiry and leadership in children's mental health is illustrated above. The fit between narrative and me as a researcher is also very clear as explained below.

My Ontology

As a social worker and as a leader, I am someone who is drawn toward and energized by human experience. I tend to see and understand the world through people, relationships, and interactions. I am someone who tends to seek and offer very concrete and clear (yet not prescriptive) suggestions. I believe that reality is constructed through the actions of people, by capturing those experiences, and by retelling those experiences. In this way, narrative inquiry is a true fit with my ontology.

My Epistemology

As noted in Chapter I, I tend to both learn and teach through story. For me, concepts and constructs only become real when they are applied in real situations. I am able to integrate information by hearing about it and by doing it. By sharing with others and hearing others talk about their experiences, I can more deeply embed the information. I find myself consistently seeking to understand through example and use applied examples as a way to illustrate points and constructs. Story to me represents a way to bring things to life, to concretize it through application.

My Leadership Style and Beliefs

Narrative inquiry is also a method that is aligned with my leadership style, beliefs, and theory preferences. Through engaging with children's mental health leaders from across the country to hear their stories, the authentic (Luthans & Avolio, 2003), relational (Uhl-Bien, 2006), and inclusive (Booysen, 2014) aspects of my leadership inclinations will be tapped as I am seeking to create a context where leaders from a variety of places and cultures (inclusive) feel comfortable (relational) sharing their personal experiences (authentic). In particular, Connelly and Clandinin (1990) touch on these aspects of narrative inquiry and note, "the importance of the mutual construction of the researched relationship, a relationship in which both practitioners and researchers feel cared for and have a voice with which to tell their stories" (p. 4).

My Experience and Positionality

As noted in Chapter I, my interest in studying the experiences of leaders in children's mental health during times of constraint comes from my own past experience of serving as a public sector leader in both a county and state children's mental system. Narrative inquiry allows for and respects the researcher's own experience. Throughout the study, I remained aware of my

potential for bias and approached the study consciously attentive to not hearing the participants' stories through my own lens. My training and past experience as a therapist equipped me well for this aspect and helped me to ensure that my own experiences promoted enabling versus disabling bias. As has been discussed, my experience is tied to the narrative turn which notes the shift from objective to relational within the research context.

<div align="center">**Study Design**</div>

Narrative inquiry has congruence with what I sought to explore in this study. Below I outline how I used narrative inquiry to understand the experiences of children's mental health leaders who were operating in constraining environments including the participant selection criteria and procedures, data collection and analysis methods, quality control measures employed, and ethical considerations.

Participant Selection Procedures

As reflected in Chapter I, this study sought participants who are or have been state children's mental health leaders in the United States. The NASMHPD is a United States based member association comprised of the state executives responsible for the public mental health service delivery system in the country including the territories, pacific jurisdictions, and the District of Columbia. Within NASMHPD is the Children, Youth, and Families Division (CYFD) which is a designated group comprised of those designated as the children's mental health lead from these jurisdictions. The official NASMHPD member is responsible for the designation of the member who serves on the CYFD. Both NASMHPD and the CYFD host monthly virtual meetings and at least one in-person meeting each year. The CYFD is assigned a NASMHPD staff member who serves as the coordinator for meetings and communications.

To begin the participant selection process, I composed an email (Appendix A) that explained the study and the assigned NASMHPD staff person distributed it to the CYFD via their established listserv. This email also included the study information summary (Appendix B) that further explained the research. Participants were encouraged to contact me via email or phone. I then attended a virtual meeting of the CYFD to explain the study, its purposes, and encourage participation. After that virtual conversation, I then followed-up with the individuals who had expressed any interest to discuss their willingness and participation. I had initial conversations with all potential participants to ensure they met the study criteria and had the ability to engage in a video session to share stories about their experience operating in environments of constraints. We also reviewed the Informed Consent Form contained in Appendix C.

Participants

Ten participants were identified from across the United States. All participants were currently or had been in a role designated by statute, law, regulation, or state leadership as responsible for the oversight and administration of the children's mental health system in a particular state within the past 48 months. Participants were not engaged in the direct provision of services to children, youth, and families as part of their role. All participants considered themselves to be operating in a constraining environment. The construct of constraint was initially defined as any environmental factor or condition that imposes some sort of restriction or limit on the leader in any way. Examples were provided which included funding reductions; political changes; policy changes at the federal, state, and local levels; media scrutiny; legal actions; and natural or manmade disasters; however, leaders were invited to identify their own constraining factors and were not limited to this list.

Nine of the 10 participants were female. The ages of the participants ranged from 45 to 69 years of age. Eight of the ten participants were Caucasian and two described themselves as people of color. Eight of the 10 were still currently working in government in their role or a similar role, and two had left government service. The participants were from various regions across the country: three from the South, three from the West, and four from the Northeast. All 10 leaders had over 20 years of experience in human services and five of the 10 had been in their role for over 10 years. Only one leader had been in their role for less than three years. The governmental structure varied across the 10 participants, with half of the participants having four or more positions between their role and the respective governors for whom they worked. No participant reported directly to the Governor although two reported directly to a cabinet-level Governor's appointee. Half of the participants worked in predominantly Republican administrations, three worked in predominantly Democratic administrations, and two had cycles with governors from both political parties.

While the sample was not racially diverse, it did represent diversity across several important dimensions.

Data Collection

Narrative inquiry is an approach that is less conversational. Instead it seeks to evoke the experiences of the participants through the sharing of stories. A well-thought out question is critical to engaging in the narrative interview. To initiate the narrative interviews, I asked participants the following question: "I am interested in hearing stories from your career that help me understand how you managed to lead during or under specific constraints or constraining circumstances." All interviews were conducted via the Zoom video conferencing platform and recorded. Recordings were professionally transcribed immediately after the interview was

completed. Interviews were continued until data saturation was reached. All transcripts and specific demographic information were uploaded into Dedoose, a cross-platform application to analyze data in qualitative and mixed method studies, to support the coding and analysis processes.

Using the framework suggested by Jovchelovitch and Bauer (2000), I engaged in five phases for my interviews which will include: preparation, initiation, main narration, questioning, and concluding talk (p. 6).

Preparation

Preparation for narrative inquiry includes "exploring the field" (Jovchelovitch & Bauer, 2000, p. 6). This exploration included the work done to complete the literature reviews for chapters II and III as well as discussions with my committee members to develop this study. As participants in the study were going to be scattered across the country, and the interviews were going to be conducted virtually, I reviewed video platforms and selected Zoom and explored confidential transcription options. As each participant was secured, I also did research on the participant's state to capture the region, the total state population, the percent of the population under age 18, the median household income, and the percent of state population living in poverty. This information was entered into Dedoose, the application I selected to use for data analysis.

Initiation

Jovchelovitch and Bauer (2000) explain initiation as the phase where the context is set, essentially describing the research and how the interview will proceed. This phase began with distribution of the study information summary to the selected participants. For each interview, I was seated alone in a room to ensure privacy of the conversation. At the start of each interview I

reviewed the focus of my research and re-reviewed the informed consent which had previously been signed and submitted. I reminded the participants that they could discontinue the interaction at any time and request that the recordings be destroyed. I also asked each participant a series of demographic questions including their age, gender, race, ethnicity, highest degree held, the number of years of human services work experience, number of years in government, and number of years in the children's mental health leader position. This information was entered for each participant into Dedoose with the corresponding state level information collected during the preparation phase.

Main Narration

To begin the main narration, I posed the interview question to each participant and allowed them to share their stories in response. Following the suggestions of Jovchelovitch and Bauer (2000), "When the informant marks the coda at the end of the story, probe for anything else" (p. 7), I prompted based on what they had shared, and also for other stories by asking, "Are there other stories or critical or defining moments that really help me understand your experience of leading under constraint."

Questioning

After participants concluded their stories, I entered the questioning phase suggested by Jovchelovitch and Bauer (2000) and asked any questions that elicited more information about their shared stories using the participants' language.

Concluding Talk

After hearing the participant's stories, I asked if there was anything else they wanted to share about their experience leading during constraining times. Once the participants responded, I stopped the recording and asked the participant for any impressions of the conversation.

Upon completion of each interview, I immediately journaled about the experience to accurately capture any initial impressions or feelings. I paid close attention to any emotional reactions I had or any comparisons that I was making to my own experience as a leader.

Data Analysis

Dodge et al. (2005) discuss three approaches to narrative inquiry in public administration and two seem most relevant and related to the intent of my study and aligned with the categorical-content approach (Lieblich et al., 2011). The first is the view of narrative as language where the stories that are shared are illustrations of the person's experience and their reality and begin to shape a picture of what was happening across the various actors. When viewing narrative as language, researchers use specific techniques to compare and contrast the themes and experiences across different people and different stories.

The second view is that of narrative as knowledge, where the researcher seeks to surface more covert themes that are situated within the context of the story. According to the Dodge et al. (2005), this view is premised on the belief "that people think and know through stories" which is very aligned with my own epistemology and ontology. These two approaches look for common patterns or themes and truly reflect my belief that the value of these stories and the resulting analysis will allow people to learn from other's experience and understand the subtleties, complexity, and nuance that are contained within both the children's mental health and leadership fields.

Categorical-Content Analysis

Categorical-content analysis is an approach that is used when the researcher is seeking to understand a problem or phenomena shared by a group of people (Lieblich et al., 2011). This approach was congruent with the intent of my study given my interest in understanding how

constraints were experienced and responded to by state-designated children's mental health leaders. Through the analysis, I sought to understand what happened and how the teller responded which is aligned with a categorical-content approach as opposed to the holistic approach which focuses on the person as a whole.

Upon receipt of the transcript of each interview, I first entered a set of demographic data into Dedoose that included the leader's geographic region and size of the region; his/her years of experience in the field of children's mental health and in government; the levels between his/her position and the governor; the political party of the governor(s) worked under; and race, ethnicity, and age band of each leader. Following this I reviewed and re-reviewed each transcript several times to immerse myself in the participants' experience and story. I then conducted an initial read of the transcript to identify the presence of two *a priori* codes (domains), "constraints" and "strategies." During this initial read, additional themes surfaced and were established within Dedoose. After several interviews occurred, the themes were re-reviewed and refined resulting in overarching themes with categories underneath them that more accurately grouped the codes. Transcripts that had previously been reviewed were re-reviewed themes and categories that had emerged in subsequent analyses. The transcripts were also read to identify strategies used by the participant to respond to the constraints they had noted. Strategies, as they emerged, were entered into Dedoose and were also refined into overarching themes and categories as the analysis progressed.

After the initial interviews were completed, the transcripts and coding were reviewed by the methodologist on my Committee who felt the codes captured the essence of the story and were tied to relevant excerpts from the stories to support them. As additional interviews were gathered, I was able to look across participants for convergent themes and strategies.

As a final step in the analysis, I drafted individual stories for each of the 10 participants that captured the overarching themes and messages within their stories. These were constructed by replaying the video from the interview and after numerous reviews of the transcripts. These stories are presented in chapter IV. The composite story that emerged from the stories in chapter IV and illustrates the convergent themes is shared in chapter V.

Quality Control Measures

To ensure the credibility and rigor of this study, I engaged in three quality control activities: reflexive journaling, regular discussion with my Committee Chair, and review of initial transcriptions and coding with my methodologist.

Reflexive Journaling

My positionality is something I remained cognizant of during my research. While narrative inquiry is conducted in a relational context, I was highly vigilant to ensuring my experience served as enabling versus disabling. After each interview and during the completion of coding, I journaled about my thoughts and impressions and reflected on where I felt the tug of my own experience in hearing the stories of my participants. These reflections are woven into the findings in Chapter V.

Transcript Review With Methodologist

After completing the initial interviews, I uploaded the demographic information and transcripts into Dedoose, performed initial coding, and shared the Dedoose project with my methodologist. We had both email exchanges and one-to-one sessions to review the initial coding. Feedback from these interactions informed the subsequent coding.

Ethical Considerations

Given that the participants in this study were career professionals who had been engaged in system level work within the field of children's mental health, I did not anticipate significant ethical issues to surface. The study did not involve protected populations. All participants provided informed consent (Appendix C) and were advised of their right to discontinue the interview and have their information destroyed at any time. Interviews were conducted via Zoom in a private setting, recorded, and professionally transcribed to ensure confidentiality. Each participant was assigned a pseudonym with only me being aware of their actual identity. Any identifiable information was removed from quotations or scenarios that were used within my dissertation. In fact, much of the demographic information collected is not specifically reflected in Chapters IV, V, and VI to protect the identity of the participants. While a few participants became emotional when recounting their stories, there were no significant emotional reactions or interactions that led to concern. I encouraged participants to speak with trusted colleagues about any feelings that arose to help ensure that I did not slip into the role of colleague or therapist and remained the researcher with as much objectivity as possible.

CHAPTER IV: RESULTS

This chapter will present the initial findings by providing summary stories from each of

the ten participants in the study. Each story begins with a brief introduction about the state and

context. These descriptions are deliberately vague to ensure the preservation of confidentiality. It

is important to note that while the geography and demographics varied for the ten participants,

their stories shared many common themes.

Having served in the state children's mental health leader role myself for nearly four

years, I experienced a certain degree of familiarity with much of what was shared. I was also at

times left in awe of the participants and all that they had accomplished. What is clear, and will

come through in their stories, is the unwavering commitment of these seasoned professionals to

the betterment of the systems serving children with mental health challenges and their families.

Mary: A Very Interesting Roller Coaster Ride

Mary's state is a highly populated northeastern state with a fairly high median income

and fewer than 10% of the population in poverty. Since she was only one step removed from the

Governor, she knew she had a relatively shorter tenure in government and had no longer than a

term or two to make significant headway with her state's children's mental health system. That,

coupled with the urgency being expressed by families, led her to take action thoughtfully, but

swiftly.

Mary didn't intend to become part of the government. In fact, she was encouraged by her

colleagues to apply for the state children's mental health leader position. She decided to go along

for the ride because as she described it, "It needed leadership, and it needed a zealot, and I saw

myself as a bit of a zealot." In her state, the children's work sat in a distinct department devoted

to children which grew while she was at the helm. Conscious decisions, like bringing in

responsibility for children with intellectual and developmental disabilities, and unforeseen circumstances, like a significant natural disaster, led to her system's continuous evolution. Throughout her time there, there was a constant barrage of needs and challenges creating an ongoing need response and many ups and downs, twists and turns: first it was addressing the needs of the children's population with intellectual and developmental disabilities, then it was substance use, then it was a state financial crisis, then a natural disaster. The environment was constantly throwing things at Mary and her job was just to figure it out and move forward.

She accomplished a great deal in her short time there, relying on a core set of values as her foundation: "That was our experience. Fix things that were broken, use System of Care values and principles to drive decision making, and ensure we were moving in the direction of being respectful and thoughtful to the [values]." Communication, in many forms, was the core of Mary's leadership, and her success. Mary devoted countless hours to talking with and listening to all sorts of people. Keeping a keen eye on the impact of systems change on the families intended to benefit, she found herself meeting frequently with parents.

> I met with a room full of parents who were furious with me, furious. I understood their fury, I was furious too. So, we were on the same page, because we weren't moving as fast as we needed to in order to meet their needs. (Mary)

These interactions were the impetus for her work, and also what fueled her.

Her sense of urgency derived both from the potential term limits of the Governor she worked for and from the people who desperately needed a system that worked better. "We used to say we were building this airplane while we're flying it." With providers and other system partners, Mary was open and transparent: "There was no reason why we shouldn't communicate what we were thinking," and was open to input and feedback: "You have to allow the same space for people to be able to communicate back." Her message was consistent: "You had to be saying

the same thing everywhere you go," and her mission was crystal clear: "The people that I was working with across the state were interested in the same thing I was. They all wanted the same thing. All of them wanted children to feel better."

Along the way, Mary realized that while relationship development and communication were critical she would at times need to just move forward: "There is a recognition that at some point, that in order to accomplish what is necessary for the whole system, there are decisions that just have to be made." Whenever possible, she used data to guide her decision-making as they provided an important foundation and justification. She also was aware that her decision making could make her unpopular or place her at risk: "The Commissioner was worried because she thought that people were going to harm me." She also realized the criticality of political work and being able to maneuver within the system, noting that

> They had a very strong politician who was an advocate for them and so we had to get to the Governor's office to do what we needed to do…there was political work that was done by folks who realized that this was in the best interest of children. And so, it took us about a year. (Mary)

Mary also "fixed Medicaid" as she understood the need for more technical solutions that would help concretize the work and sustain the changes that she had her team work so hard to implement.

Mary's efforts as a state children's mental health leader were an ongoing and evolutionary process: "So that's kind of what it looked like. It was this constant sort of fixing of what we were doing, and refining, and make it work better. And getting feedback and talking to people." In reflecting on her work, and all that she both faced and accomplished, Mary said, "my experience was really this very interesting roller coaster ride."

Cindy: Persistence and Humility

Cindy is a longstanding state government employee. She has worked in her largely

middle-class Western state for nearly 30 years. In that time, she has seen a lot of change, has

worked in both Republican and Democratic administrations, and been a part of different agency

configurations. Her position has been funded by different departments over the years – mental

health, Medicaid, child welfare – and situated just far enough down from the Governor that

elections do not result in loss of her position. Elections do result in a shift in leadership above her

and in priorities, something she has learned to weather by using a slew of different approaches.

Cindy has worked to effect change in a slow and steady manner: "It hasn't been always

these big watershed moments. It's been really just consistent work over time, and eventually

things come to pass." Having a sense of where you are heading and coupling that with an

inordinate amount of patience has allowed her state's children's mental health system to

progress: "I think it's important to know where you want to go, but to be a little flexible about

how you get there or what pieces get put forward first." She spoke candidly about the need to

seize on opportunities that present themselves that may not have been predicted. "I have no

qualms with saying I am a total opportunist. And being able to connect your work to whatever is

going on." She also realizes the importance of having ideas of where you want to head at the

ready given the unpredictability of the environment:

> It's kind of like you get a piece here, you get a piece there. So that's why I think you have
> it in your pocket, because you know what all those pieces of a system are, and then when
> the time is right for a certain piece, because I don't think it happens in a neat order, at
> least not in my experience. It would be so lovely if somebody just said, here's millions of
> dollars, go create a system. But that's not how it has happened for us, and so it's been
> piece by piece by piece. (Cindy)

She relies heavily on data as she knows that a combination of hard cold facts and emotional

stories can spark action. "If you don't have a big constituent group out there screaming, then

what you've got is data. So, I think data is the thing that can expose what's wrong with the system or expose how it could be better."

Cindy relies on some of her personal skills and attributes to keep her system evolving. She has spent the past nearly three decades building relationships and leveraging them to make change.

> Critical to our success is having a strong network of supporters across state agencies, external community, so that the support that you have for the work isn't just constrained to inside the agency. Because there's going to be a lot of change, especially the people above you. So we've always . . . I feel like in my work, we've always had a really good broad-based support among other state agencies, people at the same level who were concerned about this work, and the community. (Cindy)

Leveraging these relationships for advocacy and policymaking has been invaluable as Cindy realizes that sustainability is supported through legislation: "There's no way this is going to happen without legislation. There is no way."

She realizes the importance of humility and knows that what matters most is getting the work done, not who gets credit for it.

> My skillset is really to get the ideas out there, to build a coalition of people, but I'm not always going to be the one to carry it across the finish line. Sometimes it means not having to be out front. (Cindy)

She acknowledges that her system's success is really about gauging the environment and titrating the response: "There's times when you step forward and there's times when you stay back, depending on the administration and what's going on."

Cindy has felt the impact of moving too quickly or attempting to do too much at once.

> Sometimes I think that happens with leaders if you're talking about really, really, really big change. I mean, you can work at the edges all day long, but if you're talking about things that are really big, sometimes the person that puts it out there is . . . there's consequences, because people don't like change. (Cindy)

These experiences have not deterred her, and she continues to fight the good fight on behalf of children and families, "So, at the end, I think part of it is persistence. You keep going."

Cindy's approach to leading change is facilitative and inclusive. "I think of myself as more of a kind of community organizer person where you bring together the right people, you bring up the issue, and then other people may lead it."

Lucy: Battling Perceived Mission Disparity

Lucy has spent over two decades in government working on children's mental health in a poor Southern state. In that time, she has reported to several different people and operated under many different structures. The state has shifted back and forth between large mega-agencies that house nearly all of the child-serving departments to separate agencies which she notes adds to the challenges and complexity she faces:

> It created some difficulty as far as collaboration because there were [many departments] . . . they also, at that time, put a lot more layers of bureaucracy in place. So, we not only had secretaries and we had undersecretaries and deputy undersecretaries and just all these additional layers. (Lucy)

With the leadership and structural changes, Lucy found herself relying on a united vision and a set of core values that helped to ground the work. "I found it helpful to always just focus back on what we do, the basics of what we do, focus on improving outcomes for kids and families." She shares that much of her work has been focused on addressing what she and a colleague have termed,

> perceived mission disparity . . . when an agency gets so focused on the specific deliverables of theirs that they forget that it ties to a higher connected goal that we all have that's really about family and community wellness.

Bringing others back to this fundamental concept and helping them to unite around it has been a core strategy for her work.

Lucy views her role as leader as creating the context for good work to happen. The foundation of her work, which is energizing for her, is the ability to effect positive systemic change by leveraging relationships—with her staff, with her state agency partners, and with providers and others at the regional level across the state. She laughs as she relates this story:

> I had a supervisor that said, "You're always out so busy collaborating. You need to be here doing your work." And I said, "Well, this is the work of children's behavioral health, collaboration is the work of children's behavioral health." I don't think she really knew what to say about that, so she let me keep doing my thing. (Lucy)

Using those relationships to "stop having parallel mental health systems for kids involved or in state custody, and [determine] how can we work more collaboratively around [an] issue" has been important to her state's progress. The collaboration is also a delicate balance where managing expectations is critical for both relationship preservation and success.

> Sometimes we get pressure to, can you all add this or look at this or can we make this more about juvenile justice reform? We have to walk a fine line sometimes and saying, we can look at that because it fits under behavioral health, but it's not going to become the primary focus of this group. (Lucy)

> Lucy's approach to leadership is about empowering others which has allowed people to

grow and to explore their passion areas in ways that have benefitted the system.

> I've ended up with staff that have come from several other places in our [government] and they all are like, "Wow, we didn't know it could be like this inside government." To me, I'm like, I don't know why somebody wouldn't do what we do, but I think it's just the building on strengths, letting people try things, coaching and supporting them from either right next to or far behind sometimes and letting them go.

This has resulted in significant enhancements to their services for the transition-age youth and early childhood populations. She also knows that at times it's important to get out of the way:

> So I did more behind the scenes work and sort of stepped back and let the people that needed it to be their name and their face to do what they needed to do, and sometimes things didn't get done and that was okay. (Lucy)

Lucy also shares the critical role of financing in her work and believes that her state's ability to make progress has been dependent on the ability to secure ongoing grant funding to seed and support innovation as well as promote a consistent values base. "We've only gone a couple of years without having a system of care grant to ground the work." During her time as leader, her state also engaged in Medicaid expansion which she noted, "added not only additional billable services but also broadened the provider network to a whole new slew of providers, including new agency types as well as individuals who could enroll, credential individuals." While not without challenges, this expanded the service array for young people and their families.

Leadership for Lucy is about adapting to the environment and uniting key people around a common mission. She knows how to adjust and respond depending on the circumstances that her state is facing.

Nancy: The Professional Hurdler

Nancy has spent the past 25 years working on children's mental health at the county and state levels. Her densely populated northeastern state has pockets of poverty scattered throughout, resulting in reliance on the public mental health system for critical services and supports. The state has multiple agencies involved in serving the various needs of children and their families that results in a high degree of complexity when attempting to effect change. Nancy's position is removed from the Governor's office by multiple levels. This, coupled with the decentralized agency structure, impacts her ability to advance the system.

Nancy notes that further complicating the situation is the lack of resources devoted to children's mental health:

Children's mental health comes secondary and almost as an afterthought to adult mental health in terms of the amount of resources devoted to services, in terms of the workforce,

both administratively here in government and in the field . . . about 20% of mental health resources go to children's mental health, and 80% goes to adult and other [areas].

She reflects on the size of her team, which in large part is covered by federal grant funds, and looks up thoughtfully, "I'd love to see their org chart," referencing the adult mental health division staff, and goes on to say, "I'm laughing about it, but definitely there are moments where it's not so funny, where you literally can't advance things because you don't have the manpower." The inequity serves as her personal call to action as she sees the benefits of earlier intervention and supporting children and young people.

> In a world of finite resources, that comes at the expense of people at the earlier end of the spectrum, and if you believe in prevention, which I do, that seems like a gross injustice to not have a more sort of equal distribution of resources, and it makes my job harder. (Nancy)

It also seems to make her job one of determination.

With so many agencies involved in the mental health and wellbeing of children and their families, Nancy relies on relationships to get the job done. "So much of what's involved with a role like this is cultivating and maintaining positive working relationships with people, because that's the leverage that you have. You have to leverage relationship, because I don't have any real authority." Given her perceived lack of authority, Nancy approaches change incrementally and carefully.

> Well, of course there were things that weren't working, but that doesn't mean you throw the baby out with the bathwater, it means you work together collaboratively to understand the strengths and weaknesses, and then you support the strengths and you grow from there.

She sees her responsibility to guide and shape the system and "bring it in for a soft landing."

Nancy works across the various state agencies to build a common purpose and to unite actions around that shared vision:

Even when you have the occasional personality conflict or some kind of strife, ultimately there is a general zeitgeist here that everybody's here because they want to be here and because they have, whatever their maybe personal experience or personal philosophy here, whatever, that makes them really committed to the work.

Critical to her success it seems is her consistency. She carries her commitment to system improvement and slowly and methodically helps people to come along. She checks her ego at the door and is willing to hang in there in the face of obstacles and challenging personalities.

I have something to offer here, and I am driving this stuff, even in, sometimes it feels very subtle, maybe, and my style is actually to be more subtle, more behind the scenes, whereas other people have a more forceful or assertive or aggressive kind of style, but it can be very subtle, and like I said, I think it all comes back to relationships. And if you can utilize those relationships as much as possible. (Nancy)

Nancy's system relies on her agility and ability to maneuver. She chuckles as she reflects, "I'm a professional hurdler, hurdling over these obstacles." Hurdling for her equates to a willingness to be patient and seize opportunities for change when they arise. She does this strategically and thoughtfully.

We'll do some workarounds, we'll work here off the side to the create something, blah blah blah, over here, but we'll also start to tinker with what we put out there, and we obviously can't do, you can't rip everything apart now that you just propped it up, but you tinker a little bit to gain control. (Nancy)

She also relies on more formalized mechanisms to get things done. Within her state there is legislation that stipulates the need to work across systems on behalf of children and families and a forum to do that is established within the regulation.

It should be someone's job to convene those people and to have a forum where kids' issues can be talked about, and to have some accountability, there's accountability built in. If you read the statute, it's actually fairly strong language around . . . hold[ing] those state agencies accountable. (Nancy)

She also realizes the importance of cementing changes through policy and has spent an extensive amount of time working with the state's Medicaid authority to adapt their Medicaid State Plan and make significant changes to the service array for public mental health consumers.

Nancy uses both her personal attributes and more structural approaches to clear the hurdles and approach the finish line.

Maureen: A Passionate Incrementalist

Maureen is the children's mental health leader in a fairly affluent, not particularly racially diverse, densely populated northeastern state. Maureen has spent over 30 years in state government holding a variety of roles across the executive and legislative branches. As the designated leader for children's mental health, she is nested within a large state agency that covers a vast number of departments. Her position reports to a Cabinet-level appointee which translates to only her boss sitting between her position and the Governor's office. She, like other leaders, talks candidly about the lack of prioritization of children's mental health: "In general, I think that's a huge challenge for children's mental health is to ever get up on the agenda in a big away." With this lack of attention to children as an overarching theme, Maureen acknowledges that her success and the success of others in children's mental health is really "about maximizing what you can do within a constraint. I think you can contrast it to people who it's easy to get beaten down by the constraints and either lose your oomph to keep pushing for quality." She sees it as her responsibility to keep pushing the envelope, even in the face of what could be seen as indifference. When speaking about the accomplishments in her state specific to children's mental health, she chuckles and reflects, "No governor can get elected with that accomplishment. It's too narrow. You know what I mean?"

Maureen is very attuned to seizing opportunities and maximizing on them to initiate change and system improvement. Although her state has faced a major lawsuit that served as an important catalyst for deep change, she realizes that leveraging smaller opportunities and developing evidence is critical to being ready for the bigger moments. "The lawsuit is this

example of where legal tools can do something very meaningful, and then there's continuous

innovation and improvement that you do in your everyday work." Maureen realizes that a

primary vehicle for big funding is through "legal leverage, so you can get a big win in the courts,

or something that's a big enough issue to mobilize public opinion to support resources." And yet,

repeatedly as she talked through the arc of her career, she reflected on the evolutionary nature of

the work to improve the children's mental health system.

> The critical thing is building little pieces of infrastructure and packets of experience
> because you can build on it over time, and so things that start out small through the
> course of a long career you can add to it every year. And if it's really good and really
> working, there's more of a chance it'll stick, and it'll grow, and it'll get built into standard
> budgets and built into the infrastructure of your system. (Maureen)

> A primary strategy in her work was paying very close attention to the needs being

surfaced by important partners—families, legislators, other state agency staff, as examples.

> I feel like that's always been true in my career of being very attuned to small, medium,
> and large opportunities . . . I think it's very apropos when you're working in government
> of like, "What are we dealing with here, and what are our opportunities to either elevate
> attention to or get some kind of a strategy going to make big change?" (Maureen)

She highlighted several examples of using pilots as a way to use an incremental—and in her eyes

effective—approach: "You do something, do it well, capture what you're doing, spread it, share

it, illustrate it." She also talked about the importance of using these smaller initiatives to

"improv[e] what you can improve, institutionaliz[e] it to the degree you can by using policy

vehicles, like Medicaid, to secure ongoing funding."

> Relationships have been essential to Maureen's success. She realizes the crucial role that

partnerships play and about being honest and transparent with her partners. She sees her role as

helping partners to seize the opportunities that she sees,

> really working in a collaborative way with stakeholders to get as creative as possible and
> to maximize the quality, using the best evidence we have, really pushing hard to really

> maximize what we can do within whatever the constraints are. I think those are skills that good government practitioners have. (Maureen)

This work may surface conflict, which in her mind is an important part of system development.

> It's really been an important part of my success of not being fazed by conflict, not being afraid of conflict, knowing not to personalize conflict, like policy conflict, and being able to help and if you're calm about it. Being able to help people step into a space of working with the real issues. I guess they're managerial skills. I think of them as political skills. And I rely on them wherever I've been. (Maureen)

Working thoughtfully, persistently, with dogged determination is Maureen's recipe for effecting change. "I am a passionate incrementalist," which has served her state and children with mental health needs in her state incredibly well.

Sara: Seeding Innovation With Grant Funding

Sara has spent her nearly 30-year career working in state government in a poor, largely rural, southern state. She reports directly to a non-appointed position that has very good access to the Governor's Office. The child-serving agencies are mostly separate in her state with heads of each turning over fairly consistently with every gubernatorial term, whether the Governor changes or not. This constant churning results in Sara's ongoing work to develop relationships as these are a cornerstone of what she has been able to accomplish. "It's very frustrating because as a new leader comes in, I've had to reestablish our partnerships, meaning catch them up to speed. What is children's mental health? What does the system look like?" To help with this, Sara works at all levels of these departments, not just the agency heads:

> We do have coworkers that have been in these systems, I say coworkers or partners that have been there a long time. So, that's a strength in that since we know them, and they did not leave when their commissioner left.

Sara has also found the advantages of concurrent work at the local level where there is lower turnover. Sara also notes the benefit of having legislation in place that creates the structure for cross-agency collaboration across all child-serving systems.

One way that Sara has been able to continuously engage her partner agencies and the localities has been through collaborative grant seeking which she uses to seed innovation and advance the children's mental health system. This collaboration often seems to result in work for Sara and her team, as they will generally be responsible for the grant writing.

> We've been able to partner . . . in writing some grants jointly or either they punt the ball to us. But that's okay. I count that. I count that as saying we want you all to apply for th[is] grant instead of us, and we'll partner with you all.

She shares similar stories from working with the counties:

> I can just go to the County Board of Supervisors and ask them, the county, would they be interested in applying for this money? And so, it was because of the relationship and the services that they provided to the county that the county said, "Well, sure. You write the grant; we'll be the applicant and work with you on that." (Sara)

Sara has learned that sustaining the activities of these grants requires policy work and she and her team have worked hard with their state Medicaid authority to write both State Plan Amendments and Waivers to ensure that once a grant ends, the services remain.

Using the co-creation process required for these grants has been helpful to cement the relationships and allow them to move forward even when funding is not awarded. Sara shared a story about an effort that did not receive funding:

> So, [my boss] said, "Okay, well, let's go ahead and fund a position." . . . So, really, we just have found bits and pieces and as well as [another state department]. They've been able to find a little bit . . . It's kind of like just find a little bit here and there and make do with what we've got.

Sara reflected on the importance of workforce development and training efforts. She and her team have been able to create a training entity within the state to ensure the ongoing implementation of best and evidence-based practices, noting particular successes in their work to address first episode psychosis. Interestingly, Sara shared that institutionalizing training was also predicated on relationships:

We knew the Dean of Social Work. So, it just started as sitting down and knowing who the dean was and some of the teachers and professors there, really, that's where it just started and sparked and it grew from there.

While there is no current lawsuit in the children's mental health arena in her state, Sara talks about the power of the ongoing looming threat to spark action. Fearing a lawsuit, Sara and her team access outside experts to help compile data and formulate recommendations which has served as a blueprint for their activities:

As much time as it took for all of us to gather all this information, charts and graphs and gathering data, I will say that report was very beneficial and very helpful because we were able to get those recommendations and say, "Hey, guess what? We're actually headed in the right direction."

This, and accessing the expertise in other states through the national membership entity that all children's mental health directors across the country participate in, has helped her to stave off action and ensure that advocacy groups and other partners understand the incremental nature of their work:

I guess you could say it's education, letting people know what our parameters are, that we are limited, that we can't change the whole system over night. But that we can make small steps to do it, which is not fast enough for a lot of people. (Sara)

Mark: The Art of Persuasion

Mark spent over four decades working in human services in some capacity, of which 30 were spent working in county and state government. As a state children's mental health leader, Mark was nested in an agency that housed many of the child-serving systems who reported under a Governor-appointed Secretary. Mark's position, in a highly populated, largely Caucasian northeastern state, was separated from the Governor by several levels which offered him some degree of protection, at least initially.

Mark begins his story acknowledging that to be in government is to be constrained, and this is a constant:

Government does not have unlimited money, so there are constraints all along. There's also political constraints, both the classic Democratic and Republican, or liberal and conservative constraints, but also the turf and the interest of individuals in advancing their own careers.

With this as his backdrop, Mark sought to continuously evolve his system under conditions that he considered to be limiting.

His initial limitation began when he started. Mark had to build, from the ground up, the division that would focus on children's mental health as it had been dismantled in prior administrations and was essentially non-existent. Mark laughs as he talks about the mundane like securing office space and furniture while concurrently trying to establish a vision and direction for children's mental health in his state. Noting the importance of the team to advancing the work, Mark shares,

I was fortunate to be able to get some people that had a real commitment to children's services, that had some experience. I was also very fortunate to have people that I reported to, who were very committed to children's mental health, and children's services in general.

While starting from scratch was daunting, it also offered an opportunity for Mark to really shape the vision and direction for their division's work. Mark speaks to the importance of bringing people together to craft the vision which helps with ownership and buy-in:

We brought probably 200 people together from across the [state], who were interested in children's mental health services. And in about a day and a half, we went through a pretty intensive process of identifying . . . doing pretty much a SWOT analysis: strengths, weaknesses, opportunities, threats, and developing kind of an outline of a plan for children's mental health services.

Having this framework, which including the voices and views of so many, really helped to ground Mark and the work of his team.

This convening is one example of Mark being comfortable identifying and using the assistance of outside experts and resources. He shares this as one of his primary strategies, being

able to call on the expertise of others to help move the system forward. Mark used assistance

from the federal government, fiscal subject matter experts, outside facilitators, and of the

national membership body supporting children's mental health directors. Mark unabashedly

shares, "One of the themes of my story is to seek and to use the help that's available," evidencing

his overall humility in how he approached his work.

Similar to other leaders, Mark also highlights several examples of capitalizing on things

that were already underway in his state. During his tenure, Mark's state was transitioning to

Medicaid managed care which was fraught with opportunities. The state engaged consultants to

help with this transition and true to his nature to seek outside expertise, he connected with those

from the consulting team with children's expertise using their knowledge to help inform and

shape his team's strategy for advancing the work. Mark pointed out that there was "concern that

we had such a large, huge reliance . . . over-reliance, probably . . . on residential placements,

out-of-home placements. So, another one of [our] efforts was to reduce the reliance on residential

placement." By working on the priorities of others in the state, Mark was able to get traction to

move important aspects of their plan forward.

To solidify and sustain the gains made, Mark relates his use of what he terms

"persuasion." When asked to explain persuasion, he pauses and then thoughtfully replies:

> I think that it's a combination of the professional approach of looking at the research . . .
> coupled with relationship . . . I believe that the decision makers in Medicaid recognized
> that we were trustworthy, we weren't reckless. We were professional. We were driven, of
> course, by our commitment to children, but we also appreciated their position, that
> funding is always tight, and that they had to justify any funding allocation decisions. And
> so, we helped them make that justification. So, it's a combination of the professional
> approach and the personal relationships. (Mark)

Mark also talks about the importance of financing. He recounted several examples where

he sought and was able to blend dollars from his division, other state offices, and private and

philanthropic entities to both initiate and to sustain the children's mental health work. Mark's team was opportunistic with regularity, identifying potential grant funds, approaching other divisions and departments within the state as co- or partner applicants, using the funds to demonstrate value through both outcomes and cost savings or neutrality, and then seeking to institutionalize these changes through Medicaid and other policy vehicles. Mark highlighted the importance of working at the state level, and also partnering with people at the county level:

> Because [the state] is such a county-driven, locally-driven state, working with local leaders was another one of those lessons learned . . . I think that sustainability, which is always a concern about any grant... for me and for [the state] was nurtured by the relationships that we were able to develop with local county leaders.

Mark's story "ends kind of abruptly," as he put it, which characterizes the fragility that can exist in governmental systems when leadership and priorities shift. "I no longer had my supervisor, who understood or appreciated children's services. And so, we basically had significant difference in philosophy and approach." However, his focus on relationships, joint funding, and state policy helped to institutionalize his legacy. As he said, "Another lesson learned certainly is, no one can do this work by themselves."

Penny: Keeping Your Head Down in the Gopher Hole

Penny has spent over two decades in government. Her state, an almost entirely Caucasian, scarcely populated, western state, is geographically dispersed with a lower proportion of poverty. Within this state, responsibility for children's mental health sits in the health department which houses both behavioral health and Medicaid. Other child-serving agencies are distinct, led by different Cabinet-level appointees.

While Penny realizes that the challenges she faces are not personal, her commitment to children's mental health is deeply personal:

Yeah, you just can't take it personally, but it is personal. It's personal because I was one of those families. I am one of those families. I grew up in one of those families . . . I know a lot of the people I work with struggle with these same issues, too, but it's weird, people pretend, there's still stigma, we're working on that.

Penny speaks candidly about the repercussions that can ensue if you push too hard, too fast, against well-connected politicos. She has experienced these firsthand and learned the hard way that "if you stick your head up out of the gopher hole too high, you become a threat and your head's going to get chopped off." Penny shares a story that clearly reflects the dangers of leading change, where she was scapegoated after being involved in a state procurement that did not have broad-based support. The procurement was pulled, and Penny's involvement and activities were questioned:

I went to our head big boss and I said, "Do you think I did whatever this is?" And he couldn't look at me, he goes, "No, I don't." But he wouldn't talk to me, couldn't look at me and it was just like a bad dream.

As a leader she has learned the advantages of humility and quiet tenacity to get things done: "I can be behind the scenes and be totally fine. In fact, I prefer it. I'm more effective that way . . . So I know how to work behind the scenes, and I don't give up."

Given the backlash Penny has attempted to maximize on her environment, leveraging other opportunities to effect change. She reflects that a lawsuit has come in handy to help her justify important changes to service delivery,

This in our state statute says that we do have to cover these people and this lawsuit says not only do you have to do it, you need to do it now and you need to do it in a thoughtful manner according to the settlement agreement. (Penny)

In this way, Penny has learned to play her own game of politics, sustaining important system evolution through Medicaid policy change.

Penny believes that leading is sometimes [sadly] about letting things get so bad, that no one can continue to ignore them. "Parents were relinquishing their child to obtain needed services. I knew that I needed to do something." She added:

> Expenditures were sky rocketing, quality was poor, there were issues with kids in inpatient settings. By then, even leadership had to realize . . . that we had an issue here, and everybody else had figured out alternatives and we hadn't. (Penny)

Providing exposure to other states and the national landscape to executive leadership helped to make change became possible. As Penny puts it, "We can use these things that seem to be obstacles, we can use them as a fulcrum or a catapult."

Penny also developed a deep understanding of the various financing vehicles available to implement best practices. She and her team applied for federal financing opportunities that allowed them to test new approaches with little impact to state cost. "So, we got this grant through to completion, used that information to get executive support to get these waivers into place, get the children's mental health waiver whipped into shape." Activities like these, executed over the span of several decades, has allowed her system to make progress, but not without those who challenge it. "They don't care if we lose our federal authority. They just want to do business as usual and they want to make money off these families because they're used to making money off residential and group home services."

Over her time at the state, Penny has learned to pick her battles so she can live to survive another day:

> I can't help people if I don't take care of myself or fill my cup up. I can't give to people if I don't have anything to give. So, I have to model self-care and that means sometimes walking away from a really bad situation or something I know is going to hurt people we serve or sometimes walking away saying, "I can't fix it. I need to pull in, I need to self-care and I need to figure out how we're going to go around this.

Her approach has allowed her system to move forward, steadily, but slowly.

Holly: Looking for Low-Hanging Fruit

Holly is the children's mental health leader in a diverse southern state that is a blend of urban population centers and more rural sparsely populated areas with pockets of poverty throughout. Her position is housed in the department responsible for both mental health and substance use services. She reports directly to a Cabinet-level appointee giving her close access to her state's Governor's Office. Complicating her work is that all of the major child-serving systems are housed within separate agencies in her state.

Holly has spent over ten years as the state children's mental health leader. As she reflected on her time in the role, she talked about the need to have clarity on what you believe and what you hope to achieve. Recognizing the inherent complexity resulting from her state's organizational structure, Holly spoke about the need to have collective ownership of and responsibility for the state's children:

> That's part of our system. We see these kids across our state, the children, youth and the families as *our* kids. At some point in time, if you're involved in one of those systems, you're going to engage in the mental health system.

That view, that the children in the state belong to everyone, helped to shape their overarching vision for their work, taking a

> much broader, global, universal approach as a state was really important to me, because what I realized is, from listening to other states, to working within the state, to working with our providers, that this system was a bigger concept. (Holly)

That approach is grounded in core values and principles and creates a common language in their state.

With that as her foundation, Holly has prioritized developing relationships—with state partners and with families—and understanding their needs as a primary approach to her work:

> Understanding their demands has really helped me to leverage opportunities that we had to work together with them, and the timing of that. Timing is definitely an important

factor. I think, also, leveraging real stories, and really having the backing of the consumers and the families has also been critical.

As she shares her experiences, she pauses and becomes more deliberate in her speech as she talks about the importance of engaging voices in her work:

> The people that were often making the decisions on behalf of the people we were serving were people that have not often been in those situations or circumstances. In our government, we have individuals that are not diverse in color, that are not diverse in ethnicity, sexual orientation, all those things. It is not a diversified system where people have multiple different lenses in order to make really key decisions for our state. (Holly)

For this reason, Holly relies on her relational skills to foster inclusion and ensure diverse voices inform the overarching design:

> Really, in a leadership capacity, I think that's important. And so, reaching out to people that may not be in key leadership roles, and understanding that even though you're not in a key leadership role, you have leadership abilities that can help me to help others to make decisions around the people that we serve. That was really important.

Holly shared several examples of how she was able to develop an understanding of another state agency's mandate or priority issue and use that to engage them in a partnership that not only solved for the presenting challenge, but also served as the foundation for ongoing system reform. She shared an example from her work with juvenile justice:

> [Their] mandate is a lot around public safety. And really how do you, again, as a base, look at the values and principles of systems of care in an entity like that? Really, helping to crosswalk . . . and understand the importance of youth involvement and family involvement [to public safety], and things like that.

Related, Holly tends to leverage partner mandates and priorities, or as she put it, "really looking at the low-hanging fruit, I call it, in our designs" as opportunities to both meet that state agency's mandate, but also to enhance the system overall. "Some of the things that we've done over time is to have initiatives that focus on their population as a part of developing our system." When talking about work with child welfare, she shared how she leveraged public perception by approaching the department and asking,

[I said,] "So how do we work with you guys so you are not the baby snatchers, but really more of individuals who could actually support a prevention area?" Knowing that there's this whole process that happens before there's a determination made for a kid to come into care. In most cases, not all, but in most cases, there's multiple things that they look at for that. For the community to hear that, that was really a good thing. (Holly)

In Holly's state, like several others, there is a need to advance efforts at both the state and county levels as the state establishes policy that is implemented locally. This has been a major focus of Holly's work:

We developed a state level infrastructure for key content, individuals and specialists who were skilled, and really helped our staff to understand this thing, this thing that had legs, and infrastructure, and activities, and supports and evidence-based treatment models and all of these things. We helped our staff to understand it. Then we started deploying, working in our communities to help local community teams.

Holly shared that the state's ability to support the work locally has largely been possible through the use of federal grant funds which allows the state to provide seed money to improve the systems at the local level.

Using these federal dollars, Holly and her team have worked with localities to raise awareness of children's mental health and understanding of the children's mental health system across their state:

In rural [areas], football games and basketball games are huge. Where schools would allow us, working with the Department of Education, and the schools in that area . . . we could have funding that would support activities, and information around mental health during things such as going to a football game and doing halftime, having conversation around mental health matters, and providing information around crisis care, or the stabilization, or supporting families in that context.

Stories like these illustrate her approach to partnering across systems and at the state and local levels.

Holly finds a great deal of satisfaction in her work and what has been accomplished in her state. Through a series of well-placed steps and strong relationships at the state and local

levels, she and her team have accomplished a great deal: "I'm so proud, and so excited about how we've progressed as a system over time in this ever-changing world."

Becky: Making Magic in the Machine

Becky has served as the children's mental health director in an affluent, fairly diverse, western state for two years. She has spent a decade in government, serving in a variety of positions at the state and county levels. Newer to her role as the state designated leader for children's mental health, she shared she is less at ease operating in the state structure and early on reflected, "I am not a bureaucrat," talking about her time working in a variety of roles in both clinical and administrative settings. She distinguishes herself from what she terms "machine people" who "know how the widgets work and they know how to say the right thing and look the right way and they can make the machine hum." She pauses thoughtfully as she thinks about this concept and added, "I've never been that interested in the machine aside from how to get stuff in there, so it works a little differently."

Becky's desire to make a difference has been realized in her current role although her state journey is shorter, reflecting less of the evolutionary and incremental approaches of her colleagues. Her system has been in the midst of significant transition during her tenure requiring her to work with ever-changing and sometimes unwilling partners across state agencies, at the regional level, and with managed care entities. Nested within the agency responsible for Medicaid, Becky has seen the importance of strong relationships with other critical child-serving departments. She is candid about the downsides of being newer to her role: "Being green and not really understanding/not really wanting to understand bureaucracy, I have not done as well of a job at communicating what's happening so people understand how giant what we're doing is." She also talks about the challenges she has faced when working with people who have served in

government for extended periods of time and who tend to approach their work with a definitive

stance, not really allowing her to voice her opinion:

> I just had to bully her right back so she would listen. Which is not my personality at all and it's what needed to happen to get her to listen to me when I was not sure she was right. (Becky)

Becky shares that there has been extensive restructuring and movement of divisions and

departments within the state which has in some ways splintered the children's mental health

work. Knowing this, she has sought to create strategies where she and her team can still

effectively advance their system:

> The vision that I set out and just ask people to keep was find all of your friends, find everybody who loves your work, who's interested in your work, who's curious about your work and give them everything they want to know and stay the person in charge of it which is the dynamic piece. And that seems to have worked pretty well for the kid's section. (Becky)

Having access to and understanding various financing streams has also been important to Becky

where she has been successful at braiding funding from various sources to bring new initiatives

to fruition.

The state has established a children's mental health work group that includes

representatives from various state agencies, legislators, partners and stakeholders, and the

governor's office. This group is critical to Becky's efforts, as "that's where a ton of our work

happens and where a ton of the magic, we get to do behind the scenes happens." Relying heavily

on collaboration, Becky has been able to make headway on specific initiatives by facilitating

broad-based groups on specific issues. She offers as one example:

> So we had youth voice representative, parent voice system advocates, clinical input, and hospital and facility input at the table. And we met 23 times . . . and they came to a consensus with recommendations for how to change what existed. (Becky)

That persistence and tenacity are hallmarks of Becky's approach.

Relationships have yielded valuable inroads for Becky and her team. Coupled with data, broader groups have begun to understand the importance of her team's involvement in addressing a broad array of issues confronting their state. Citing a specific example about youth homelessness that she is particularly proud of, she becomes animated as she shares:

> This is the power of those partnerships, that magic behind the scenes. Because of the connections, or I don't know why, but the group that was [brought] on to do the report to write up around youth homelessness, when they looked at data, our transition age youth discharged from residential behavioral health into homelessness within a year at like 70% of the time. And so, one of the strong advocates behind this . . . made sure we were at the table. (Becky)

With all of these moving pieces in the broader state landscape, Becky has had to rely on some concrete strategies in addition to her work on relationships and collaboration. She shared that one strategy has been to develop guidance documents that explain specific aspects of the system to her colleagues. She also has relied on training to help people understand both the system and specific practices that they are implementing.

Despite her belief that she is not cut out to be a bureaucrat, Becky is aware of the importance of her current position and the potential impact she can have. Having worked her way up through the provider and county levels she realizes:

> I think now I might have a spot where I have the right people in the right places, or know who those people are to leverage and start, and that's part of that behind the scenes work. It's finding the tribe of people who say what we're doing is not helpful to everyone. And really looking outside the status quo, or the people that the traditional services work for, and figuring out what we can do that's different. And trust from leadership to go explore that, which really makes all the rest okay most days. Tolerable most days. (Becky)

Summary and Reflection

After each interview, I took time to reflect on what I had heard and consider what of my own experience I saw in their stories and also where I had strong feelings or reactions to their stories. These reflections and insights will be more fully explored in Chapter VI. Prior to these

reflections, in Chapter V, I will more fully describe the analysis and findings including the themes that emerged specific to the leader, the constraints, and the strategies. Looking back at the literature, I will discuss what was reaffirmed, learned, enhanced or complexified. I will also present a conceptual model that helps to illustrate and explain the interwoven nature of leader, constraints, and strategies in the complex adaptive systems that are the state children's mental health systems across our country.

CHAPTER V: DISCUSSION

Analysis

After data collection was completed, the ten interview transcripts were reviewed using two a priori codes, "constraints" and "strategies." Additional thematic analysis revealed emergent themes that further refined and added specificity to the constraints and strategies and uncovered specific factors and attributes of the leaders.

First, I will share the themes that emerged specific to the individual leaders. The analysis specific to constraints is presented next. Constraints are ever-present in the leader's stories, an ongoing and consistent part of the children's mental health landscape. Constraints have been grouped into four primary categories: environmental, structural, interpersonal/relational, and procedural.

Following the constraints, the strategies used by leaders are presented. Clear from the stories is that leaders engage in an ongoing process of encountering constraints and working to create strategies that will still facilitate progress. The leader weaves through, across, and around the constraints formulating a variety of approaches to move their system forward. These strategies include relationships, visioning, maximizing the environment, financing, policy and legislation, service development, and education and workforce development.

While presented separately, the constructs and concepts are inextricably woven together and are not distinct and linear, as is reflected below. For this reason, to conclude the chapter, a composite or integrated narrative is presented. This is the grand story of the leader in children's mental health and reflects the points of convergence across the ten leaders who participated in the study and illustrates the interconnectedness of their work.

Leader Characteristics

The ten leaders who participated in this study shared their experiences of operating in environments of constraint and how they have worked to advance their children's mental health systems within this context. The stories reveal a set of leader characteristics that seem nearly universal across all participants and include a personal connection and commitment to the work and also some specific personality attributes and characteristics. These are reflected in Table 5.1 and described below.

Table 5.1

Leader Characteristic Codes

Themes	Personal Connection and Commitment	Personal Attributes and Characteristics
Categories	Personal experience Personal conviction	Humility Persistence & tenacity

Personal Connection and Commitment

As the participants reflected on their stories, a sense of personal connection and commitment to the work emerged. As shared in her story, one leader talked about her own experience growing up in a family that was involved with the children's mental health system. Others spoke about their conviction to make change, even in the face of resistance: "We're going to do it. It's right. And if somebody wants to fire me, fine. You want to fire me for serving kids that need it, I'll take that." Another reflected on a time when she had considered leaving the state but remained:

> There was a time here a few years ago, I was ready to go. I was ready to leave . . . I think what got me through was . . . the work we do is still important. Administrators, high level leaders come and go, and the work still needs to be done. It was really good that I still believe in the work. Sometimes I just felt like I had to hunker down.

Throughout the stories, the leaders' personal reasons for being involved in the children's mental health system work emerged. Another leader talked about her own need to contribute to making things better: "I am a firm believer in that if you're going to have the chance to complain about something, you have to have tried to be a solution first."

The data reflect that for many leaders, the work is personal. They have either come to the work because of some experience in their lives or feel very personally attached to system improvement. These feelings help to see them through the challenging times that they inevitably face.

Personality Attributes and Characteristics

Humility. One of the primary themes that emerged from the stories is the leaders' humility. Throughout the stories are many examples of leaders not needing to take or expecting credit for advancements in their systems. Ultimately, for these leaders, it was about getting to the outcome of system improvement and not the recognition that would result. As one leader shared:

> So, I did more behind the scenes work and sort of stepped back and let the people that needed it to be their name and their face to do what they needed to do, and sometimes things didn't get done and that was okay.

For these leaders, it was about contributing to the ongoing process of improvement for the sake of children and families, and not for the recognition:

> I have something to offer here, and I am driving this stuff, even in, sometimes it feels very subtle, maybe, and my style is actually to be more subtle, more behind the scenes[ways], whereas other people have a more forceful or assertive or aggressive kind of style.

The stories reflect that while countless hours are invested in system improvement, leaders keep their eyes on the prize which is not adulation from others:

> My boss, [one other], and I are walking down the hall to this [press conference], and we look at each other. We were the key internal . . . the worker bees, the policy people, the

writers, all that internal work invisible to the outside. We looked at each other with a lot of feeling of pride and a little irony.

Persistence and Tenacity. The ten leaders who participated in the study each had over 20 years of experience in human services, and all but one had worked in government for over one decade. This longevity seems tied to another common theme: the understanding that their work would require an ongoing and relentless pursuit of their ultimate outcome of system improvement. All realized that the work required both persistence and tenacity and was seldom accomplished expediently. As one leader shared:

> They talk about people who build cathedrals very often never see the finished product. But you lay the foundation . . . I laid a lot of that groundwork. I had a lot of those cornerstones, and somebody else is going to carry it through. But it takes a lot to be able to say that.

Another leader recalled something a legislator had said to her as they engaged in system transformation work. She laughed as she shared the story, "He goes, 'I'm going to say what Italian mothers say to their children. Abba pazienza. Have patience.'" Related to the persistence is the process of garnering buy-in for system changes. As one leader described:

> I think you have to accept that not everybody's going to do it, especially initially. It doesn't mean you give up on them. But you focus initially on where you can have the greatest success and bring along the others. Eventually, they all will come in, I think.

Clear from these leaders' stories is that the work to effect system change requires enduring attention and persistent commitment.

Constraints

The transcripts from each interview were reviewed multiple times to determine the primary constraints that leaders identified. Two-hundred sixty-nine excerpts were coded as constraints which were initially grouped into 12 different categories. Further review and refinement yielded four themes reflecting the primary types of constraints under which the 12

categories are nested. See Table 5.2 which shows the themes and categories that resulted from

the analysis. Both themes and categories are further explained and illustrated.

Table 5.2

Constraint Codes

Themes	**Environmental**	**Structural**	**Interpersonal/Relational**	**Procedural**
Categories	Political changes	Leadership shift	Politics	Communication
	Legal/lawsuit	Government structure	Negative attitudes & resistance	Contracting & procurement
	Negative media attention	Government staff knowledge		
	Natural disaster	Provider/service array		
		Funding		

Environmental Constraints

Environmental constraints represent outside pressures and factors that are not controlled

by the leader. Nearly all of the leaders who participated in the study had experienced some form

of environmental constraints.

> I think that's what keeps [change] going . . . I think it's a lawsuit, some kind of media
> thing, or a large group of constituents complaining. And if you don't have those three
> things, then you have to come up with something else.

Political changes were the most common environmental factor that influenced the work of the

children's mental health leaders in this study. Fewer leaders talked about having experienced the

impact of a lawsuit, although several commented on the threat of a lawsuit serving as both a

constraint and a potential catalyst for action. This duality, of constraint and strategy, emerged

several times throughout the analysis and will be discussed in greater detail later. Two of the

leaders talked about the impact of negative media attention or in one case, a natural disaster.

Interestingly, the last three interviews occurred in mid- to late-March just as COVID-19 was

surfacing in the United States and state authorities were beginning to address the potential impact.

Political Changes. In a government environment, political changes are expected: "It changes every four years. Even if we've had the same governor for eight years, it changes because something happens. And so that director or commissioner resigns and then somebody else gets appointed." While few who participated in the study experienced a change in their position as a result of political shifts, those above or around them were frequently impacted: "An ongoing issue has been . . . those other child systems that are operating under directors that are appointed by the governors." As a result, work must be done to bring new people up to speed and momentum can be lost. Of the ten participants in the study, seven operated in states with gubernatorial term limits, and all ten had experienced changes in governor during their time in their role.

> We started out with a very supportive governor whose wife was a champion, so we had a lot of support then. And then when they left, it's sort of the kiss of death because it's like the next governor doesn't want to just pick up something from another governor.

Changes in governor often mean changes to priorities and requires these leaders to help orient a new administration and forge new relationships. Several had worked under administrations from both political parties and shared that priorities and plans shifted as a result of a new Governor in office, but the data reflected that this was no more significant if there was a change in party: "It's always changing. As soon as there's a new administration. I would say this is my fifth governor."

Lawsuits. "There's always these impending lawsuits in the Department of Justice that lingers over each of the states and they especially like the South." This comment captures the essence of many of the leaders' stories. While a few had either wrestled with a settlement or were in process of doing so, others talked about the ongoing possibility and the impact this had on

their activities or the activities of the appointees above them. The data reflect that lawsuits, generally focused on the inadequacy of the service array and lack of adherence to federal requirements, pose a significant challenge for the children's mental health leader. Those in the midst often face intense political pressure and public attention. That scrutiny can feel limiting to the children's mental health leader by placing parameters around their activities, ranging from who they can talk to, to what they can actually do. The children's mental health leader is not always involved in the settlement terms, which poses its own set of challenges:

> When we got the lawsuit it was challenging . . . in that there [were] basic outlines of the services determined in the court case, so you've got lawyers working with technical experts, but it's getting hammered out between lawyers, and so it's not ideal.

While being threatened by or in the early or settlement negotiation phases of a lawsuit can constrain, this is one of the areas where leaders shared that this constraint often turned into a strategy as settlement implementation began. This will be discussed further below.

Negative Media Attention. Somewhat tied to the presence of a lawsuit is negative media attention. When something "hits the paper" it can constrain children's mental health leaders, who must adhere to government communications protocols. Given the collaborative nature of the work and the interdependencies across various child-serving departments, negative attention to another department can also impact their work, "Well, that's played a lot for child welfare, because along with the lawsuit they've had a lot of exposés about how horrible things are in child welfare."

Natural Disasters. Many children's mental health leaders have never faced a natural disaster, but for those who do, it can have significant impact on their activities and progress. Similar to lawsuits, the data suggest that a disaster can first present as a constraint—something immediate and unforeseen that diverts resources—and then potentially be leveraged to bring

about significant systemic reform. Regardless, when the natural disaster first occurs, it impacts

the children's mental health leader's ability to carry on their work as planned:

> They were so traumatized by the storm, they couldn't even see . . .The people who had done this work really, really well, couldn't even see that their data was off the charts, in a way that was powerful, and it was so connected to the storm. So, we had to do something fast, and we had to be prepared to do something fast. We needed to negotiate quickly around that.

As noted above, three of the interviews were conducted just as the COVID-19 virus

began surfacing in the United States necessitating an immediate shift in both systemic work and

service delivery across the country. As has been discussed, children's mental health leaders do

their work in collaboration—with other government departments, with providers, with

community partners, with families, and with young people. How this collaboration looks is

different in a COVID-19 environment. As one leader reflected on the in-person convenings they

had planned, "So before she started, I was messaging her saying, 'So you might want to get

really creative about using young adults' actual comfort zone in technology for doing the

stakeholdering, because we're not going to do them in person.'" Another talked about needing to

support their provider community: "Now, this Coronavirus. What does treatment look like?

Thank God, we work huge in telehealth and technology, so when our state pushed in this

direction, our providers were somewhat ready . . . Going to those sites has been overwhelming"

Structural Constraints

For purposes of this study, structural constraints refer to the arrangement or construction

of various component parts of the broader children's mental health or governmental system. The

stories of the participants revealed several structural factors that inhibited their work including

shifts in leadership, the organizational structure within the government, government staff

knowledge, the provider community and service array, and funding. These are further explored below.

Leadership Shifts. Within government, a churn routinely happens as a result of elections and term limits. Governors change and as a result their cabinet appointees change. While none of the participants in this study held cabinet level appointments, many sit directly below an appointed position and the remainder sit not far beneath an appointed position. Given their overall longevity in their positions, each had experienced change in their governors, in their appointed Cabinet leader, and if not supervised by the Cabinet level position, in their supervisor. These changes directly impacted the ongoing work in children's mental health: "And all of that, over the years, gets lost when a director leaves or resigns and a new one comes in because they always have a different focus."

In addition, given the interdependent and overlapping work of children's mental health across child-serving systems, leaders reported that changes in other departments also had a significant impact on their work. One leader, reflecting on her work with Medicaid, said, "I spent a lot of years laying groundwork, because our Medicaid just was not ready to jump on it. Laid a lot of groundwork, and then I had my leadership completely dismantled." Another participant shared, "I've always had to renegotiate terms informally, not formally, but 'this is what we've done for you all in the past few years and this is what you've done for us, and this is how we've worked together.'" Another talked about the loss of momentum that can result from a leadership change, "I have never been able to gain traction with the [child welfare department] like I had it before."

Government Organizational Structure. While many view government as an unchanging monolith, the experience of the children's mental health leaders in this study

reflected differently. Several leaders shared that they had endured broader cross-departmental changes where responsibility for children's mental health had been moved from one department to another or moved into an entirely newly created department during their tenure:

> And so the office of mental health, the office of children, youth and family services didn't always collaborate and work together. And so, this was an effort to bring those two more closely together, as well as to bring education and juvenile justice, and drug and alcohol . . . which is a separate department together.

Others reflected on how that type of unification had been dismantled: "There was some centralization of the child serving systems in that one office, and then they pulled them apart." Another shared a similar experience: "Everything under that department became its own cabinet." This changing organizational structure can result in energy being diverted from work on the children's mental health system to more internally focused activities and can result in a lack of progress. One leader summed it up this way:

> A lot of people being moved around, a lot of reorganization, a lot of new concepts that didn't always match with maybe our philosophy and framework . . . I think sometimes when there's confusion, it's easy to just get stuck in your spot.

> While some leaders did not face these larger departmental structural changes, they did

talk about the challenges involved in moving change forward as children's mental health touches so many systems. Working across departments, multiple missions and multiple cultures must be negotiated in order to advance change. This can be complicated: "Because of personalities involved and systemic dynamics between the agencies, we have not had the opportunity to truly collaborate. None of this has been truly collaborative, even though it's touted as being that way." At times, the organizational structure can lead to power struggles:

> It's been a total "We know better, let's start from scratch," and that coming from an agency that doesn't have implementation experience, and they don't, their style is not to trust [mental health, substance use, child welfare], etc., to help support them.

Many leaders also spoke of internal structure as an impediment to their work. At times, it was specific to changes within their department: "I've had a new job every three or four months for the past couple of years." While another reflected, "I've had my section changed three times, maybe four. Just about the time I learned enough to feel like I can acclimate, it shifts." Others talked about the complexity within their departments that makes it harder to move things along. "All of these issues that I talked about involve other parts of [the department]: licensing, quality, financial management, our [local] offices are involved." Those internal structures and dynamics can be challenging to weather. As one leader spoke, she talked about the departures of several key people and shared:

> For those of us that stayed, it was like hunker down, but don't forget to still collaborate with other people. Get out of the building. If you don't feel good here, get out of the building and go do some work with somebody else for a while and just think about why you came here to begin with.

Several also talked about the structural arrangements between the state office and the local offices at the county level. Several systems were described as being "state-funded, but county-managed" which contributed to the need to work at multiple levels—state and local—to initiate change and system improvement. Those relationships vary by state, but in many cases are hard to negotiate as the localities have independent authority: "I don't have any real authority over the [local] office directors."

Regardless of the specific types of organizational structure dynamics being faced by the participants, all participants noted the organizational structure of government to be a constraint.

Government Staff Knowledge. Related to the constraints posed by the organizational structure within government discussed above is the knowledge and expertise of staff within government. Many state governments operate in a civil service or unionized environment. As a result, staffing rules and requirements can be rather inflexible. The ability to hire, fire, promote,

or move people is often governed by prescriptive rules that have less to do with job knowledge and ability and more to do with seniority and at times, politics. As a result, children's mental health leaders shared that they can find themselves working for, with, or supervising people with little knowledge of mental health, let alone children's mental health. As one participant put it, "Recruiting and hiring new staff . . . that's always a challenge in government, mostly constrained by the civil service system." Another talked about a specific challenge that resulted from the absence of children's mental health knowledge and how that could have impacted the available services in her state:

> Like we'll just take all the adult codes and then put children's . . . you know what I mean? It's like no, that's not what science indicates. Evidence-based practices tell us we need to do these things and we do need to work with their family. Because when we first started it was like, no, you can only provide services to kids.

Several leaders commented on the lack of expertise within those responsible for management and decision-making. "The people who are managing it didn't have the level of expertise in that work. The challenge was that the folks who were making these decisions, I don't think understood the implications of those decisions." Another leader shared that decisions rested with people who did not have expertise and also did not seek input: "And then in reality what ended up, the implementation ended up being built on one person's decisions from one limited perspective that didn't take into account the other systems' strengths. . ."

Another person reflected on the gap between decision-makers and those impacted by the decisions:

> Some of the things that were an eye-opener for me in state government [were] the people that were often making the decisions on behalf of the people we were serving were people that have not often been in those situations or circumstances.

Noting the seriousness of this type of staffing constraint, a participant reflected, "It is not a diversified system where people have multiple different lenses in order to make really key decisions for our state."

The data suggest that this can place a lot of pressure on the children's mental health leader who feels both compelled to educate those around him or her and responsible for the system that results.

Provider and Service Array. The children's mental health system is comprised of an array of providers and services that come together to meet the needs of the young person and their family. In advancing systemic change, children's mental health leaders are often striving to build out or enhance this array as what constraints them is the lack of necessary services and resources. Talking about families, one leader shared, "They didn't actually have all of the resources in the community that they needed." Another leader commented that while they may have certain service types, they are not of sufficient quality. "Not all of [the providers] always offer the quality of service that we would prefer." Another echoed this sentiment by noting, "We had some pretty poor performers in the residential world." Yet another leader lamented about times in the past when the service array was inadequate: "Parents were relinquishing [custody of] their child to obtain needed services [from other systems]."

While these challenges are often widely known, several leaders shared that specific provider groups have significant influence and can make it hard to expand the array despite the fact that children, youth, and families need more than what they offer: "If the community mental health center kicked you out or didn't like you or you no showed or whatever, you really didn't have anywhere else to go. You would end up in the hospital or dead." Despite this, that group would continuously exert pressure resulting in the leaders' inability to broaden the array. She

wondered out loud, "How do we embrace that families and individuals have more choice of providers but also continue to support our safety net of the community mental health centers?" Another commented that given the inability to advance new services in her state she was haunted by "concerns about children slipping between the cracks and going unserved and then having to end up in these high-end services or far away from home."

Leaders shared that these challenges, of expanding both the array and the thinking of the existing provider base, posed barriers for them when attempting to enhance their systems.

Funding. "The largest constraint that I deal with as children's mental health director, it's totally inequitable. You just start out at a disadvantage relative to the rest of the field." This comment summarizes the experience of the 10 children's mental health leaders who participated in this study. Children's mental health consistently does not get a large piece of the financial pie. One leader illustrated it this way: "I'm now at the Department of Mental Health. It's primarily an adult agency. We're about 10% of the funds." Similar sentiments were echoed by another leader who mused that if it were not for federal grant funding, her staff would be reduced by 20–25%.

As is reflected in the stories in Chapter IV, many of the leaders describe environments characterized by shrinking resources. One leader reflected on the overarching funding challenge in state government: "We really haven't solved the healthcare problem, and it is cannibalizing the rest of government." All leaders shared that they have operated in environments where resources are being reduced and they are increasingly asked to do the same or more with less. "There are no longer surpluses in the budget. There are minimal deficits and big deficits depending on the economic cycle." The most enduring constraint for the participants in this study is funding. Succinctly stated by one participant, "Government does not have unlimited money, so there are constraints all along."

With these ongoing structural impediments impacting the efforts of children's mental health leaders, interpersonal and relational constraints further complicate their work.

Interpersonal/Relational Constraints

In this study, interpersonal/relational constraints are those that involve the emotional or behavioral traits/characteristics within or between people. Constraints tended to group around two primary areas in this area: politics and negative attitudes and resistance. It should be noted that other constraints previously discussed above can also have interpersonal/relational overlays. For example, leadership shifts and the subsequent cascading impact on staff within government give rise to a host of new relationships to develop and negotiate, which can be constraining. These examples, from the interviews, illustrate the interconnectivity of constraints and further illuminate the complexity and interdependence of the children's mental health system as a whole.

Politics. In government, politics takes many forms. In this study, politics is defined as the relationships and dynamics that result from political connections and considerations. In any government setting, politics proliferate. The power and influence of these dynamics cannot be overlooked or underestimated. One leader described her futile attempt at systemic change this way:

> There was nothing solid to latch onto within state government to help that stick, to rappel up, to get those ideas where they needed to be at the leadership level. The leadership that I worked with was not politically willing . . . they weren't willing to take that risk really of really getting into children's issues.

That political willingness is one example of the politics that children's mental health leaders face in their daily work.

A smart leader realizes that politics are at play and recognizes the impact on their possible actions. To effectively operate under this constraint is to be have an appreciation for the dynamics and an awareness of what it will take to move things forward: "So there was political

work that was done by the folks who realized that this was in the best interest of the children.

And so, it took about a year." Politics also means that leaders are faced with skillfully navigating

uncertain terrain with certain people who have important relationships; and with managing their

backlash:

> The main stakeholder that was behind all of that is a tenacious woman who is an amazing advocate with a perspective that is hers . . . I've had numerous times where she has emailed myself, my team, several senators, several representatives, and the governor's office, about . . . Because something isn't going the way she thinks it should . . . That's the kind of stuff that has been really hard this last year and a half for me, because it takes the wind out of the team who has been far exceeding what a normal person can do in a job that's not sustainable.

Another leader talked of her experience dealing with the concerns and needs of elected officials

who raise issues based on scant anecdotal information:

> We go into a meeting, and the Representative we have, who is the co-chair of the children's mental health work group, has this particular constituent in her district. So, the constituent has a lot more power than she would otherwise, is my assumption. So, she gets leadership positions in that children's mental health work group and takes her time to make sure and talk about all of the things that we're doing wrong.

> Data reflected that at times, politics is what can cause change to be interrupted and

stopped. Generally speaking, when children's mental health leaders are attempting to initiate

systemic change, competing views can be damaging to the effort if they are organized and have

political connections. One leader talked about the deep changes they were seeking to initiate in

their service array to better meet the needs of children and youth at home and in their

communities versus in out-of-home or inpatient settings:

> So [two provider associations] and the [out of home placement facilities] wrote a paper to present at [the] legislature that basically said that [the managed care organization (MCO)] was an out of state for profit company that came into [the state] to steal their money and that they've always been here and they've always done a good job and the money going to [the MCO] should go to them.

Another leader shared similar challenges, "[The provider groups] tried some political . . . bringing political pressure to stop the RFP process, but because it was an RFP, they had an equal opportunity."

The data suggest that effectively negotiating these sometimes covert and unknown landmines takes both tenacity and skill. Children's mental health leaders need both or need to ensure that they access to someone who is equipped to address these constraints. As one leader put it:

> I'm glad that our state Medicaid [leader] knows how to get in there and do what she does and play dirty pool because it seems like our sick system requires that and I don't want to do it. I don't have the skills.

Negative Attitudes/Resistance. Children's mental health leaders work to move their systems forward and improve outcomes for children, youth, and families. This work generally includes initiating a range of changes—to service array, to the provider network, to financing, to policy—and as a result, can often cause negativity and resistance. The data reflected that the potential and real reactions of people to change is another constraint that these leaders faced regularly. Several leaders reflected on the specific challenges they faced when attempting to broaden the service array and provider network, as one leader shared, "There was a lot of resentment on behalf of the community mental health centers of the additional providers." Another talked of providers actively pushing to maintain the status quo, regardless of the consequences:

> At the end, I think they had maybe a little bit better understanding, but they were still pushing for things that were in violation of the [Medicaid] waivers in the state plan. So, then I realize [that] they don't care if we lose our federal authority. They just want to do business as usual and they want to make money off these families because they're used to making money off residential and group home services.

Data suggested that this resistance and negativity can also come from the other child-serving systems who have not yet come to understand the benefits to their systems for making change. One leader shared a story where one of their partners came on fairly strong in a stakeholder meeting, essentially paving the way for others to resist a change being proposed:

> It's being in a meeting with broad stakeholders and having someone say, "No, that's not accurate at all actually. It's really just like this." And then not allowing space or time to come back and say, "Here's the context I meant that in," or any conversation.

The data indicated that occurrences like these are regular for the children's mental health leader and require an array of relational strategies to address them, which will be explored in detail below.

Procedural Constraints

In this study, procedural constraints include the prescribed processes that exist or are required within the children's mental health or governmental system that were mentioned by the leaders in telling their stories. Two primary procedural constraints emerged: communication and contracting and procurement. These are further described below.

Communication. Communication as a constraint has multiple angles: one is what a children's mental health leader can say, another is what people will say to the leader, and a third is about what people hear. Several leaders talked about the need to understand and accept that as a part of government you cannot always share your own views and opinions, not unlike the previous discussion of Politics. As one participant reflected, "It is important, in some cases, in a lot of cases, not to articulate on some of those things, because people can misunderstand your articulation of events and activities that happen around the world." Another talked about her challenges with not communicating specific information: "They were keeping secrets that I thought weren't necessary to keep." On the flip side is that people will not always share honest

opinions or information with you. As one leader remarked, "I wasn't getting direct

communication, that when you're in that place, you're in a bubble. People don't talk to you when

you're in the bubble, in a way that you need them to." Feeling limited in what you can say and

what will be said to you also impacts whether people have heard and interpreted information

accurately. Several leaders talked about challenging situations that resulted from

misunderstanding or misperception. As one leader succinctly summarized this sentiment, "People

don't always hear you when you need them to hear you." Having to attend to and factor these

communication dynamics into their activities proved to be a very real limitation for some

leaders.

Contracting and Procurement. Evolving a children's mental health system often

requires the development of new services and supports for children and families. Several leaders

talked about the need to alter existing contracts to meet needs or to secure new vendors to offer

things previously not available. Regardless of whether a leader was developing something new

or modifying something already in existence, they experienced restrictions on their activities.

One leader shared a story about needing to quickly meet the needs of an entirely new subset of

the children's population based on the Governor's choice to "roll that in" to their system. To have

someone simply answer the phone when these families called was a significant undertaking: "It

took six months to get their contract expanded, so that they could do the work." In the meantime,

the leader needed to redeploy existing government staff to serve this function. Another illustrated

the complexity of procurement in this way:

> The challenges of having a governmental system in the point of: I can run to Walmart and
> purchase a new pen [today], and it takes me four weeks to get it [from government] . . .
> it's higher when you order through your system. Things like that complicate things.

Issuing requests for proposals, dealing with vendor protests when they do not win contracts, fighting to award contracts to those most qualified and not simply those most connected were all noted as constraints that are regularly negotiated by leaders in children's mental health.

With all of these constraints continuously operating in the environment in which children's mental health leaders exist, creating a host of strategies that allow system progression is necessary.

Strategies

The leaders in this study offered an array of insight into how, despite constant constraints around them, they are able to engage in forward movement within their states. From multiple reviews of the interview transcripts 870 excerpts were identified as strategies falling under 21 codes. These codes were consolidated to more clearly reflect the overarching approach being described and not the nuanced and specific situation. This resulted in seven primary themes of strategies used by leaders in children's mental health to effect system change in their states under which the 21 categories fell. The seven themes include: relationships, visioning, maximizing on the environment, financing, policy and legislation, service development, and education and workforce development. One code, data, was found to be a component across nearly all of the seven strategies and was treated as a meta-theme across the strategies versus as a specific strategy in and of itself. Themes and categories are depicted in Table 5.3. It is important to note that while these themes and categories are described separately, they are often employed in concert with one another. Multiple co-occurring themes and categories are often at work at any one time which is reflected in the discussion that follows.

Table 5.3

Strategy Codes

Themes	Relationships	Visioning	Maximizing the Environment	Financing	Policy and Legislation	Service Development	Education and Workforce Development
Categories	Relationships with child-serving system partners	Big picture vision	Lawsuits	Federal grant seeking	Policy mandating collaboration	Pilots	Training & coaching
	Relationships with local governments	Specific need vision	Leadership changes	Braiding/blending funding	State Medicaid policy	Provider network development & refinement	Technical documents
	Relationships with families		Natural disasters	Medicaid	Federal policy	Creating new services	
	Relationships with funders						
	Relationships with external experts						

Relationships

"No one can do this work by themselves."

Permeating the stories of all 10 participants in the study was the attention paid to relationship development and maintenance as a primary means toward achieving system change. The ability to establish trusting and mutually beneficial connections across an array of audiences appears to be a necessary condition for forward movement. As one leader shared, "So much of what's involved with a role like this is cultivating and maintaining positive working relationships with people, because that's the leverage that you have." Participants talked about their relationships with partners from other child-serving systems, with local governments, with families, with providers, and with external experts as essential to their work: "Something that's always been, I think, critical to our success is having a strong network of supporters across state agencies, external community, so that the support that you have for the work isn't just constrained to inside the agency." These relationships are further described below.

Child-Serving System Partners. As has been discussed, the children's mental health system is a complex web of interlocking parts that often include aspects of other state agencies' systems. As a result, the ability to work collaboratively and cultivate positive working relationships is a fundamental part of the children's mental health leader's activities. As one participant reflected, "All of that rides on the capacity to have good, collegial relationships that are sort of symbiotic or reciprocal, because they need me, I need them." Relationships are complicated by the constraints outlined above. Specifically, leadership changes resulting in staff changes have significant impact on the children's mental health leader. The data reflected that changes in leadership and staff often require the children's mental health leader to go back to

"square one" and start fresh with a new group of people. This can be a significant setback and as

a result the leader's ability to engage in ongoing relationship development is critical as moving

forward is dependent on engagement from varied partners. Using data to help move

conversations forward was cited as a useful component of these discussions, particularly as the

leaders work to educate those new to the job:

> I felt like I was constantly courting people and kind of giving them the information and then they would leave. But then sometimes they would end up in a better position and you take the next person. It's just constant, constant, constant having to educate people and give them the information.

Participants shared that understanding and acknowledging the challenges being faced by the

other child-serving systems was a large part of relationship development. As one participant

reflected, "I think it's just so much easier to get collaboration when people see that you

appreciate their challenges as well as what opportunities might exist."

Local Governments. Many of the leaders who participated in this study work in states

that have strong regional or county components to their system. In these systems, the state may

set policy, but how it is operationalized or implemented is dependent on the local governments.

For this reason, effective working relationships between state leaders and local implementers are

essential. One leader captured this sentiment, shared by several others, in this way, "So, that's

where we concentrated building partnerships, was more on the local level from the ground up."

Relationships with local governments was cited as an intentional strategy by some leaders who

noted that there was more stability in those people and so strong local allies allowed work to go

uninterrupted despite personnel changes at the state level.

Families. Many of the leaders who shared their stories talked of the importance of

ongoing engagement with families as a strategy to both understand the challenges within their

system and formulate the solutions. One leader talked about regular meetings across her state

that were focused on hearing from "furious families." As she reflected on those experiences a degree of solemnity surfaced in her voice and affect: "There were glitches in the system that I needed to understand, and this group of [families] really were impactful in terms of helping me understand the glitches." Many leaders described conflictual and emotionally charged relationships with families, and all understood the importance in developing a better system: "I think leveraging real stories, and really having the backing of the consumers and the families has also been critical." Those real stories were critical data points that complemented quantitative information that leaders used to continue to advance change. Several leaders shared that they had established family advisory groups or had designated a specific number of seats in a state level leadership group for family representatives: "We wanted at least 50% of that state leadership team to be youth and families." The infusion of family voice into both problem identification and solution creation was present in nearly all of the leaders' stories.

Providers. As will be discussed later in this chapter, service development is one key strategy that is used by children's mental health leaders to improve their systems. However, system improvement is not simply building new services. The stories reflected that many times, it is about evolving or modifying existing services. Success is therefore dependent on establishing trusted relationships with the provider community that allow the leader to facilitate providers toward change. These relationships, at times, are hard won and require intense interaction. As one participant shared, "We met 23 times . . . and they came to a consensus with recommendations for how to change what existed." Another leader talked candidly about what it takes to establish the relationship: "Working out those bugs, figuring out how to come alongside people that sometimes it feels like are publicly smacking you down." These efforts are necessary so that honest conversations can occur about the service array and service quality. Difficult

conversations that drew on data were often used to help perpetuate change and were more effective when done in the context of an ongoing relationship: "I went to the leadership of that organization and said, 'This isn't going to work for us.' And I worked with them for a while, they started moving slowly."

External Experts. There is an old adage that you cannot be a prophet in your own land, and several leaders shared illustrations of this adage in their stories. The willingness to "seek and use the help that's available" was described as a frequent strategy to support efforts toward system improvement. The expertise came from a range of different sources. Several leaders referenced the national association for state mental health leaders that they belonged to as a place for support, sharing knowledge, and generating ideas to enhance their systems:

> I value the membership, my membership and partnership with NASMHPD Children's Division because we were able to use a lot of materials that they [and other states] developed . . . to develop our [system] and make it our own.

Another leader talked about their epiphany when they started participating in the national association: "I started going to the NASMHPD meetings and I figured out there was this whole world out there of really great ideas and the information that came to us."

Other leaders talked about engaging with consultants to help their system improvement efforts. At times, this work was focused on helping to make the case by collecting and presenting data that garnered attention:

> The [consulting group] came in and did, I mean, I'm talking just meetings with everybody across the state, all the providers and wrote up this big report that showed where we were at as far as children's mental health and where we could be going and wrote some recommendations.

Other times outside expertise was used to help design specific aspects of the children's system:

> Two of the consultants had great expertise in children's services, and so I . . . began to inquire about how we might be able to take advantage of those two consultants. Because

our focus was on children that were part of the Medicaid system, we were able to begin to work with these two consultants.

The leaders reflected that these outside experts were able to illuminate challenges and opportunities that they were then able to capitalize on to advance their efforts.

Visioning

"We weren't reckless. We were professional. We were driven, of course, by our commitment to children."

Leaders all described how establishing a common vision was used as a strategy to execute the work and how this personally aligned with their beliefs and skills. As one leader described, "We spent years visioning, and that fits well with my skillset, I enjoy doing that visioning. We did a good job of using all the tools at our disposal to create a vision." Another leader talked about investing in an effort to establish the vision at the outset of his work: "To have that much broader, global, universal approach as a state was really important to me." All recognized the importance of a co-created vision that could serve as an anchor point: "We were all on the same page, in terms of what the vision [wa]s."

Vision setting is often situated within the context of relationships; the two are interwoven according to the experiences shared by these leaders. The data suggest that people both create relationships through the act of establishing a vision and people create vision through establishing relationships. It is not easy to discern which comes first, but what it is clear is that both appear necessary to move a children's mental health system forward. Leaders described vision in two different ways—big picture visions and then visions that had a specific focus or need as the impetus. Both provide the necessary grounding for the work and are further described below.

Big Picture Vision. Leaders who participated in the study often relayed stories that specifically referenced their big picture or overarching ideal. This idealized end point was often used as a way to keep partners on track and activities moving forward. When conflict or entrenchment surfaced, leaders drew on their vision. As one leader shared when describing how she managed disagreement, "I focus back on what we do, the basics of what we do, focus on improving outcomes for kids and families." Another talked about the importance of their overarching endgame to keep work and partners aligned: "The people that I was working with across the state were interested in the same thing I was. They all wanted the same thing. All of them wanted children to feel better." Another captured it this way, "We're all really wanting healthier kids in communities." These unifying aspirations were leverage points for leaders to keep people at the table and the work going.

Specific Need Vision. Several participants also talked about a specific need in their systems being the driving force behind their activities. Across many leaders, this was often tied to the use of out of home placement or residential care. A shared concern, that often relied on the use of data to illustrate the magnitude of the problem, provided the foundation for a co-created vision to improve the children's system. As one leader relayed, "There was concern that we had such a large, huge reliance . . . over-reliance, probably . . . on residential placements, out-of-home placements. So, another one of the efforts…was to reduce the reliance on residential placement." Another leader shared similar impetus for efforts underway in her state:

> A lot of that I think was driven around . . . residential placements, out of state placements, concerns about children slipping between the cracks and going unserved and then having to end up in these high-end services or far away from home.

Several other leaders talked about a desire to eliminate restraint and seclusion in out of home settings as the unifying idea that brought groups together to improve their system.

Maximizing the Environment

Related to the concept of visioning is what I have termed "maximizing the environment." Maximizing the environment, as one leader put it, is "being able to connect your work to whatever is going on." In this way, the leader seizes an opportunity that is already occurring in their environment and uses it to leverage or propel change in the children's mental health system. Countless examples of what one leader referred to as being a "sicko opportunist" or "the perfect time to plant some of these things in ways we never could before" appeared in the stories of the leaders.

Similar to other strategies, the use of this strategy is intertwined with other strategies. In particular, it seems that the ability to maximize the environment is tied to the relationships the leader has formed. In order to leverage opportunities, the leader must be aware of what is going on in his or her own environment and the environments of their colleagues and counterparts: "You find out who the stakeholders are, if they're open and willing you share the pieces that are already in play they could leverage and/or areas where we could really make what we're doing more effective, broader, more impactful." Another leader described this knowledge in this way, "Really critical is understanding aspects of other state agency demands and understanding their demands has really helped me to leverage opportunities that we had to work together with them" In the absence of relationships, awareness may not exist, and opportunities like these, referred to as "low-hanging fruit" by one leader, may be lost.

Leader attributes also factor into the use of this strategy. As noted above, humility is a critical personal characteristic that several leaders shared. Maximizing the environment at times summoned the leader's ability to exercise humility:

> The other thing that's great is once you know what their priorities are, you can sometimes connect whatever it is that you're doing to their priority, and if they want to rename it or if

they want to do something different so they can put their stamp on it, then you [let them and it] can keep going.

The leader's willingness to not be credited for the idea or initiative ties to the leader's ability to successfully maximize the environment.

Another leader described the ability to maximize the environment as a "combination of whether you want to call it . . . organizational savvy, political savvy, and then clinical knowledge or program knowledge, so you can recognize the strategic moments." Capitalizing on those "strategic moments" again reflects the dynamic interplay between strategies and constraints, as a savvy leader can and will use a constraint as a lever for change, transforming it into a strategy. Several leaders shared how this was possible, with specific examples tied to lawsuits, leadership changes, and national disasters.

Lawsuits. "When you think about it, what are the things that really move systems? Lawsuits do." This succinctly summarizes the views held by many of the leaders in this study. While only a few were working in a settlement environment, many reflected that a lawsuit or the simple threat of a potential lawsuit could propel their system change efforts. One leader talked about the looming risk of a lawsuit pertaining to the use of detention centers for youth involved in juvenile justice. She shared that this concern resulted in some fairly significant changes to the system in her state. Others talked about lawsuits in the adult mental health division of their state serving as a catalyst for change by planting a seed of fear that could be capitalized upon in the children's system.

Leadership Changes. The ongoing churn that occurs in government at the leadership level was identified as a constraint by many of the leaders who described halted momentum as a result of staff changes. At the same time, these changes can also provide opportunity. One participant explained, "We presented that plan to the two people that were running for the

governorship that year. And one candidate embraced that plan. He was the one who got elected."

At times, leadership changes bring welcome opportunities to engage new partners and breath

fresh life into system reform efforts.

Natural Disasters. Natural disasters can have devastating consequences for

communities. And yet, they can also serve to illuminate significant issues or result in an influx of

unanticipated funding to a state. After weathering a significant disaster in the state, there was an

influx of users to the public mental health system from all socioeconomic levels. The result was

more attention across the political spectrum for the availability of mental health services and

supports, as no longer just the poor were relying on the public mental health system. This shift in

user population, driven by the disaster, was capitalized on to make needed system improvements.

From the data, it is clear that an effective leader is one who is attuned to the environment

and their partners' needs and who is willing to be part of the solution. This ability to seize

opportunities is clearly an important strategy for effecting system change.

Financing

One of the primary constraints identified by all leaders who participated in this study was

funding. Whether it was enduring steep financial reductions or simply making do with the

inequitable amount of funding provided for children's mental health, leaders across the board

talked about money being a significant impediment to accomplishing their work. Not

surprisingly then, financing emerged as a primary strategy for children's mental health leaders

seeking to engage in system improvement. The three primary financing means that emerged from

the stories included grant seeking, braiding/blending funding from various sources, and

Medicaid. All of these approaches are heavily intertwined with the relationship strategies

outlined previously and are explained more fully below.

Federal Grant Seeking. Many federal grant programs are available for children's mental health and nearly all participants identified grant seeking as a critical strategy for system improvement. Successful grant awards often provide a sizable infusion of cash to engage in both system-building and service delivery enhancement. Grants also provide an opportunity to build relationships with child-serving system partners or further support existing relationships by requiring partners and cross-system collaboration or by offering an enticement for that collaboration.

One particular program, the Comprehensive Community Mental Health Services for Children and Their Families Cooperative Agreement (referred to as the System of Care grant) offered by the Substance Abuse and Mental Health Services Administration, was the most common grant funding referenced in the participant's stories. One participant noted, "We've always had a System of Care grant coming to the state department, since 1999." SOC grants require a cross-system governance structure to oversee the funds and can be used to leverage engagement or reinforce the value of engagement to other child-serving systems. The funding provides not only the necessary infusion of dollars to initiate new activities, but also a powerful enticement to get others to the table: "We were working pretty closely with child welfare at that time, so decided that this would be a great opportunity to write a grant that would support the evidence-based practices [we had identified]." Another shared that, "The system of care grants, and these other grants were helpful in getting started, getting startup funds."

Other leaders spoke of specific funding opportunities that required co-application with education partners for suicide prevention or with public health systems for early childhood intervention or physical health/behavioral health integration all of which were leveraged to build or sustain relationships and create necessary services and supports. As one leader shared, "It was

$3 million a year for four years, and it really brought us much closer together with the education system. We were having a great run with [Substance Abuse and Mental Health Administration] grants."

Braiding/Blending Funding. Many of the leaders shared stories of how they pieced together financing from multiple sources for specific initiatives. One leader shared a story of working to pull together a grant application with state education partners that did not receive funding, but decided to proceed with some of what they had proposed regardless:

> So, really, we just have found bits and pieces and as well as the Department of Education. They've been able to find a little bit . . . It's kind of like just find a little bit here and there and make do with what we've got.

Other leaders talked about partnering with universities in their states who provided some of their own funding as contributions to the effort. Several leaders discussed their efforts to ensure the appropriate use of mental health funding for services being provided by other systems, which freed up funding in those systems. Similarly, leaders shared that they worked to ensure that federal funding was drawn down whenever possible to free up state and local monies and maximize the dollars available within the state: "We get federal reimbursement for some of the services we provide or our child welfare agency provides."

Medicaid. The interviews reflected that the most frequently used financing strategy employed by children's mental health leaders to improve their systems was Medicaid. Medicaid is the public health insurance program available to low-income individuals and families and others with disabling conditions in the United States. For many states, children with mental health diagnoses qualify for Medicaid. Medicaid is often a preferred vehicle to pay for services as states are responsible for only a portion of every dollar spent. While noted as a financing

strategy, Medicaid is also a policy strategy as once a state has established a service in its Medicaid program, it becomes an entitlement that is available to all who qualify for Medicaid.

Several of the participants shared stories that resulted in changes to their state's Medicaid program, either through modification to their state Medicaid plan or establishment of a Medicaid waiver, which allows states to create a service array for a specialized population. As one leader put it, "We had to fix Medicaid, and the Medicaid rules around what was allowable, and not allowable." Others talked about ensuring coverage across settings: "One of the major financing initiatives was to make sure that Medicaid reimbursement was available for youth that were in residential services that had behavioral health problems." Another spoke about creating new services that were covered by Medicaid, such as Family Support and Peer Support (which will be discussed further below): "We were able to add all of those services into the Medicaid State Plan under the Rehab Option, so that was a big accomplishment as well." Medicaid is a complex insurance program with both federal and state rules that can be difficult to comprehend. Leaders who are well-versed in Medicaid have an advantage as maximizing Medicaid is complicated. One leader talked about her ability to get certain things accomplished because she was able to "find the loopholes" in the Medicaid state plan. Often times, making the case to include something in Medicaid was dependent on data. Demonstrating cost neutrality or savings was a frequent approach. One leader shared that they showed that they were "saving money by bringing up community-based alternatives to out of home care," while another talked about the importance of "looking at the research . . . including the cost savings research."

While Medicaid was consistently used as a strategy to finance new services and supports, Medicaid itself was also viewed as constraining. For most of the leaders interviewed, the responsibility for Medicaid was housed in a separate department from mental health which

required these leaders to negotiate relationships, power dynamics, and politics to effectively

leverage this strategy. This could be a complex negotiation mired in personalities and turf. As

one leader shared:

> Part of what went wrong was [the state Medicaid office] at a certain point decided that
> they know better and that they wanted to call the shots in terms of how a lot of this stuff
> got operationalized. And we could talk all day about sort of the ins and outs of that, but
> it's summarized by that. It's simply a fact that at a certain point they took over, and now
> we are in a phase of implementation where it's starting to become clear that there are
> critical flaws in how this has been implemented or operationalized that need to be
> corrected.

In this, and other cases shared by the participants, while Medicaid was a strategy being used, it

was also riddled with challenges that could impact system progression. Other factors that

complicated the use of Medicaid included the limitations on eligible populations (poor and

disabled) and the criteria for specific services, i.e., that they be "medically necessary" which is

determined through a highly subjective assessment process when dealing with mental health

conditions.

Despite these challenges, Medicaid emerged as a primary strategy for state children's

mental health leaders. Their ability to leverage Medicaid was very closely intertwined with the

strategies further described below—Policy and Legislation and Service Development.

Policy and Legislation

"There's no way this is going to happen without legislation. There is no way. Because I

had done everything I could do to just make it happen voluntarily, and it wasn't going to

happen." So begins the story of one leader in children's mental health who was seeking big

change within her system. Bumping into constraints ranging from politics to personalities, she

recognized that both impetus for and sustainability of change was dependent on changes to

statute. This sentiment was supported by several leaders in their stories who talked frequently

about the pathway to sustainability being paved with policy. As another reflected, "It's like you've got to have a legal leverage" Policy and legislative work fell into three main categories: mandating collaboration, state Medicaid policy, and federal policy.

Mandating Collaboration. The ability to collaborate is a theme woven throughout the findings, surfacing in the individual leader characteristics, the constraints, and across the strategies. Collaboration is the intended end product of the relationships the children's mental health leader forms and is a critical component of visioning, of maximizing the environment, and of financing. Several impediments to effective collaboration can occur as the leader encounters environmental, structural, interpersonal/relational, and procedural constraints. While seemingly artificial, mandating collaboration in statute or policy can be a useful tool. While the mere existence of policy requiring collaboration is unlikely to result in system change, it can provide a foundation that leaders can rely on, particularly when there are multiple separate child-serving agencies involved in the overarching system. In thinking about that, one leader shared:

> And so [mental health and child welfare] didn't always collaborate and work together. And so, this was an effort to bring those two more closely together, as well as to bring education and juvenile justice, and drug and alcohol . . . which is a separate department . . . together.

Another leader shared, "They're not meeting but at least there's legislation there that does exist, so the structure is there." Another talked about the power that this mandate has with respect to collective accountability:

> So the [interagency group] is actually all of the child-serving agencies state agencies . . . There's accountability built in. If you read the statute, it's actually fairly strong language around the capacity of the [leader of the interagency group] to hold those state agencies accountable.

State Medicaid Policy. For most children's mental health leaders, state policy change is often related to financing and Medicaid. There is a reason for this. Once a service or provider

type is committed in writing to the Medicaid State Plan or a Waiver, it becomes nearly

impossible to remove it. As noted above, it becomes an entitlement. Any reduction or elimination

of an entitlement under Medicaid is not a state decision. It must be reviewed and approved by the

federal government or in lawsuit by the magistrate responsible for the settlement. The level of

scrutiny that accompanies these types of benefit changes is difficult to justify and to endure.

Changing a state Medicaid plan often brings extensive federal involvement and seldom do state

government officials willingly invite that level of involvement in their efforts. As a result, once

memorialized in Medicaid, a service is often there to stay. This can provide necessary leverage

for ensuring the availability of these services on an ongoing basis. One leader shared a story

about how, within her own department, she needed to assert the statutory responsibility their

office had to offer children's mental health services:

> This in our state statute says that we do have to cover these people and this lawsuit says not only do you have to do it, you need to do it now and you need to do it in a thoughtful manner according to the settlement agreement.

Federal Policy. An effective children's mental health leader will often leverage federal

policy as the impetus for change within their states. Participants in the study spoke specifically

about two federal policies that provided important opportunities for them—the Patient Protection

and Affordable Care Act and the Family First Prevention and Services Act. These are explained

below.

The Patient Protection and Affordable Care Act. The passage of the Patient Protection

and Affordable Care Act in 2010 proved to be a watershed moment for some of the leaders in the

study. This act allowed states to expand Medicaid eligibility for adults and children thereby

widening the net of who had access to the benefit package under Medicaid. As a byproduct of the

increased eligibility, increased demand necessitated that states expand the types of services

available and who was permitted to provide them. As one leader relayed, "Our Medicaid expansion added not only additional billable services but also broadened the provider network to a whole new slew of providers, including new agency types as well as individuals who could enroll, credential individuals."

The Family First Prevention Services Act. Several leaders talked about the more recent 2018 Family First Prevention Services Act, which is federal child welfare legislation that aims to keep children in their homes and communities safely versus being placed into foster or group care settings. The importance of this legislation to children's mental health leaders underscores the overlapping nature of children's mental health work which is not bounded within a singular system. As children in child welfare often have mental health needs, the Family First Prevention Services Act opens up a new range of possibilities to help develop the community-based system and service array for children and youth. One leader shared her hope to leverage this legislation to broaden the service array: "I am hopeful that Families First will push the funding away from the same old group home, residential, crisis bed stuff. We do need those, but that's only part of an array."

Family First Prevention Services Act is just one of the countless examples of the tremendous interplay of the strategies these leaders use that pull on their efforts to create a common vision, establish relationships, maximize the environment, and as will be discussed below, service development.

Service Development

"I always say you should have a couple of million-dollar ideas in your pocket, just in case."

One of the most visible strategies a children's mental health leader can engage in is making changes to the service array. In fact, when people consider children's mental health system work, services are often the first thought. What emerged from the stories of the leaders in this study is that a large part of their jobs was about evolving the thinking and belief system that serves as the foundation for the service array, as is reflected above. With that foundation established, service development occurs. Stories from the leaders grouped around several themes: using pilots, developing and refining the provider network, and creating new services, particularly those that would meet system partners' needs.

Pilots. Several leaders shared that an important strategy for them was establishing pilots. When discussing a successful pilot that eventually led to statewide implementation of a new service, one leader reflected, "Pilots have a bad name because they tend to be created and then die . . . The way we talk about it now here is we have some resources to make strategic investment." Several leaders talked about this strategy as a way to seed innovation. These leaders shared that they would use grant funding, try something new, collect data to determine efficacy, and use that information as leverage to more broadly disseminate. One leader commented, "If it's really good and really working, there's more of a chance it'll stick, and it'll grow, and it'll get built into standard budgets and built into the infrastructure of your system." Here again we see the role in data in supporting many of the strategies used by leaders. As one leader shared, "We could monitor the data, [it would] tell us what was working, what was not working, [and] try to fix the challenges."

Provider Network Development and Refinement. Leaders shared several examples of both helping their existing provider network to adapt and embrace new ways of conducting business and also expanding their network to allow new providers to enter. In dealing with a

particularly challenging group of providers who were not supportive of some of the systemic changes that were emerging, one leader recalls standing in front of a large group of well-organized providers and saying, "I have to find services for the people we serve. You can be one of those providers, or you cannot, but I'm going to do what I'm going to do." She went on to share that many of those providers came along, others simply ceased to exist. One leader talked about the extensive efforts that their team had engaged in to support providers in adapting to a new philosophy and set of services: "To be able to work within the organization and their agency to develop this treatment infrastructure…to deliver a continuum of care for kids." Another leader shared a story about expanding the provider base beyond the established community mental health centers:

> [We] broadened the provider network to a whole new slew of providers, including new agency types as well as individuals who could enroll [and be] credential[ed] individuals . . . There was a lot of resentment on behalf of the community mental health centers of the additional providers.

Creating New Services. All of the leaders who participated in this study shared stories about creating new services as one way they had brought about change in their states. Fundamental to many of these activities was meeting needs of important system partners. In this way, this strategy ties to the relational and maximizing the environment strategies outlined above. Being able to respond to a specific need of a system partner through service development helped to build trust and was an overt way to demonstrate commitment to the partnership. It was also a way to be able to ask for things from these partners in the future in an "I give you this and you give me that" approach. Leaders talked about creating new services that would address waiting list issues in other systems, for example developing Medicaid-reimbursable therapeutic foster care to address the needs of the child welfare population or establishing specialized

services that would more effectively meet the needs of a complex population, such as residential

care for youth with developmental disabilities and mental health needs. As one leader shared:

> We've been specifically asked, wherever possible, to actually create new programming to
> better meet the needs of these dually-diagnosed kids. [We] had already been working
> with [the state department focused on developmental disabilities]. We created [residential
> treatment] for dually-diagnosed kids, and that's been operational for a year and a half
> now.

Others spoke of working with their state education department to create suicide prevention

programming after an increase in suicides in a particular part of their state or creating mobile

crisis response services to help reduce placement disruption for children placed in foster care by

child welfare. These are just a few of the examples of leaders doing what is right or needed for

children and families while also leveraging their relationships and in some ways playing the

game of "politics" that was cited as a constraint by many.

Not all service development was in response to a specific partner's needs. Many leaders

talked about establishing new services after looking at their data and identifying unmet needs in

their states. Several talked about the implementation of High-Fidelity Wraparound for youth with

complex needs and their families and others shared bringing up new evidence-based services,

such as Functional Family Therapy or Multisystemic Therapy. As one leader shared, "We're

headed in the right direction with this wraparound facilitation and the intensive, in-home,

community-based services that we're providing for the kids."

Another large area of focus across the leaders was the implementation of peer support

services, both family and youth support. These nontraditional approaches pair family members

and young people with others with lived experience to offer both support and skill development.

One leader, recalling how powerful this service development was in their state, said:

> Our peer support workforce has been huge. [At] every level, our peer supports are
> somewhat like the frontline of crisis care, in a sense, where they can't do crisis diversion

like a case manager can. They can't do crisis intervention like a therapist can. But they can do de-escalation and teaching [parents] how to deescalate.

Another leader noted, "Having a peer support, whether it's a family support provider or a peer support specialist connected to them where they were reaching out and had experiences [was] huge for individuals." The creation of peer support is one example of the interconnectedness of the strategies that leaders use. Several leaders spoke about the need to create ongoing financing for peer support services and working to establish that service in their state's Medicaid plan. That data reflect that service development often has ties to both financing and policy strategies to ensure sustainability.

Education and Workforce Development

The final set of strategies that emerged from the stories of the leaders in this study were their efforts in education and workforce development. These fell into two main categories: training and coaching and technical document development. These are further explained below.

Training and Coaching. "You can't just train and pray. You have to do something to make sure that the training is actually working"—wise words from one leader during his story about coupling training activities with coaching and supervision. Leaders stories all highlighted an array of training activities that included awareness building and basic knowledge development and then more specialized skill-based efforts.

Awareness Building and Basic Knowledge. Many leaders talked about the need to provide basic understanding of children's mental health including signs and symptoms across their states. As shared in Chapter IV, one leader spoke of offering mental health awareness training at high school football games which are a huge draw in her state. Other leaders spoke of equipping non-mental health professionals with understanding so they could more accurately identify and respond to mental health needs: "Like here's a broad group of professionals who are

interacting with these families regularly, early on and don't have any training about what indicators are for behavioral health for either the mom or the child, so things like that." Others talked about helping to raise awareness around the roles of their system partners (which supported their partner relationships). One leader talked about efforts to help a specific area of their state understand the child welfare system:

> Just to address the stigma around the child welfare system, that knowing the process that they go through was so eye-opening for people. Who are these workers? We started there. In addition to that, [we] gave their community profile . . . they would do a rundown of things that they're investigating in the community, reasons why kids are coming into care . . . So for the first time, the community heard, "Oh my God." These are real things that are happening in our community, and these people put their lives on the line every day.

Many leaders also commented on the need to educate on the vision and the guiding values and principles as an important part of both awareness raising and partner engagement: "Deploying the foundational principles of systems of care within that to really help to leverage understanding for systems of care, or how they are a part of the system of care is a part of that process." All leaders talked about the need to use a broad-brush approach in some of their training activities to begin to get the traction and support needed to advance change. As one leader put it, "Helping the broad array of the public as well as human service providers to understand children's behavioral health."

Specialized Training. In addition to the broader efforts to raise awareness and provide foundational knowledge, several leaders spoke about specific training activities in their states that were used to bring about systemic change. Many shared stories of using grant funding to support the implementation, including training, for High-Fidelity Wraparound, Multisystemic Therapy, Functional Family Therapy, and other evidence-based practices. This work included intensive training for practitioners as well as ongoing coaching to ensure implementation.

Leaders also spoke about training focused on cultural and linguistic competence and trauma-

informed approaches and practices. Leaders talked about ways they incentivized participation:

"We ensure[d] that continuing education is provided for teachers, social workers, psychologists,

juvenile justice workers, law enforcement. We try and get the whole gamut." This was also a

strategy that helped with their partner engagement. A handful of leaders talked about establishing

training centers or institutes in their states, often in partnership with local universities or in

conjunction with the statewide family organizations. These established centers provided the

initial training as well as the follow-up coaching and monitoring to help ensure effective

implementation, and when necessary, fidelity to the practice models being employed. Another

leader spoke of the detailed training she had personally offered on Medicaid funding to the

provider network:

> I literally did three three-hour classes where I walked them through all our waivers . . . I
> literally did on Zoom Meetings, walk[ed]them through line by line. It was arduous, it was
> long. I walked them through the state plan as well.

> **Technical Documents.** Mixed in with the more adaptive strategies outlined previously,

leaders shared some very concrete approaches they had used to facilitate change in their states.

Leaders talked about committing the vision to paper in ways that provided clear guidance to the

field. One leader talked about their logic model as a way to get very clear on both bigger vision

and concrete action:

> Our logic model is just not a state logic model, but it can literally drill down to a
> community, a provider . . . I mean down to the specifics of how to maneuver [in that]
> community . . . Things like that have really been helpful.

Other leaders talked about developing reports that were broadly disseminated across the state to

educate on specific needs, provide justification for activities being undertaken, or offer evidence

of system progression:

> As much time as it took for all of us to gather all this information, charts and graphs and gathering data, I will say that report was very beneficial and very helpful because we were able to get those recommendations and say, "Hey, guess what? We're actually headed in the right direction."

Establishing "blueprints" or "frameworks" proved to be a valuable strategy for many.

A Synthesized Picture: The Composite Narrative

Chapter IV presented each of the leader's stories as shared and seen through my lens as a professional engaged in children's mental health system change for nearly three decades and as a former state and county children's mental health leader. This chapter has provided a more in-depth view and understanding of the themes and categories that emerged through the analysis of the leaders' stories. From the analysis, it has become clear that the stories of children's mental health leaders are congruent and similar in many ways. Despite geography, politics, demography, consistencies emerge painting a composite and elaborate picture of what it means to be a state leader in children's mental health.

State leaders in children's mental health have decades of experience in the human services field which provides them with the ability to hone and refine the skills necessary for the job. These leaders all evidence a deep, often personal, commitment to the work. They are passionately dedicated to the children in their states and their cause. The leader in children's mental health is a chameleon, adapting their style and approach to the circumstances they are operating in and the people they are operating with. Being comfortable with being seen and not being seen are chief among their abilities. Effective children's mental health leaders can be out front or behind the scenes, as the situation and players dictate. Demonstrating a high degree of humility that allows them to put the work first and their egos aside, these leaders are extremely proud of the work they have undertaken and the things that they have accomplished. They do not need to be credited or acknowledged for their efforts or the progress of their systems despite

evidencing high degrees of persistence over many years. This tenacity can and has taken a toll on the leader, but it does not extinguish the fire they feel to continue on with a mission of system improvement.

The work of a children's mental health leader is marked by its evolutionary and incremental nature. The factors that constrain them can and are used to leverage change over time—constraints and strategies can look very similar. As a result, the leaders must be vigilant and attuned to the environment around them. While big deep profound change can and may occur, particularly in the wake of an unforeseen circumstance, lawsuit, or natural disaster, more often it is the constant persistence of the leader and their team that leads to more sustainable systemic change.

The path to system improvement, while unique to each leader, is one where the leader is in constant motion—engaging with their environment, encountering constraints and barriers, leveraging them when possible, mobilizing strategies and solutions—all with the intent of moving forward. The leader weaves in, out, and across environmental, structural, interpersonal/relational or procedural constraints to formulate a range of approaches or strategies to continue their and the system's journey toward improvement. A primary focus of the leader is understanding the needs and priorities of a broad range of critical partners inside the community including young people, family members, their own staff, staff and leadership from other child-serving agencies, service providers, advocates, and legislators. Leaders leverage relationships with these people and work to create a shared picture of an improved system that they frequently reference and rely on when things start to go off track. They are vigilant, paying close attention to their surroundings and are relentlessly opportunistic in seizing moments that will allow them to advance the established vision.

These leaders understand that it is far easier to create short-term fixes and that to truly advance their systems, they must work to achieve sustainability of those things with demonstrated efficacy, by engaging in financing and policy reform. The leader understands that the children's mental health system is essentially a system of complex, interlocking, cross-system parts and not a single bounded system. They recognize that concrete technical strategies, like service development and training, are necessary, but that these must be coupled with a range of more adaptive approaches that help all involved to ascribe to a higher calling that includes a strong values base and vision that ultimately results in success for children, youth, and families. Effective children's mental health leaders are first and foremost, relational and inclusive. They are both transactional and transformative, using incremental steps and a series of evolutionary activities to move forward toward a broader, large-scale change.

This is the story of children's mental health leaders across our country.

CHAPTER VI: SUMMARY

Clandinin and Connelly (2000) describe narrative inquiry as the retelling of experience "to offer possibilities for reliving, for new directions, and new ways of doing things" (p. 189). This study has allowed the stories of ten state children's mental health leaders to paint a rich interconnected picture of what it means to lead change in an effort to illustrate possible directions and approaches for future leaders. In this chapter, I will first offer a brief recap of the key findings from Chapter V. Then, I will discuss how these findings tie to the literature reviewed in Chapter II with three primary areas of focus: what from the literature was reinforced, what was complexified, and what emerged that was new. I will then reflect on how these findings relate to my own experience as a past state and county leader in children's mental health. I will close the chapter by sharing thoughts on the implications for policy and practice and for further research.

Key Findings

Through the stories of the children's mental health leaders who participated in this study, I identified several key findings that fall into three primary areas: the leader themself, constraints, and strategies. Importantly, it is the concurrence of all three and the ability for them to be interwoven that contribute to system evolution.

The Leader

All of the leaders who shared their stories spoke of their own personal connection and commitment to the work they were doing. In addition to their explanations for why they were engaged in children's mental health system building, each shared stories that reflected their humility, and their persistence and tenacity. These three traits, bundled with in intrinsic drive and reason for their work, were consistently present.

Constraints

Children's mental health leaders operate in environments that are riddled with a range of factors and conditions that constrain their activities. In fact, the leaders tend to view their environments as consistently constrained; that constraint is an ongoing environmental condition. The leaders who participated shared stories that illustrated how they engage in their work while being both impacted and impeded by environmental, structural, interpersonal/relational, and procedural constraints. Environmental constraints included political changes, lawsuits, negative media attention, or natural disasters. Structural conditions included changes in leadership, the organizational structure within government, the provider and service array, and funding. Interpersonal and relational challenges included what I referred to as "politics" or the sensitive and at times charged nature of working in an elected official environment and negative attitudes and resistance, so common when leading change. Procedural constraints fell into two primary areas: communication, and contracting and procurement. Constraints are ever present in the children's mental health leaders' experience. It is a constant that requires the formulation of a range of strategies that facilitate system improvement in the face of ongoing impediments.

Strategies

The leaders in this study shared stories that illustrated the use of a broad array of strategies that allow them to advance their systems. Primary among the strategies is the development and maintenance of relationships with a range of important partners including those from other child-serving systems, local governments, providers, external experts, and family members. Leaders also shared that holding a shared vision, both a broad overarching vision and a vision for specific activities, was useful to their efforts to improve their systems. Each of the leaders spoke about the need to be strategic and opportunist and maximize on environmental

changes as levers to move activities forward. Leaders also shared stories of how financing, policy, and legislation could be used to initiate and sustain change within their systems; and how service development that was responsive to emerging needs or inclusive of new evidence was an ongoing effort within their work. Relatedly, education including workforce development on philosophy and specific practice models as well as general awareness building, and documentation that captured and explained aspects of the system, were all seen as essential tools to leading change.

Interconnectedness

The leaders in this study offered many stories that illustrated the co-mingling of their own traits, the constraints, and the strategies. In none of the stories was there simply a presenting constraint and a strategy in response, but rather a leader who embodied humility and had the ability to be both persistent and tenacious, engaged in an ongoing interplay where constraints were constant and strategies were evolutionary and contextually driven by the environment around them. Constraints were often leveraged, serving as critical catalysts for systems change and as a result, became strategies for the opportunistic and politically savvy leaders in this study. These findings and their interconnectivity tie directly to some of the literature and offer potential extensions or refinements to the current thinking. The findings also yielded new insights that have implications for the future work of children's mental health leaders, and more broadly, for public sector leaders.

Comparing Findings to the Literature

The stories of the participants in this study painted rich pictures of their experiences leading change within their state's children's mental health system. Some of the stories

reinforced the literature in the field, while others offered new insights or nuance. Some of the leaders' stories suggested entirely new dimensions that expand the existing knowledge base.

Reinforcement of Existing Literature

The findings from this study reinforced some of what is contained in the literature specific to the inadequacy of resources, the attributes of the leader, and the role of policy and legislation.

Inadequate Resources. The literature specific to children's mental health consistently reflected on the inadequacy of the resources available for mental health and children's mental health more specifically (Cummings et al., 2013; Howell, 2004; Pires et al., 2013). This was supported by the leaders' stories: many commented not only on the lack of resources, but also the inequity of resource allocation between adult and children's mental health. Many shared that compared to their adult counterparts, they had a fraction of the allocation. The experience of these leaders was congruent with the literature in this way and represents a much-needed area for further attention. The data reflected the continued inequity of resource allocation for children with mental health needs which is incomprehensible given the extensive awareness that healthy children become healthy adults (National Research Council Institute of Medicine, 2004).

Leadership Attributes. The literature reviewed specific to leadership traits or attributes in environments of decline offered some important insights. Bunker and Wakefield (2010) discuss the need for leaders to be communicative and Carmeli and Sheaffer (2009) reflect that self-centeredness can be damaging to leading through decline. The stories of leaders in this study supported this. Specifically, communication was seen as critical to success and humility was present in all of the leaders' stories.

"Inclusive leadership focuses on valuing diversity and the effective management of diversity and inclusion of all" (Booysen, 2014, p. 297). Like relational leadership which "considers leadership as a process of organizing" (Uhl-Bien, 2006, p. 665), "inclusive leadership thinking falls squarely in the relationship-based process and follower-focused, less-dominant way of leadership thinking" (Booysen, 2014, p. 303). What emerged from the leaders' stories is their reliance on both inclusive and relational leadership approaches without every labeling it in this way.

The Role of Policy and Legislation. The literature on the use of policy and legislation as a strategy for change was supported in the stories of many of the leaders who participated in this study. Both state and federal policy were found to be important vehicles to advance and most importantly sustain change in these leaders' states. Most frequently cited by the leaders in this study was the use of policy to ensure sustainable financing of system changes. Less common was the use of policy to mandate collaboration, as was noted in the studies led by Evans et al. (2007) and Armstrong and Evans (2010).

New Insights

The findings from this study also yield an array of new insights to the existing literature. In this way, the findings extended or complexified what was found in the literature specific to complex adaptive systems; structures, processes, and relationships; the new public management; and collaboration and partnership.

Complex Adaptive Systems. Plsek and Greenhalgh (2001) wrote about the fluidity of boundaries, changing membership, and the multi-system engagement of members in complex adaptive systems. The stories from the participants in this study illustrated all of these concepts. Leaders consistently shared their experiences that the children's mental health system was more

than just their department and that it informally included other child-serving systems as key components of "the system." These leaders shared that the children's mental health system in their states was not a single bounded system, but rather a shared or distributed system across several departments and key constituencies. Also emerging from the stories was the ongoing impact of elections that resulted in new governors and subsequent child-serving system leadership changes, which were noted as both a constraint and at times also a strategy.

Uhl-Bien and Arena (2017) talk about complexity as a "rich interconnectivity" (p. 11) and this certainly emerged from the stories of participants. This richness is illustrated by the stories of leaders who address myriad constraints simultaneously with a range of concurrent strategies. The children's mental health leaders in this study all talked about operating in an environment of ongoing constraint and shared stories that illustrated how they weave across and around these constraints and engage multiple constituencies and partners that include other state child-serving departments, local governments, providers, and families, while engaging in a range of concurrent strategies. The data indicate that leadership in these complex adaptive systems requires not only an awareness of the interconnectivity, but an ability to identify potential levers for change within the complexity. While many of the stories illustrated an awareness of this complexity, the group of activities that I have referred to as maximizing the environment appear to reflect a leader's ability to leverage the complexity. In these situations, leaders recognize the interdependencies, capitalize on them, adapt to the needs of these people or systems, and as a result, are able to advance the established big vision. Several authors (Barker & Barr, 2002; Schmitt & Raisch, 2013) discuss the concept of strategic reorientation in the retrenchment response literature where leaders engage in a re-engineering of approaches in response to declining environments. This also relates to the literature specific to complex adaptive systems

where change is often incremental and grows in accordance with connections among the systems

and the literature specific to complex adaptive systems in healthcare that discuss the multiple

components and variety of systems involved in healthcare delivery (Tan et al., 2005). This too

demonstrates the interconnectedness of many of the findings.

Structures, Processes, and Relationships. The work of Hodges et al. (2007) to study

children's systems of care across the country resulted in the formulation of their definition of a

system of care which included the concepts of structures, processes, and relationships. This

represented an evolution from prior definitions (Stroul & Friedman, 1986) which focused more

specifically on service and support arrays. The stories of the children's mental health leaders in

this study identified constraints that fell into similar categories. Some constraints were structural,

others were procedural, yet others were relational, and lastly those that were environmental.

Interestingly, strategies used to undertake system advancement were also structural, procedural,

and relational. In this way, the findings from this study support the work of Hodges and her

colleagues (2007) and extend these constructs to not only defining what the system *is*, but also

the factors that impact and facilitate its continued evolution to better meet the needs of children

with mental health challenges and their families.

The New Public Management. The retrenchment literature offered the concept of the

"new public management" as one set of possible responses to environments of decline

(Kaboolian, 1998). New public management is the application of business strategies to the

nonprofit and public sectors. Several of the financing strategies contained within the stories of

the participants of this study exemplify new public management-like approaches. Specifically,

the diversification of funding sources through grant seeking and braiding/blending funding show

a more revenue-oriented mindset that is often seen in business and less often evident in public

sector environments. Similarly, some of the awareness building activities that leaders shared as critical strategies for system building are forms of marketing which are frequently employed in for-profit environments to increase interest and profitability. In children's mental health these are employed to increase buy-in and commitment. The data reflected that leaders in children's mental health also seemed to know that through awareness raising activities, the increased visibility could yield increased attention and funding or mitigate the risk of reductions as the potential for public scrutiny and backlash would serve as a deterrent.

Collaboration and Partnership. Several authors noted the role of collaboration and partnership as a strategy in environments in decline (Behn, 1988; Bishop, 2004; Crohn & Birnbaum, 2010). The stories of the children's mental health leaders in this study consistently included relational themes of working in collaboration with other systems and constituencies. What emerged from the stories of the leaders was an ongoing environment of constraint which necessitated the need to work closely and in partnership with many others, both inside and outside of government. This work was not optional; it was necessary to make progress. Each leader shared stories reflecting that relationship building, seeking opportunities for partnership, and working to solve for the problems being experienced by others who were critical to meeting the needs of children with mental health challenges, were core components of their work. The foundational nature of this strategy seems directly tied to these leaders' understanding that the children's mental health system is not a single bounded system and is consistently operating under constraint. As an under-funded system, the data reflected that survival techniques to ensure the ability to serve young people with mental health challenges and their families included creating relationships and interdependencies across systems and constituencies.

New Dimensions

Constraint is the environmental norm for children's mental health leaders. Yet, the literature specific to these conditions is scant. While a fair amount of literature is devoted to retrenchment and decline, less research is devoted to operating in an ongoing and enduring environment of constraint, even less so in public sector environments. As a result, the experiences of the children's mental health leaders in this study yielded a host of new insights. These include how the notion of retrenchment applies to the children's mental health context, the interwoven and overlapping nature of constraints and strategies and the dynamic tension that must be carefully held to support systemic change, the important role of data to children's mental health leaders, and the evolutionary and incremental nature of change in children's mental health systems over time.

Retrenchment. The concept of retrenchment has historically been characterized as an environmental condition or as an array of possible responses to environments of decline. Most often, these responses focus on reductions and eliminations (Behn, 1988; Crohn & Birnbaum, 2010). Interestingly, none of the children's mental health leaders who participated in this study shared stories about cuts as part of their journey. It became increasingly evident as each interview transpired that retrenchment for children's mental health is a constant environmental condition. Economic scarcity in public sector children's mental health is the baseline according to the experiences of these leaders. They note the longstanding disproportionality of funding and staffing as a constant. While certain unprecedented or unanticipated events may occur that further constrain them, these leaders are always constrained. As a result, they do not view their environments as being in a state of decline nor do they immediately think about reductions, eliminations, and cutbacks as strategies. This is contrary to the literature on retrenchment

responses (Behn, 1988; Crohn & Birnbaum, 2010), where these types of actions predominate. Instead, leaders in children's mental health do as much as possible with whatever they are afforded. That data from this study showed that these leaders seek clever and creative workarounds by engaging partners to maximize whatever resources are available to meet the needs of children with mental health challenges and their families. Data indicated that these leaders may reprioritize or adapt their goals and strategies as a result of this environment, but reductions were not mentioned. Leaders in children's mental health create rather than cut.

Constraints are Strategies. One of the most striking themes from the leaders' stories was how often a constraint was also a strategy. As one leader put it:

> It feels like it's about maximizing what you can do within a constraint . . . pushing hard to really maximize what we can do within whatever the constraints are. I think those are the skills that good government practitioners have.

Countless examples existed throughout the leaders' stories about how they took something that could have been a limitation and used it as a catalyst to move something forward. From capitalizing on a leadership change to reinvigorate or breathe new energy into people's commitment to children's mental health, to using a catastrophic event that impacted people from all socioeconomic levels to shine a light on children's mental health, these leaders used whatever was at their disposal to continuously propel their systems forward. Their eyes remain focused on the endgame, or their mutually crafted vision.

A striking example of this can be found in the lawsuits or threats of suit that children's mental health leaders who participated in this study faced. Several shared that the presence or threat of a lawsuit put their work under a microscope resulting in involvement and scrutiny from those inside and outside of government, which was difficult. At the same time, these leaders shared how they were able to take what was an unfortunate circumstance and use it to get

something that they wanted or that their system needed, whether that was being allowed to create a new service, use a new provider, or engage a new partner. From the stories, it was evident that an effective leader in children's mental health is one who creates opportunities from challenges and who sees what is possible in the face of impossibilities. Given that the environment surrounding these leaders is consistently constrained, this ability, to make lemonade from lemons, is both a critical mindset and skill.

      Data. Several of the leaders' stories included references to the use of data as a critical component of their efforts. Initially, data was coded as a strategy. During the re-review and code cleaning process, it became clear that data, in and of itself, was not a strategy. Rather, data was used to identify a constraint or to support a strategy. Leaders shared examples of how they were able to use data as the foundation for a specific relationship, for example, by showing leaders in child welfare how the child welfare population had significant mental health needs that could be addressed through more active partnership. They shared examples of using data to support visioning, by pulling together various data points and using them as the basis for a comprehensive Strengths, Weaknesses, Opportunities, and Threats (SWOT) assessment. Yet another leader talked about maximizing the environment, when data reflecting an increase in suicides surfaced in a particular school district and resulted in joint federal grant seeking with the state education department. Other leaders talked about using cost-savings data to support policy and financing change, for example, demonstrating the cost benefits of providing a certain service under Medicaid. Data play a critical role in the life of the children's mental health leader (Armstrong et al., 2012), and the ability to collect and couple data with other strategies was found to be a nearly universal experience for those who participated in this study.

Small Moments. As I approached this study, I considered using critical incident method as I was interested in learning about how leaders in children's mental health were able to advance system change. I was operating from an assumption that there would be specific catalysts or experiences that were the defining moments on their change journey. Through extensive discussion, I decided instead to proceed with narrative inquiry to hear these leaders' stories and uncover the richness and variety that would result which might contain these critical moments. Shortly into data collection and listening to the stories of leaders, I realized and heard that leaders seldom spoke of big watershed moments. While there were large, unprecedented, or unpredictable occurrences, these were simply a part of their story. They were not *the* story.

What was revealed through the stories of these participants is a far more methodical and well-orchestrated journey that occurs over years with constant attention, adaption, and refinement. These leaders hold the big picture and incrementally work toward that vision with full realization that it will likely not fully occur under their watch. Theirs is a long game of incremental evolution that capitalizes on the less frequent radical and revolutionary moments, similar to the discussion by Foster-Fishman et al. (2007) of the coexistence of both first and second order change. These leaders blend both adaptive and technical work; they are concurrently transactional and transformational. They embody the ability to hold tension, between what currently is and the co-created aspirational vision, as a way to perpetuate and effect change within their systems. Similar to puzzle pieces, these leaders assemble the constraints and the strategies together in ways that allow them, and those around them, to move toward the shared vision they have worked so diligently to collaboratively develop.

Reflexivity

My interest in children's mental health and systemic change is rooted in my own experience and history. Just after graduating high school, I lost a close friend to suicide. Matt was diagnosed with Bipolar Disorder and when experiencing a manic episode, he behaved in bizarre and often dangerous ways. One evening he engaged in a misdemeanor offense and as a result was detained in a local county jail. It was unfortunate that despite his known psychiatric history he was placed in jail instead of a forensic psychiatric unit. It was also unfortunate that despite this history and an active doctor's order for psychiatric medications to stabilize his functioning, Matt was not administered medication during his time in jail. The culmination of these actions was tragic. Matt completed suicide while in jail. Matt's death served as my personal call to action to engage in systems reform on behalf of those who were challenged by mental health issues, a pledge I made to my mother moments after I learned of his death. My career has been shaped and influenced by this experience and has led me to serve in roles as both a county and state children's mental health leader. My own experience and my very personal connection and mission have clearly influenced my work and this study.

Being aware of the very personal nature of this study to me, I approached it carefully. After each interview, I journaled about the experience and reflected on how certain aspects of the leaders' stories affected me. I wrote about the things that caused me to actually physically feel something in my body in reaction to what they shared and my emotional reactions—the things that were more triggering. After one interview I thought intensely about how much the leader had done in such a short time and wondered how they had been able to do all of what they done so quickly and that I did not feel I had accomplished nearly as much. After several of the interviews I thought about how these leaders were able to stay and address this ongoing environment of

constraint and how I had been able to endure state level work for only about four years. I was awed by and perhaps a bit envious of their staying power. Another leader talked about having to learn how to titrate her own reactions or beliefs and go along with the party line which reminded me so much of my experience working in a conservative Republican southern state. I captured my observations and thoughts about emerging themes and the consistency or inconsistency with my own experience. While there were definitely parallels, I was also left in awe of this tremendous group of leaders who through their relentless commitment to do what is right for children with mental health challenges and their families, weathered and endured consistent obstacles and barriers and still made significant progress advancing their systems.

What was most surprising to me in conducting this study was the longevity of nearly all of the leaders. Of the ten who participated in the study, all but two had been in their positions for over one decade. This was different from my experience where I served as a state leader for just less than four years (the second term of the governor). These leaders had spent years and years operating in the constrained environment, holding the vision of system improvement, weathering significant changes, and through it all, advancing and improving their systems. Their unwavering commitment and ongoing pursuit of excellence spanning years and administration changes led to a slower, more incremental, and evolutionary approach to systems change. While some shared stories that included a more revolutionary occurrence or change, they were the exception. These leaders were predominantly engaged in the long game, focusing on change over the course of years, if not decades.

I was also surprised by the extent to which state leaders in children's mental health leveraged and depended on their relationships with county leaders. In my role as a county leader, this was not my experience. In fact, I spent a fair amount of time in my county role resenting the

state for not putting the necessary regulation and policy in place that would pave the way for

broader systemic change. I was frequently at odds with the state children's mental health leader,

who from my perspective was ineffective and unwilling. I will admit that, years later as a state

leader, I developed a stronger appreciation for the challenges faced by those in state government.

I became more aware of impediments a state leader faces when attempting to make policy and

regulatory change. That clarity would have been helpful to me years earlier when working in the

county. The actions of the leaders in this study to forge local connections and work in partnership

with the local systems likely contributes to their ability to make more sustainable change

statewide.

I also spent a fair amount of time considering the impact of lawsuits. This was

particularly salient for me as the threat of a lawsuit was ongoing when I served as a state leader

and it seemed to have significant impact on what I was able to do. I worked in an administration

that was very risk averse likely because of the Governor's presidential aspirations. As a result,

these threats were not opportunities for me. They were the cause of great anxiety and

apprehension and at times resulted in taking a far less direct or bold approach to change. I was

surprised to learn through these leaders' stories that while a lawsuit or threat of a lawsuit could

make their lives incredibly difficult, they could also make their mission possible. The leaders use

of these threats to push change that had previously been delayed or avoided was completely

incongruent with my own experience. I will admit feeling some sense of envy for the leaders

who strategically used this to leverage important changes to their systems.

A final reflection that I think is important to note is the concept of being a prophet in your

own land. The stories of leaders in this study frequently included the use of outside experts to

help move something forward or to make the case for taking action. Several leaders expressed

that the presence of outside credibility was a key component to advancing system change in their states. I had a similar experience as a state leader where, as one example, high-priced consultants were engaged to make recommendations for service expansion when our state team had a very good sense of what the state needed and what was in the best interest of children and families. What also struck me was my own experience serving as a prophet in my former lands. I left New York State in 2011, and in 2017, was invited back to serve as the keynote speaker for the state children's mental health conference. Much of what I shared were things that I believed and attempted when I worked in New York State. When I said them when I lived in New York, they were not heard and suddenly, six years after leaving, I could say the same things about my beliefs and strategies and be heard. Similarly, I left Louisiana in 2014, and in 2018, I was invited back to serve as the keynote for their state behavioral health conference. Again, much of my address included things that I had said and attempted to act on when serving in state government that were ignored or overruled. The irony of this is not lost on me.

Limitations of the Study

As with other qualitative methods, narrative inquiry is vulnerable to a set of biases that are different from those that threaten the credibility of quantitative studies. The data gathered are the stories that reflect a person's experience. These stories are told through the participant's lens and retold through the researcher's lens. Both the participant and I color the stories shared. While this poses limitations, it also allows for a richness to the results that could not be achieved if the stories were told or heard by someone who did not have the experience. Careful consideration after each interview of what was actually said, and subsequent journaling was a critical part of each encounter. Recordings and transcripts were reviewed several times to establish the final codes, and initial coding was reviewed by a member of my committee to offer an objective lens

to the emergent themes. What is captured in these stories is the leaders' experience and my interpretation through my lens of experience. What is presented is the essence of their experiences after an ongoing iterative process that was intentionally focused on what was expressly said versus what I as the listener might have assumed. The intentionality of my actions helps to preserve the enabling nature of the bias that is present and helps to mitigate the possibility of it becoming disabling.

Another limitation to this study is the participant criteria for inclusion. I chose to focus on the experience of children's mental health leaders working at the state level. As a result, the pool of possible participants was finite. There are only 51 people who fill this role in the continental United States. Selection of participants was also limited to those who expressed a willingness to share their stories which could mean that those who offered to participate believed they had stories worth sharing. They could represent those who felt that they had made significant systemic progress in their states and therefore be biased towards those states where change was discernible. While geographic representation was disbursed, other demographic variables such as gender and race, were less diverse. This information is not presented in the leaders' stories to protect their confidentiality which was a promise made to them given the high visibility of their roles and the political considerations each faces.

Relatedly, another critique of narrative inquiry is a failure to account for contextual factors that may impact the stories being told. To address this challenge, I captured information from each leader about their own career arcs and experience, and their government structures. I also captured demographic factors for included states which were woven into the stories presented in Chapter IV in a way that would not lead to identification of the leader or their state. Maintaining confidentiality was critically important in developing the stories presented. In

sharing their stories, these leaders expressed vulnerability that could place them at risk. Respecting that sensitivity is critical to the research process.

Implications for Practice

While having utility, leadership theory often lacks the practical application or the contextual grounding that is necessary for practice. From the stories of the leaders who participated in this study, a picture emerges that is not just theoretical in nature. It provides concrete suggestions for those seeking to lead change in environments marked by constraint. Specifically, it is important to have a well-articulated big picture strategy that is co-created and mutually held. Across all stories, leaders shared that this vision not only guided their activities, but also allowed them to enforce boundaries when needed. It helped them to stay the course and take incremental steps in pursuit of improvement. The vision provided both the what and why for the system change that was being undertaken.

What also emerged from the leaders' stories was the "how"—the steps they took to move their systems forward. The ability to establish and achieve the big vision was largely dependent on relationships. The leader who invests their time to establish close bonds and develop a deep understanding of and appreciation for partners' needs is a leader who is most often able to advance change. Effecting change in environments characterized by constraint is an act of building social capital over time that is then put to use in service of a shared vision. Leadership in environments of constraint is a blend of technical and adaptive work (Heifetz et al., 2009). The stories from these leaders painted a picture that technical strategies are more successful when nested within the adaptive labyrinth of relationship work and deep values-based alignment. Leadership in these environments is also highly relational and inclusive (Booysen, 2014). Leadership development then must be focused on helping leaders to develop relational and

interpersonal skills, to build inclusivity, to understand the art of compromise and negotiation, and to espouse and exude vulnerability and humility.

What also emerged from the stories is the leader's ability to be comfortable being uncomfortable. As the literature captures, from Mezirow (1991) and the "disorienting dilemma" to Heifetz et al. (2009) and the "productive zone of disequilibrium," change happens in the space where people are just uncomfortable enough to be open to alternative views and new ways of operating. The constraining environments that children's mental health leaders find themselves in is a constant state of disorientation and disequilibrium and the leader needs to use that discomfort as a catalyst for change. They also must do their best to contain the discomfort to ensure it does not become incapacitating or paralyzing. Again, this requires emotional attunement and relational abilities, critical skills that leaders must develop.

Implications for Policy

Policy is a tool that can be more intentionally leveraged to effect sustainable systemic change, whether in children's mental health or more broadly (Hodges & Ferreira, 2013). Policy change is an often arduous and difficult process, but what emerged from the stories of leaders in children's mental health is that policy change allows something to endure. In my experience, leadership development does not typically focus on policy analysis and policy making. For public sector leaders, these skills are essential. Leaders who were able to successfully enact policy and legislative change were often able to point to successes from many years prior that had withstood repeated changes in administration. In state government work, this is critical as the majority of states have established gubernatorial term limits and as a result change typically occurs at least every 8–12 years.

Relatedly, while policy development was cited as highly successful for those who used it, it was less frequent in participant's stories and even less common in the literature. Specific policy vehicles, such as those that mandate cross-system collaboration or those that seek to establish financing for specific services in children's mental health, are essential to system evolution in children's mental health (Armstrong & Evans, 2010; Hodges & Ferreira, 2013). Policy that mandates cross-system collaboration coupled with leadership development that focuses on inclusivity and establishing deep relational and interpersonal skills as suggested previously would equip future leaders to more effectively execute on the constant evolutionary journey of system change, whether that be within children's mental health, or in other parts of government, or across sectors.

Implications for Future Research

This study has sought to examine more closely the experience of public sector children's mental health leaders in environments of constraint. While this study had a highly focused and specific population, constraining environments are increasingly becoming the norm within both the public and private sectors (Honberg et al., 2011; McMorrow & Howell, 2010). The literature specific to constraining environments is surprisingly scarce. Even fewer studies address this type of environment in the public sector, despite this being an omnipresent condition. The vast majority of research that does exist in this area tends to focus on retrenchment and places a heavy emphasis on cuts and reductions as primary strategies (Behn, 1988; Bishop, 2004; Crohn & Birnbaum, 2010). From the stories of leaders in this study, it seems that these are not the strategies typically being used to address the constraints being faced. In fact, these leaders, who viewed themselves as operating in environments that were consistently constrained, were more focused on and engaged in system building activities and strategies. Not one leader shared a

story that included rash actions and activities, such as reductions and position eliminations. While these may have occurred during their careers, instead, these leaders shared stories that highlighted the range of creative and adaptive solutions that integrated new knowledge and information and moved them toward their mutually held vision of an improved system.

It appears then that further research is needed to continue to better understand the constraints that surround leaders' work and the strategies they employ. This research could be done both within the public sector and across sectors. A mixed methods approach using quantitative surveying to comb more broadly for both constraints and strategies, followed by deeper qualitative interviews, could yield valuable insights about the different constraints that are affecting leaders in the modern environment and how they are responding. Further research could also seek to explore more fully individual leadership traits and attributes and their correlation with specific strategies to better understand the competencies needed for leading in environments of constraint. Within the public sector, where constraints are ever present and policymaking occurs, future studies could also seek to understand the role and importance of policy in constraining environments, which could be useful in elucidating the skills necessary for successful public sector leadership.

Conclusions

The public sector is an important context for leadership to affect broadscale systemic change. Yet the literature on leadership within public sectors is scant. This study examined the experience of state public sector leaders in children's mental health and has revealed some important findings. Primary among them is the notion that the leader in public sector children's mental health is consistently operating within an environment of constraint. It is not a specific environmental condition or factor—it is the ongoing and pervasive environmental condition.

Given this environment, these leaders must set their egos aside and engage in a persistent and tenacious ongoing and evolutionary journey to improve the children's mental health system. These leaders must create a range of strategies that facilitate their journeys which include both inclusive and relational adaptive and technical approaches. In our current environment, leaders must pay keen attention to their environments, understand the motivations of those around them, and capitalize on highly attended-to relationships. The leaders in this study embodied a unique combination of commitment, personal attributes, environmental attunement, and use of strategy to effect change. They understand what to do, with whom, and when—and the children with mental health challenges in their states benefit immeasurably.

References

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). One size does not fit all: Taking diversity, culture and context seriously. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1), 48–60. https://doi:10.1007/s10488-010-0283-2

Alexander, J. (1999). The impact of devolution on nonprofits. *Nonprofit Management and Leadership, 10*(1), 57–70. https://doi:10.1002/nml.10105

Armstrong, M. I., & Evans, M. E. (2010). Fostering an unnatural act: Does policy make a difference in collaboration in systems of care? *Best Practice in Mental Health, 6*(2), 27-38.

Armstrong, M. I., Milch, H., Curtis, P. & Endress, P. (2012). A business model for managing system change through strategic financing and performance indicators: A case study. *American Journal of Community Psychology, 49*, 517-525. https://doi:10.1007/s10464-012-9512-z

Barker III, V. L., & Barr, P. S. (2002). Linking top manager attributions to strategic reorientation in declining firms attempting turnaround. *Journal of Business Research, 55*(12), 963–979. https://doi.org/10.1016/S0148-2963(00)00217-4

Beels, C. C. (2009). Some historical conditions of narrative work. *Family Process, 48*(3), 363–378. https://doi:10.1111/j.1545-5300.2009.01288.x

Behn, R. D. (1988). The fundamentals of cutback management. In K. S. Cameron, R. I. Sutton, D. A. Whetten (Eds.), (pp. 347–356). Publishing Co/Harper & Row Publishers.

Biester, D. J., Duggan, M., Perkins, M., Powers, L. K., & Classick, S. (1999). Quality care in an era of retrenchment. *Journal of the Society of Pediatric Nurses: JSPN, 4*(4), 141–145. https://doi.org/10.1111/j.1744-6155.1999.tb00230.x

Bishop, S. W. (2004). Building a profile of Missouri CSBG community action agencies: Capacities, coping strategies, and the new public management. *Nonprofit Management & Leadership, 15*(1), 71–93. https://doi.org/10.1002/nml.54

Bold, C. (2013). *Using narrative in research*. Sage. https://doi:10.4135/9781446288160

Booysen, L. (2014). The development of inclusive leadership practice and processes. In B. M. Ferdman, & B. R. Deane (Eds.), *Diversity at work: The practice of inclusion,* (pp. 296–329) Jossey-Bass. https://doi.org/10.1002/9781118764282.ch10

Brown, W. (2008). Narratives of mental health recovery. *Social Alternatives, 27*(4), 42–48.

Bruner, J. S. (1986). *Actual minds, possible worlds*. Harvard University Press.

Bunker, K., & Wakefield, M. (2010). A question of leadership. *Leadership in Action, 29*(6), 14–15. https://doi.org/10.1002/lia.1313

Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child & Family Psychology Review, 2*(4), 199–254. https://doi.org/10.1023/A:1021826216025

Butz, A., & Zuberi, D. (2012). Local approaches to counter a wider pattern? Urban poverty in Portland, Oregon. *The Social Science Journal, 49*(3), 359–367. https://doi:10.1016/j.soscij.2011.12.001

Carmeli, A., & Sheaffer, Z. (2009). *How leadership characteristics affect organizational decline and downsizing.* (No. 86). Springer Science & Business Media B.V. https://doi:10.1007/s10551-008-9852-7

Centers for Disease Control and Prevention. (2013). *Mental health surveillance among children, United States 2005–2011.* (Morbidity and Mortality Weekly Report Supplement No. 62(2)). Office of Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/mmwr/pdf/other/su6202.pdf

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: experience and story in qualitative research*. Jossey-Bass Publishers.

Clandinin, D. J., & Rosiek, J. (2012). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 1–48). SAGE Publications, Inc. https://doi:10.4135/9781452226552

Clayton, R., & Pontusson, J. (1998). Welfare-state retrenchment revisited: Entitlement cuts, public sector restructuring, and inegalitarian trends in advanced capitalist societies. *World Politics, 51*(1), 67–98. https://doi:10.1017/S0043887100007796

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational Researcher, 19*(5), 2–14. https://doi:10.2307/1176100

Cooper, J. L. (2008). *Towards better behavioral health for children, youth and their families: Financing that supports knowledge*. National Center for Children in Poverty. Retrieved from http://www.nccp.org/publications/pdf/text_804.pdf

Corrigan, P. W., & Boyle, M. G. (2003). What works for mental health system change: Evolution or revolution? *Administration and Policy in Mental Health and Mental Health Services Research, 30*(5), 379–395. https://doi:10.1023/A:1024619913592

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). SAGE Publications.

Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative research designs. *The Counseling Psychologist, 35*(2), 236–264. https://doi:10.1177/0011000006287390

Crohn, K., & Birnbaum, M. (2010). Environmental education evaluation: Time to reflect, time for change. *Evaluation and Program Planning, 33*(2), 155–158. https://doi:10.1016/j.evalprogplan.2009.07.004

Culbertson, J. (1976). Educational leadership: The uses of adversity. *Theory into Practice, 15*(4), 253–259. https://doi:10.1080/00405847609542641

Cummings Graduate Institute for Behavioral Health Studies. (2020). *How budget cuts are affecting mental health care.* Retrieved from: https://cgi.edu/resources/infographics/budget-cuts-affect-mental-health-care/

Cummings, J. R., Wen, H., & Druss, B. G. (2013). Improving access to mental health services for youth in the United States. *Journal of the American Medical Association, 309*(6), 553. https://doi:10.1001/jama.2013.437

D'Aveni, R. A. (1989). The aftermath of organizational decline: A longitudinal study. *Academy of Management Journal, 32*(3), 577. https://doi.org/10.2307/256435

Deci, E. L., Connell, J. P., & Ryan, R. M. (1989). Self-determination in a work organization. *Journal of Applied Psychology, 74*(4), 580–590. https://doi:10.1037//0021-9010.74.4.580

Dodge, J., Ospina, S. M., & Foldy, E. G. (2005). Integrating rigor and relevance in public administration scholarship: The contribution of narrative inquiry. *Public Administration Review, 65*(3), 286–300. https://doi:10.1111/J.1540-6210.2005.00454.X

Evans, M. E., Armstrong, M. I., Beckstead, J. W., & Lee, J. (2007). Examining the impact of policy on collaboration in systems of care. *Journal of Child & Family Studies, 16*(4), 567–576. https://doi.org/10.1007/s10826-006-9107-0

Feldman, M. S., Sködberg, K., Brown, R. N., & Homer, D. (2004). Making sense of stories: A rhetorical approach to narrative analysis. *Journal of Public Administration Research & Theory, 14*(2), 147–170. https://doi:10.1 093/jopart/muh010

Foster-Fishman, P., Nowell, B., & Yang, H. (2007). Putting the system back into systems change: A framework for understanding and changing organizational and community system. *American Journal of Community Psychology, 39*(3–4), 197–215. https://doi:10.1007/S10464-007-9109-0

Frank, R. G., Koyanagi, C., & McGuire, T. G. (1997). The politics and economics of mental health 'parity' laws. *Health Affairs, 16*(4), 108–119. https://doi.org/10.1377/hlthaff.16.4.108

Gadamer, H. (1989). *Truth and method* (2nd rev. ed.). Crossroad.

Hannah, S. T., Uhl-Bien, M., Avolio, B. J., & Cavarretta, F. L. (2009). *A framework for examining leadership in extreme contexts*. https://doi:10.1016/j.leaqua.2009.09.006

Hauerwas, S. (2001). Character, narrative, and growth in the Christian life. In J. Berkman & M. Cartwright (Eds.), *The Hauerwas Reader* (pp. 221–254). Duke University Press. https://doi.org/10.2307/j.ctv11hpktr.17

Heifetz, R. A., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership: Tools and tactics for changing your organization and the world*. Harvard Business Press.

Hernandez, M., Armstrong, M., Green, A. L., & Johnson, M. H. (2017). National survey of state children's mental health directors: Current status and future directions. *The Journal of Behavioral Health Services & Research, 44*(1), 3–24. https://doi:10.1007/s11414-016-9514-y

Hinkley, S. (2017). Structurally adjusting: Narratives of fiscal crisis in four US cities. *Urban Studies, 54*(9), 2123–2138. https://doi:10.1177/0042098015618167

Hodges, S., & Ferreira, K. (2013). A multilevel framework for local policy development and implementation. In A. M. Culp (Ed.), *Child and family advocacy: Bridging the gaps between research, practice, and policy* (pp. 205-215). Springer New York. https://doi:10.1007/978-1-4614-7456-2_14

Hodges, S., Ferreira, K., Israel, N., & Mazza, J. (2007). *System implementation issue brief #1—Lessons from successful systems: System of care definition*. University of South Florida, Louis de le Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Retrieved from http://rtckids.fmhi.usf.edu/rtcpubs/study02/IssueBrief1Definition.pdf

Hodges, S., Ferreira, K., & Israel, N. (2012). 'If we're going to change things, it has to be systemic:' Systems change in children's mental health. *American Journal of Community Psychology, 49*(3), 526–537. https://doi:10.1007/s10464-012-9491-0

Honberg, R., Kimball, A., Diehl, S., Usher, L., & Fitzpatrick, M. (2011). *State mental health cuts: The continuing crisis*. National Alliance on Mental Illness.

Honoré, P. A., Stefanak, M., & Dessens, S. (2012). Anatomy of a public health agency turnaround: The case of the general health district in Mahoning County. *Journal of Public Health Management and Practice, 18*(4), 364–371. https://doi:10.1097/PHH.0b013e3182548e1a

Howell, E. (2004). *Access to children's mental health services under Medicaid and SCHIP* (Series B, No. B-60 ed.). The Urban Institute. Retrieved from

https://www.urban.org/sites/default/files/publication/57751/311053-Access-to-Children-s-Mental-Health-Services-under-Medicaid-and-SCHIP.PDF

Hummel, R. P. (1991). Stories managers tell: Why they are as valid as science. *Public Administration Review, 51*(1), 31–41. https://doi.org/10.2307/976634

Joint Commission on Mental Health of Children. (1970). *Crisis in child mental health: Challenge for the 1970s*. Harper and Row.

Jordan, J. (2011). Health care politics in the age of retrenchment. *Journal of Social Policy, 40*(1), 113–134. https://doi:10.1017/S0047279410000528

Jovchelovitch, S., & Bauer, M. W. (2000). *Narrative interviewing* [online]. LSE Research Online.

Kaboolian, L. (1998). The new public management: Challenging the boundaries of the management vs. administration debate. *Public Administration Review, 58*(3), 189–193. https://doi:10.2307/976558

Karanikolos, M., Mladovsky, P., Cylus, J., Thomson, S., Basu, S., Stuckler, D., Mackenbach, J. P., & McKee, M. (2013). Financial crisis, austerity, and health in Europe. *The Lancet, 381*(9874), 1323–1331. https://doi:10.1016/S0140-6736(13)60102-6

Knitzer, J. & Olson, L. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Children's Defense Fund. Retrieved from http://diglib.lib.utk.edu/cdf/main.php?bid=117&pg=12

Konner, M. (2010). *The evolution of childhood: Relationships, emotion, mind*. Belknap Press of Harvard University Press.

Krantz, J. (1985). Group process under conditions of organizational decline. *The Journal of Applied Behavioral Science, 21*(1), 1–17. https://doi:10.1177/002188638502100102

Latour, B. (1979). *Laboratory life: The social construction of scientific facts*. Sage.

Lee, C. W., & Romano, Z. (2013). Democracy's new discipline: Public deliberation as organizational strategy. *Organization Studies, 34*(5–6), 733–753. https://doi:10.1177/0170840613479233

Lewis, P. J. (2014). Narrative research. In J. Mills (Ed.), *Qualitative methodology: A practical guide* (pp. 1–23). SAGE Publications, Inc. https://doi:10.4135/9781473920163

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (Eds.). (2011). Categorical-content perspective. In *Narrative research* (pp. 112–140). SAGE Publications, Inc. https://doi:10.4135/9781412985253

Luthans, F. &. Avolio, B. (2003). Authentic leadership development. In R. E. Quinn, J. E. Dutton, & K. S. Cameron (Eds.), *Positive organizational scholarship: Foundations of a new discipline* (pp. 241–258). Berrett-Koehler Publishers.

Luton, L. (2010). *Qualitative research approaches for public administration.* M.E. Sharpe.

MacIntyre, A. (1984). *After virtue: A study in moral theory* (2nd ed.). Notre Dame University Press. https://doi.org/10.2307/1051043

Maynard-Moody, S., & Musheno, M. (2000). State agent or citizen agent: Two narratives of discretion. *Journal of Public Administration Research & Theory, 10*(2), 329. https://doi.org/10.1093/oxfordjournals.jpart.a024272

McMorrow, S., & Howell, E. (2010). *State mental health systems for children: A review of the literature and available data sources*. The Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/29126/412207-state-mental-health-systems-for-children-a-review-of-the-literature-and-available-data-sources.pdf

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey-Adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(10), 980–989. https://doi:10.1016/J.JAAC.2010.05.017

Mezirow, J. (1991). *Transformative dimensions of adult learning* (1st ed.). Jossey-Bass.

Mullan, F., Ficklen, E., & Rubin, K. (2006). *Narrative matters: The power of the personal essay in health policy*. The John Hopkins University Press.

Mulvale, G., Kutcher, S., Randall, G., Wakefield, P., Longo, C., Abelson, J., Winkup, J., & Fast, M. (2015). Do national frameworks help in local policy development? Lessons from Yukon about the evergreen child and youth mental health framework. *Canadian Journal of Community Mental Health, 34*(4), 111–128. https://doi:10.7870/cjcmh-2015-011

Musteen, M., Liang, X., & Barker, V. L. (2011). Personality, perceptions, and retrenchment decisions of managers in response to decline: Evidence from a decision-making study. *The Leadership Quarterly, 22*(5), 926–941. https://doi:10.1016/J.LEAQUA.2011.07.012

National Research Council Institute of Medicine (US). Children's Health, The Nation's Wealth: Assessing and Improving Child Health. Washington (DC): National Academies Press (US); 2004. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK92210/

Norman, S. M., Avolio, B. J., & Luthans, F. (2010). The impact of positivity and transparency on trust in leaders and their perceived effectiveness. *Leadership Quarterly, 21*(3), 350–364. https://doi:10.1016/j.leaqua.2010.03.002

O'Kane, C., & Cunningham, J. (2012). Leadership changes and approaches during company turnaround. *International Studies of Management & Organization, 42*(4), 52–85. https://doi.org/10.2753/IMO0020-8825420403

Ospina, S. M., & Dodge, J. (2005). It's about time: Catching method up to meaning—The usefulness of narrative inquiry in public administration research. *Public Administration Review, 65*(2), 143–157. https://doi:10.1111/j.1540-6210.2005.00440.x

Pierson, P. (1996). The new politics of the welfare state. *World Politics, 48*(2), 143–179. https://doi.org/10.1353/wp.1996.0004

Pinnegar, S., & Daynes, J. G. (2012). Locating narrative inquiry historically: Thematics in the turn or narrative. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 1–38). SAGE Publications, Inc. https://doi:10.4135/9781452226552

Pires, S., McLean, J. & Allen, K. (2018). Faces of Medicaid: Children's behavioral health care utilization and expenditures infographic. Retrieved from https://www.chcs.org/resource/faces-medicaid-childrens-behavioral-health-care-utilization-costs/

Pires, S. A., Grimes, K. E., Allen, K. D., & Gilmer, T., & Mahadevan, R. M. (2013). *Faces of Medicaid: Examining children's behavioral health service use and expenditures*. Center for Health Care Strategies, Inc. Retrieved from http://www.chcs.org/media/Faces-of-Medicaid_Examining-Childrens-Behavioral-Health-Service-Utilization-and-Expenditures1.pdf

Plsek, P. E., & Greenhalgh, T. (2001). Complexity science: The challenge of complexity in health care. *British Medical Journal, 323*(7313), 625–628. https://doi.org/10.1136/bmj.323.7313.625

President's Commission on Mental Health. (1978). *Report of the sub-task panel on infants, children, and adolescents*. Author.

Ridgway, P. (2001). ReStorying psychiatric disability: Learning from first person. *Psychiatric Rehabilitation Journal, 24*(4), 335–343. https://doi:10.1037/H0095071

Riley, T., & Hawe, P. (2005). Researching practice: The methodological case for narrative inquiry. *Health Education Research, 20*(2), 226–236. https://doi.org/10.1093/her/cyg122

Rubin, I. S. (1979). Retrenchment, loose structure and adaptability in the university. *Sociology of Education, 52*(4), 211–222. https://doi:10.2307/2112402

Schmitt, A., & Raisch, S. (2013). Corporate turnarounds: The duality of retrenchment and recovery. *Journal of Management Studies, 50*(7), 1216–1244. https://doi.org/10.1111/joms.12045

Smith, R. (2010). Children's rights and youth justice: 20 years of no progress. *Child Care in Practice, 16*(1), 3–17. https://doi:10.1080/13575270903369301

Stelk, W., & Slaton, E. (2010). The role of infrastructure in the transformation of child-adolescent mental health systems. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1–2), 100–110. https://doi:10.1007/S10488-010-0282-3

Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances*. Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B. A., Heflinger, C. A., Alegría, M., Slaton, E., Farmer, E. M. Z., Betts, V. T., Outlaw, F. H., & Gruttadaro, D. (2010). Improving the linkage between research and system change: Making it real. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1–2), 125–127. https://doi:10.1007/s10488-009-0261-8

Stroul, B. A., & Manteuffel, B. A. (2007). The sustainability of systems of care for children's mental health: Lessons learned. *Journal of Behavioral Health Services & Research, 34*(3), 237–259. https://doi:10.1007/s11414-007-9065-3

Tan, J., Wen, H. J., & Awad, N. (2005). Health care and services delivery systems as complex adaptive systems. *Communications of the ACM, 48*(5), 36–44. https://doi.org/10.1145/1060710.1060737

Tangpong, C., Abebe, M., & Li, Z. (2015). A temporal approach to retrenchment and successful turnaround in declining firms. *Journal of Management Studies, 52*(5), 647–677. https://doi:10.1111/joms.12131

Thornhill, H., Clare, L., & May, R. (2004). Escape, enlightenment and endurance. *Anthropology & Medicine, 11*(2), 181–199. https://doi:10.1080/13648470410001678622

Uhl-Bien, M. (2006). Relational leadership theory: Exploring the social processes of leadership and organizing. *Leadership Quarterly, 17*(6), 654–676. https://doi:10.1016/j.leaqua.2006.10.007

Uhl-Bien, M., & Arena, M. (2017). Complexity leadership: Enabling people and organizations for adaptability. *Organizational Dynamics, 46*(1), 9–20. https://doi:10.1016/j.orgdyn.2016.12.001

United States Department of Labor. (2010). The mental health parity and addiction equity act of 2008 (MHPAEA) fact sheet. Author.

Walsh, I. J., & Glynn, M. A. (2008). The way we were: Legacy organizational identity and the role of leadership. *Corporate Reputation Review, 11*(3), 262–276. https://doi:10.1057/crr.2008.20

Weitzel, W., & Jonsson, E. (1989). Decline in organizations: A literature integration and extension. *Administrative Science Quarterly, 34*(1), 91. https://doi.org/10.2307/2392987

Whetten, D. (1980). Organizational decline: A neglected topic in organizational science. *The Academy of Management Review, 5*, 577. https://doi:10.2307/257463

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W.W. Norton.

Whitney, D. G., & Peterson, M. D. (2019). US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatrics, 173*(4), 389–391. https://doi:10.1001/jamapediatrics.2018.5399

Appendix

Appendix A

Contact Email for NASMHPD CYFD List Serve

Hello NASMHPD CYFD Members,

My name is Jody Levison-Johnson. I once served as the Children's Director in Louisiana and was a member of the CYFD. I am a Ph.D. candidate at Antioch University pursuing my degree in leadership and change and I am writing to see if you might be willing to participate in the research I am conducting for my dissertation.

My dissertation is focused on learning about how leaders in children's mental health have gone about their work to refine and enhance their systems and attempt to improve outcomes for children, youth, and families in the face of constraints or obstacles. As part of my study I will conduct confidential interviews via videoconference to ask you to share your stories about facing constraints or obstacles. There are a lot of different ways you can define a constraint or an obstacle, some examples include funding reductions or changes, policy changes, changes in administration, manmade or natural disasters. These are just some examples and is not an exhaustive list.

I am hoping some of you may be willing to talk with me about your experience.
Attached is a document that provides more information about the study. I am also happy to talk with you (phone, video, email, text) and answer any questions you might have. My contact information is below.

Please consider spending some time sharing your stories with me so we can help future leaders in children's mental health learn from your experience.

I look forward to hearing from you all very soon and will attend an upcoming CYFD meeting to share more and answer any questions.
Best,
Jody

Jody Levison-Johnson
Ph.D. Candidate
Graduate School of Leadership and Change, Antioch University

Appendix B

Study Information Summary

What is this research about?

Leaders in children's mental health face a variety of constraining factors. Understanding the stories of how leaders approach their work, their successes, and their failures can begin to paint the picture of a rich and interconnected field and offer future leaders invaluable lessons about leadership in complex systems that are often riddled with a variety of constraints.

Why is this study being done?

The research study is part of a dissertation that will fulfill degree requirements for a Ph.D. in Leadership and Change at Antioch University.

The topic was selected to better understand the experience of leaders and how they define, interpret, and perceive their current environments; the constraining factors that impact them – decline, instability, risk, politics, policy, random events, etc.; their priority goals; and the strategies they engage in to achieve their goals.

Who is conducting this study?

The research study is being conducted by Jody Levison-Johnson, a Ph.D. candidate at Antioch University. Jody has worked in the field of children's mental health for over 25 years and has spent much of her professional career leading systems change. Jody believes that the field is lacking information that helps leaders be successful when trying to initiate change in constraining environments and hopes this study, and the experiences of her colleagues, will provide valuable insights and strategies for future leaders in children's mental health.

What is required of me if I participate?

Participants in the study will be asked to share their stories of leadership during challenging (constraining) times. These conversations will take approximately 45 minutes and be conducted via videoconference. After completion of the interview, participants will be asked to review a summary of the interview that identifies themes and keywords to ensure it accurately reflects their stories and experience. This review should not take more than 60 minutes.

Will what I say be shared with anyone?

Themes from the interviews will be included in the final dissertation. Quotes may be used; however, any identifiable information will be removed, and pseudonyms assigned. Only the researcher will know which pseudonym goes with which participant.

What if I decide to participate and then change my mind?

You can withdraw your participation from this study any time prior to completion of data analysis. Any interview recording, transcript, or summary will be immediately destroyed upon withdrawal.

Who do I contact if I have additional questions?

You can contact the researcher, Jody Levison-Johnson, by email at
████████████████████████ or by phone/text at ████████ .

Appendix C

Informed Consent to Participate in a Dissertation Research Study

Note: A copy of the full Informed Consent Form will be provided for your records.

Name of Researcher: Jody Levison-Johnson
Name of Organization: Antioch University, Ph.D. in Leadership and Change Program
Name of Study: "The Experience of Children's Mental Health Leaders During Times of Constraint: A Narrative Study" (working title)

Introduction: This dissertation research study is being completed as part of the degree requirements for a Ph.D. in Leadership and Change at Antioch University. The researcher, Jody Levison-Johnson, is both a student in that program and a leader in children's mental health.

What follows is information about the project, along with an invitation to participate. You may discuss this information with anyone you wish, and you may take time to reflect on whether you would like to participate or not. You may also ask questions of the researcher at any time.

Purpose of the Research Study: The purpose of this research study is to better understand the experience of children's mental health system leaders and how they define, interpret, and perceive their current environments; the constraining factors that impact them – decline, instability, risk, politics, policy, random events, etc.; their priority goals; and the strategies they engage in to achieve their goals. Very little research is available regarding leadership under constraint or to help leaders be successful when trying to initiate change in challenging environments. The findings from this study and the participants' experiences have the potential to provide valuable insights and strategies for future leaders in children's mental health.

Research Study Activities: Participants in the study will be asked to share their stories of leadership during challenging (constraining) times. These conversations will take approximately 45 minutes, be scheduled at a time convenient for the participant, and be conducted via videoconference. After completion of the interview, participants will be asked to review a summary of the interview that identifies themes and keywords to ensure it accurately reflects their stories and experience. This review should not take more than 60 minutes.

Interviews will be recorded for research purposes. These recordings, and any other information that may connect you to the study, will be kept in a secure location. All participants will be given pseudonyms and "de-identified" prior to publication of the study or sharing of the research results.

Participant Selection: You are being invited to take part in this dissertation research study because you are (or were) a leader of a children's mental health system. You are not eligible to take part in this study if you are/were not a leader of a children's mental health system.

Voluntary Participation: Your participation in this research study is completely voluntary. You may choose not to participate. You will not be penalized for your decision not to participate, nor will you be penalized for any of your contributions during the study. You may withdraw from this study at any time prior to the completion of data analysis.

Risks: It is not expected that you will be harmed or distressed as a result of participating in this study. Should you choose to participate, you may stop the interview at any time if you become uncomfortable.

Benefits: Some people find talking about their experiences to be positive and personally beneficial. However, there is no assurance of benefit to you from participating in this research study. Your participation will assist in the researcher's learning and may help others in the field.

Reimbursements: You will not be provided any monetary incentive to take part in this research study.

Confidentiality/Limits of Confidentiality: All interviews will be recorded and transcribed. The interview recording, its transcription, and the signed Informed Consent form will be kept in a secure location. For the purposes of the dissertation study write-up, you will be given a pseudonym and your location/system will also be given a pseudonym. Only the researcher will know which pseudonym corresponds to which participant.

Generally speaking, your contributions to the study are considered private information. However, there are times when this is not the case. Information cannot be kept private (confidential) when:
- The researcher finds out that a child or vulnerable adult has been abused.
- The researcher finds out that that a person plans self-harm, such as by committing suicide.
- The researcher finds out that a person plans to harm someone else.

There are laws requiring many professionals to take action if they think a person is at risk for self-harm or is self-harming, harming another, or if a child or adult is being abused. In addition, there are guidelines that researchers must follow to make sure all people are treated with respect and kept safe. In most states, there is a government agency that must be told if someone is being abused or plans to self-harm or to harm another person. Please ask any questions you may have about this issue before agreeing to be in the study. It is important that you do not feel betrayed if it turns out that the researcher cannot keep some things private.

Future Publication: The researcher, Jody Levison-Johnson, reserves the right to include any results of this study in future scholarly presentations and/or publications. As noted above, all information will be "de-identified" prior to publication.

Right to Refuse or Withdraw: You do not have to take part in this dissertation research study if you do not wish to do so, and you may withdraw from the study at any time prior to the completion of data analysis.

Whom to Contact: If you have any questions, you may ask them now or later. If you have questions later, you may contact the researcher, Jody Levison-Johnson, via email at ███████████████████████ or by phone/text at ███████████.

If you have any ethical concerns about this study, you may contact Lisa Kreeger, Ph.D., Chair of the Institutional Review Board, Antioch University Ph.D. in Leadership and Change. Email: ███████████.

The proposal for this dissertation research study has been reviewed and approved by the Antioch Institutional Review Board (IRB), which is a committee tasked with ensuring that research participants are protected. If you wish to find out more about the IRB, contact Dr. Lisa Kreeger.

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

DO YOU WISH TO PARTICIPATE IN THIS DISSERTATION RESEARCH STUDY?

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it, and any questions I have asked have been answered to my satisfaction. I voluntarily consent to be a participant in this dissertation research study.

Name of Participant (printed): _____

Signature of Participant: _____

Date: _____

DO YOU FURTHER CONSENT TO BE VIDEOTAPED IN THIS STUDY?

I voluntarily agree to have my interview conversation recorded for the purpose of this study. I agree to allow the use of these recordings as described in this form.

Name of Participant (printed): _____

Signature of Participant: _____

Date: _____

To be completed by the researcher or the person taking consent:

I confirm that the participant was given an opportunity to ask questions about the dissertation research study, and that all questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Name of Researcher/Person Taking Consent: _____
Signature of Researcher/Person Taking Consent: _____
Date: _____