Concept Mapping Project Developing and Sustaining Mississippi's System of Care

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Uses in Mississippi

- In the COMPASS Project, the first System of Care, to determine next steps toward statewideness
- In the new System of Care community in the Pine Belt community

Purpose of Concept Mapping

To determine next steps in statewide development of Systems of care, we sought input from
- the state level planning body of 13 years
- the community interagency team of 7 years

Joint effort of MS Department of Mental Health and Mississippi Families as Allies

Reasons for Choosing this Strategy

- Wanted input from stakeholders in a group process
- Wanted an energized activity—not long, drawn out meetings
- Wanted a fair process
- Wanted an equal voice for all

Potential Uses

- To shape direction of state-level planning
- To shape direction of local-level planning
- As a basis for development of a logic model—identifies areas of focus
- As a basis for the development of a strategic plan

Concept Mapping Process

Concept Mapping Is....

- a process in which a group brainstorms their ideas on a certain topic
- a way to look at everyone's ideas and how they merge with other's ideas
- a visual map that illustrates what the group's ideas are, how the ideas are related to one another and how they can be organized or clustered into general concepts

Advantages of Concept Systems

Integrates qualitative group processes (brainstorming, and sorting and rating of statements) with multivariate statistical analyses , which include

- multidimensional scaling of the sort data
- hierarchical cluster analysis
- computation of average ratings for each statement and cluster of statements

More Advantages

- Software generates clusters, graphs, charts, and item ratings
- Findings are based on statistical analyses
- No personal biases interjected

Disadvantage

- Findings are complicated and need explanations and discussions

Concept Systems, Inc. Example of Clients

Concept Mapping Participation

Two Parts to the Process

Part 1: Brainstorming (group activity)

Part 2: Sorting and Rating (individual activity)

Those who participate in the Brainstorming, also must complete the Sorting and Rating

Brainstorming on the first day

- The participants generate ideas in response to a prompt

The next day they do Sorting

- They sort each idea into groups they believe are related to each other
- They label each group

and Rating

- They rate each idea as to importance using a 1-5 point scale
- They rate each idea as to feasibility using a 1-5 point scale

The Brainstorming Process

- The prompt statement sets the task
- As someone makes a statement, it is typed into the computer and projected onto the screen
- Brainstorming is complete when the group cannot generate any more statements
- Or until they create 100 statements

Brainstorming

Focus Statement

What specific actions/steps need to be taken for the system of care to be successful in Mississippi?

Findings from State Level & Local Level Concept Mapping

How It Worked

- The community group met first
  - Brainstormed 96 ideas
- The state group met next
  - Brainstormed 71 more ideas
  - Sorted and rated all 167 ideas
- The community group sorted and rated the 167 ideas

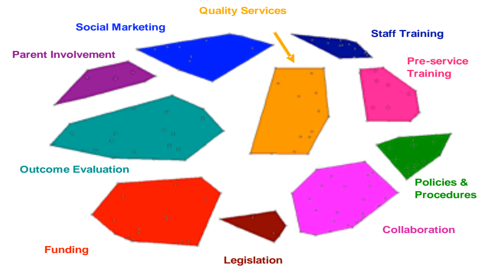
Findings

- The 2 groups generated 10 clusters
- The groups rated the clusters very differently
- The groups rated the items within clusters very differently
- The groups' ratings reflected the different perspectives/missions of state and local groups

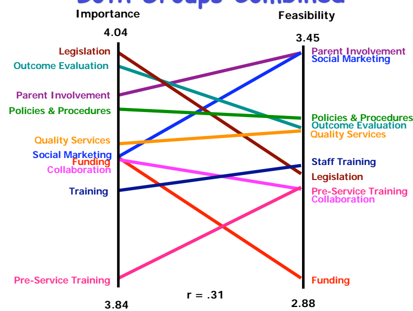
Use of Information

- Facilitates development of a logic model for systems change; clusters define areas of importance
- Action plans can be created by focusing on those statements that are perceived to be the most important and most feasible

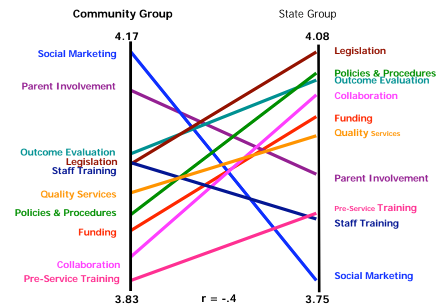
Cluster Map with a Ten-Cluster Solution



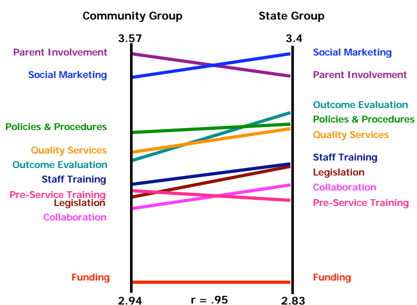
Comparison of Cluster Ratings for Importance & Feasibility Both Groups Combined



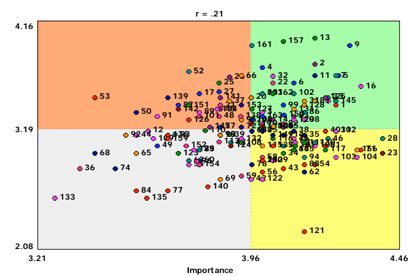
Cluster Ratings for Importance Community Group vs State Group



Cluster Ratings for Feasibility Community Group vs State Group



Go Zones



Top Items for Importance & Feasibility Both Groups, Combined

Statement	Importance	Feasibility
Develop more/better communication	4.20	3.88
Teach parents to communicate concerns to educators as early as possible	4.29	3.76
For families new to SOC, identify all interested agencies & providers	4.28	3.76
Explain diagnosis, medication & side effects to family & child	4.33	4.08
Educate educators on mental health issues for children	4.28	3.76
Identify target populations for services	4.20	4.16
Develop stronger partnerships between agencies that are part of the SOC	4.38	3.64

Top Items for Importance and Feasibility Community Group, Alone

Statement	Importance	Feasibility
Develop more/better communication	4.20	3.88
Teach parents to communicate concerns to educators as early as possible	4.29	3.76
Be informative in educating the community about types of care	4.12	3.68
Explain diagnosis, medication & side effects to family & child	4.33	4.08
Identify target populations for services	4.20	4.16
Have a MAP Team in each county, even if funding is not immediately available	4.12	3.08
Make educational materials more kid and family friendly so they can learn about their issues or those of others in the class or community	4.00	3.56

Top Items for Importance and Feasibility State Group, Alone

Statement	Importance	Feasibility
For families new to SOC, identify all interested agencies & providers	4.28	3.26
Have clear objectives; what are we going to do and how are we going to do it	4.16	3.48
Clarify expectations; what the family expects from SOC and we expect from the family	4.25	3.52
Develop written agreement at local and state levels to carry out best practices associated with system of care	4.16	3.28

Top Items for Importance and Feasibility State Group, Alone

Statement	Importance	Feasibility
Involve families and consumers in the design/operation of the system of care	4.12	3.56
Deter institutional placements as opposed to community services	4.16	3.44
Develop a mission statement for the overall system of care	4.08	4.16

Similarities and Differences

- The common ground between the groups is the emphasis on families
- The community group emphasized services
- The state group emphasized structures

Moral of this Story

- State level and local level people see things differently; their priorities for action steps differ
- How you stand has to do with where you sit!

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PLANNING THE STATEWIDE DEVELOPMENT OF SYSTEMS OF CARE FOR CHILDREN WITH SERIOUS MENTAL HEALTH DISTURBANCES

CONCEPT MAPPING REPORT

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ACKNOWLEDGEMENTS

We have thoroughly enjoyed the opportunity to work with leaders in the State of Mississippi to plan for the future development and support of systems of care for children and youth with serious emotional/behavioral disorders and their families. We recognize that Mississippi was one of the first states to have a state-level coordinating council to oversee systems reform and to have legislation to mandate these changes. We also recognize that there have been many challenges along the way, both economic and programmatic. During the past year, the State of Mississippi and those in the state who work on behalf of children, youth and families have been faced with the overwhelming task of recovering from Hurricane Katrina, which devastated the Gulf Coast and the southern part of the state.

Even with such challenges, the parents and professionals concerned about children, youth and families have taken time to help with the task of planning for the future. We appreciate the time and effort they have dedicated to this task by participating in the concept mapping process. Their dedication to this effort was apparent and it is our perception that they enjoyed the chance to express their thoughts and priorities. Our greatest thanks go to the participants in the planning process. We hope that we have produced results will be considered interesting and useful.

We would like to give special thanks to Brenda Scafidi, Ed.D., Director of the Division of Children and Youth Services of the Mississippi Department of Mental Health and to Tessie Schweitzer, LMSW, the Executive Director of Mississippi Families as Allies for their faith in this process and for the leadership they provided. We are also grateful to Tumutual Norton, Ed.D., Division of Children and Youth Services, who skillfully and efficiently organized the process, and to Becky Kelly, LMSW, of Mississippi Families as Allies, who assisted us most ably with data collection. We could not leave unmentioned Victor Behar, M.D., F.A.C.P, F.A.C.C., F.A.H.A., (retired), who provided the benefit of his extensive research and editorial experience to this endeavor.

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EXECUTIVE SUMMARY

The Division of Children and Youth Services of the Mississippi Department of Mental Health and Mississippi Families as Allies jointly sought information to determine the critical steps necessary for statewide implementation of community systems of care for children and youth with serious emotional/behavioral disorders and their families. Concept mapping techniques were used to engage two knowledgeable and experienced groups to identify the actions that were important and feasible to develop and sustain a statewide system. The first group was comprised of community stakeholders who had been involved in the federally-funded, system of care demonstration project in Hinds County and neighboring Rankin County. The second group included members of the existing Interagency System of Care Council (2000 – present) and other representatives of key state level task forces and committees that are providing input into the ongoing efforts to develop the system of care statewide.

The first group, comprised only of individuals on the local consortium (Hinds and Rankin Counties), and the second group, comprised of regional and state level representatives, met separately. Each group was asked to "Generate a list of things that need to be done if the system of care is to be developed and sustained successfully throughout the state." They engaged in brainstorming sessions which resulted in the creation of 163 unduplicated action statements.

The participants then sorted the 163 statements into piles that "go together." A concept map was created, using the groups' sorting of the statements. Statements perceived to be similar to one another based on the group's sorting were positioned close to each other and statements perceived to be dissimilar were located farther apart. Similar statements were grouped together in non-overlapping categories called clusters based on their proximity to one another. A ten-cluster solution for the map was chosen, as this number of clusters appeared to provide the best description of the data. The cluster names were derived from the labels assigned by the participants in the sorting process. The ten clusters are: Legislation, Outcome Evaluation, Parent Involvement, Policies & Procedures, Social Marketing, Quality Services, Funding, Collaboration, Staff Training, and Pre-service Training.

After the groups completed the sorting process, they rated the statements in terms of importance and feasibility. The average importance or feasibility rating for a statement is the statistical average of the score given to that statement by each rater. A detailed discussion is presented to reflect the similarities between the two groups on the dimension of importance and then the similarities on the dimension of feasibility. The findings are that there is a moderate amount of disagreement (correlation of -40) between the groups regarding importance, but remarkable consistency regarding feasibility (correlation of +.95). The interpretation is that the two groups, with their different roles and responsibilities, place importance on different factors. Years of experience in developing systems of care have led to their agreement about what is feasible.

When a comparison is made of importance and feasibility, using both groups combined, the resulting correlation reflects a low level of agreement, indicating that there is little consistency between what is important and what is feasible. More insight into this discrepancy is gained by viewing the ratings between importance and feasibility for each group separately. The community level group showed a reasonably high level of agreement (r =.73 or 73%) on what is important and what is feasible. The state level group, however, had a correlation (r= -.30 or -30%) which reflects means a moderate level of disagreement between what they consider to be

important and what they view as feasible. One interpretation of this interaction might be that the state level group is in a position of knowing that what they consider important will not happen, under current state level realities. The community level group is more optimistic with 73% agreement between importance and feasibility. Another interpretation might be that important actions are more possible or occur more quickly at the community level, where the priorities are the clusters of Social Marketing, Parent Involvement, and Outcome Evaluation, and Staff Training. At the state level, the issues of Funding, Legislation, and Policies & Procedures are the priorities and they are considered less likely to occur, under current circumstances. These policy actions may occur more slowly than the implementation actions.

As noted above, the 163 statements were rated for importance and feasibility. The most highly rated importance statements reflect the priorities for action, that is, the most important next steps. However, if the concept of feasibility is brought into the picture, the priorities for action are changed, as they are tempered by what is possible. The areas that would be most fruitful to pursue are those judged both important and feasible.

The seven most important and feasible next steps rated by the community level group translate into action steps for a community to implement a system of care. Those steps include:

- Develop more or better communication/publicity
- Teach parents to communicate concerns to educators as early as possible
- Be informative in educating the community about types of care
- Provide clear explanation to family & child of diagnosis, medication & side effects; clarify whose responsibility is it to make sure the family receives the information
- Identify target populations for services
- Have a MAP Team in each county, even if funding is not immediately Available
- Make educational materials more kid and family friendly so they can learn about their own issues or those of other kids in the class or community

The seven most important statements rated by the state level stakeholders translate into action steps for the state level council to implement a system of care. Those steps include::

- For families new to SOC, identify all interested agencies & providers
- Have clear objectives; what are we going to do and how are we going to do it
- Clarify expectations; what the family expects from SOC and we expect from the family
- Develop written agreement at local and state levels to carry out best practices associated with system of care
- Involve families and consumers in the design/operation of the system of care
- Deter institutional placements as opposed to community services
- Develop a mission statement for the overall system of care

The unifying factor in planning for next steps is the focus on the family, which cuts across the ratings by both groups.

In planning for future development of systems of care throughout the state, it is important to understand that there are differences between how people at the state level and those at the community level view the next steps. Understanding these distinctions is important, as systems change will need to address the responsibilities at both levels for maximum benefit.

Planning the Statewide Development of Systems of Care for Children with Serious Mental Health Disturbances

Concept Mapping Report

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Child & Family Program Strategies

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INTRODUCTION

The Division of Children and Youth Services of the Mississippi Department of Mental Health and Mississippi Families as Allies jointly sought information to determine the critical steps necessary for statewide implementation of community systems of care for children and youth with serious emotional/behavioral disorders and their families. Concept mapping techniques were used to engage two knowledgeable and experienced groups to identify the actions that were important and feasible to develop and sustain a statewide system. The first group was comprised of community stakeholders who had been involved since 1999 in the federally-funded, system of care demonstration project that serves Hinds County, of which Jackson is the largest city, and two targeted schools in neighboring Rankin County. The second group included the members of the state level Interagency System of Care Council ISCC), which has been developing a Strategic Plan for the implementation of statewide systems of care since 2001 and was preceded by a Children's Advisory Council from 1993-1999. This ISCC has a membership of mid management representatives from state agencies and a family organization. It is overseen by the State Level Interagency Coordinating Council for Children and Youth (ICCCY) comprised of the executive leaders of each of the state agencies represented on the Interagency System of Care Council (ISCC). These two groups were statutorily authorized by State legislation in 1999 and were preceded by a Children's Advisory Council from 1993-1999. It was anticipated that the local and state level groups would bring different perspectives to the process.

The community group met in November 2005 and the state-level group met in March 2006 to discuss the actions necessary to develop and sustain community systems of care across the entire State of Mississippi. The two groups engaged in brainstorming sessions which resulted in the creation of 163 unduplicated action statements. They sorted and rated these items for importance and feasibility. A sequence of multivariate statistical analyses, including multidimensional scaling and hierarchical cluster analysis, was used to generate maps, comparison graphs, and feasible and important statements reflecting next steps. The results provide guidance for planning and implementing a statewide system of care.

BACKGROUND

The System of Care as National Policy

System of care policy has evolved over the past twenty-five years, stimulated by Knitzer's (1982) national study of mental health services for children and youth which revealed serious

deficits throughout the country. In 1984, the federal response to these findings launched the first phase of service reform through the Child and Adolescent Service System Program (CASSP), which provided funding to the states to begin restructuring their children's mental health services. Descriptions of the reform efforts can be found in the writings of Behar (1985, 2002), Behar, Friedman, & Lynn (2005), Stroul and Friedman (1986, 1994), Lourie (2002), and Friedman (2005a, 2005b). The Surgeon General's Report (1999) and the report of the New Freedom Commission (2003) have emphasized the value of this policy in serving children and families as national policy.

System of care policy is promulgated by the Child and Family Services Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The second phase of services reform, named the Comprehensive Community Mental Health Services Program for Children and Their Families, is described at http://www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/grantcomm.asp (2006) as a grant program providing funding to states, communities, territories, Indian tribes, and tribal organizations. These funds are designated to improve and expand community-based systems of care to meet the needs of children with serious emotional disturbances and their families. The systems of care are designed to address the needs of an estimated 4.5-6.3 million children with serious emotional disturbances and their families. Systems of care are developed on the premise that the mental health needs of children, adolescents, and their families can be met within their homes, schools, and communities. The Comprehensive Community Mental Health Services Program for Children and Their Families is based on a philosophy that includes four elements.

1. The mental health service systems are driven by the needs and preferences of the child and family addressed through a strength-based approach;
2. The focus and management of services occur within a multi-agency collaborative environment and are grounded in a strong community base;
3. The services offered, the agencies participating, and the programs generated are responsive to the cultural context and characteristics of the populations served; and
4. Families are lead partners in planning and implementing the system of care.

From the beginning, agencies serving children, youth and families have been encouraged to forge new partnerships across the relevant agencies and with parents to design and deliver services for their children. A major emphasis has been placed on serving children and youth in their own homes, to the extent possible, and in their own communities, rather than through institutional care. According to this reasoning, positive changes in community systems, i.e., programs, policies, practices, infrastructures, and other factors that shape service delivery, are an important mechanism for achieving lasting effects.

The Development of System of Care Policy in Mississippi

State Level Initiative: Most states have adopted system of care policy to shape their mental health systems for children and their families, either by state statute or administrative guidance. In Mississippi, formal state level efforts began in 1993, with an interagency initiative in two regions of the state, mandated by the state legislature. The focus of this initiative was to provide community based care and decrease the use of inappropriate out-of-home placements by using pooled resources from mental health, education, child welfare, and Medicaid. By legislative mandate, a state level advisory council was to provide oversight to the interagency initiative.

From that point forward, efforts in developing systems of care for children, youth and their

families have steadily evolved, supported by additional legislatively mandated requirements; mechanisms to review the quality of services; and, policy guidance from the State. As part of this effort, state level and community level interagency teams were formed across the State of Mississippi, to develop individualized resource plans for children and youth who were at greatest/immediate risk of being inappropriately institutionalized and were difficult to serve. These teams include representatives of agencies that delivered services to children and parent representatives. In 1999, the Mississippi Legislature amended earlier legislation (1993) to more firmly establish a statewide policy with the interagency system of care as the basis for services. In 2005, the legislature extended that statute to 2010. The 1999 legislation enhanced the earlier legislation and established the state level Interagency Coordinating Council for Children and Youth (ICCCY) and a state level Interagency System of Care Council (ISCC). The ICCCY is comprised of executive leaders of the respective state agencies named by the legislation and the executive director of the family support/education organization MS Families as Allies (MSFAA). The ISCC is comprised of appointed mid management level staff of each of the respective state agencies on the ICCCY and a family staff member of MS FAA. The local Multidisciplinary Assessment and Planning Teams (MAP Teams) were identified in that legislation as the bodies to oversee identification of resources/services to children and youth targeted in the legislation, i.e., those with mental health/behavioral disorders.

Family Organization Development: Mississippi Families as Allies for Children's Mental Health (MSFAA), established in 1991, was one of the first family-run, family focused organizations in the country (Schweitzer & Knutson-Eide, 2005). A group of Mississippi parents organized this non-profit agency, which was one of the first 15 Statewide Family Network projects funded by the National Institute of Mental Health. MSFAA is Mississippi's only statewide parent-run organization providing information, support and advocacy on behalf of the families of children with emotional, behavioral or mental disorders. The Executive Director of MSFAA was a member of the former Children's Advisory Council (1993-1999) and, presently is a member of the Interagency Coordinating Council for Children and Youth. In 2005, she was appointed as chair of the ICCCY.

Local Level Initiatives: In 1999, a community-based, system of care initiative, begun in Hinds County funded through the federal Comprehensive Community Mental Health Services Program for Children and Their Families, was developed to serve as a demonstration site for statewide mental health reform by putting into place a system of care for children's mental health. Hinds County encompasses both rural and urban areas, and Jackson, the State capital, is the county seat. In 2003, two targeted schools/communities in neighboring Rankin County were included in this initiative**.** That multi-year system of care initiative partnered with public and nonprofit community agencies, with a special focus on education, to develop a comprehensive interagency and family network of home and school based services.

Over the past seven years, the Hinds and Rankin County system of care, named Children of Mississippi and their Parents Accessing Strength Based Services (COMPASS), has established a collaborative service system providing coordinated community-based services to youth with serious emotional or behavioral problems and their families in schools targeted in those counties. The services are coordinated by a case manager who is part of a youth and family team that meets regularly to determine service and support needs. The team is comprised of family members, agency representatives and other individuals who are determined to be important in the child's life. (i.e., service providers, ministers, youth leaders). The goals of the project are to assist families in maintaining their children with serious emotional disturbances in the least

restrictive environments, reducing the number of out-of-home placements, and developing a coordinated system of service delivery within the community.

As COMPASS matured, both the state level interagency councils (ICCCY and ISCC) and the local consortium have gained considerable insight into the many issues involved in developing and sustaining a system of care in the community. These groups may offer different perspectives on the issue, as their responsibilities and activities have differed. As the State of Mississippi moves forward with efforts to establish similar systems throughout the state, advice and direction from both ~~of~~ the state level ICCCY and ISCC and the local level from groups such as the local (community) consortium developed/formed for COMPASS and local MAP teams, seems most relevant.

STUDY METHOD

The following concept mapping project was designed to capitalize on the experience of the state level Interagency System of Care Council and the project's local consortium and two MAP teams (Hinds and Rankin Counties) to develop an understanding of the community and state level factors in Mississippi that affect the development and sustainability of systems of care for children and youth with serious mental health/behavioral disorders. The goal was to delineate action steps in this complex process by synthesizing input from state level and local stakeholders who had several years of experience with such activities.

Although there is considerable professional discussion of the factors that are important for systems reform and sustainability (Behar, Friedman, & Lynn, 2005; Friedman, 2005a; Hernandez & Hodges, 2003; Manteuffel, Katana, Petrila, Rosales-Elkins, & Stroul, 2006), it is important to gauge where a system is in its development and to modify guidance based on local/state issues. This project was designed to gather participants' ideas about factors that would support widespread development and sustained change in the context of state and local issues in Mississippi.

Concept Mapping

Trochim describes concept mapping (Trochim, 1989a; Trochim & Linton, 1986) as a mixed-methods (Greene & Caracelli, 1997) planning and evaluation approach that integrates familiar qualitative group processes (brainstorming, and sorting and rating of statements) with multivariate statistical analyses to help a group describe its ideas on any topic of interest and represent these ideas graphically through maps. The process typically requires the participants to brainstorm a large set of statements relevant to the topic of interest, individually sort these statements into piles of similar ones, and rate each statement on one or more dimensions. The analyses typically include multidimensional scaling (MDS) of the sort data, hierarchical cluster analysis of the MDS coordinates, and computation of average ratings for each statement and cluster of statements. These data were then used to generate the maps which show the individual statements, with more similar statements located nearer each other and grouped into clusters. Concept mapping has been used effectively to address substantive issues across a wide range of fields, including human services, higher education and industry (Trochim 1989b; Trochim, Milstein, Wood, Jackson, & Pressler, 2003). Samples of groups using concept mapping include the Hawaii Department of Health, the National Cancer Institute, Hallmark, University of North Carolina School of Public Health, Delta Airlines, Nortell, Citgo, and Hallmark.

Participants

Two groups with experience in system of care development were invited to participate in this project. The first group (N = 19), i.e., the local consortium and two interagency case review teams (MAP teams), were children's services professionals and leaders from community agencies in Hinds and Rankin Counties and local representatives from Mississippi Families as Allies. The members of Group 1 were involved in the COMPASS Project's local consortium in the guidance of the effort locally. The second group (N = 15) was comprised of public/state agency administrators and managers of children's services and programs, and those at the leadership level of Mississippi Families as Allies. This Group 2 included ~~were~~ all members of the state level Interagency System of Care Council, which is the mid management level support council for the Interagency Coordinating Council for Children and Youth.

Procedure

The concept mapping process was conducted by the authors of this report, both of whom are certified facilitators by Concept Systems, Inc. They are both highly experienced consultants in the development and sustainability of systems of care. Thus, the two facilitators brought considerable experience in both the content of the task and the concept mapping process. They used the methods of data collection and data analysis designed by Concept Systems, Inc.[1]

The process took place in two stages, from November 2005 through June 2006. The first phase involved Group 1 and Group 2, each coming together to generate a list of factors (statements) that they considered to be relevant to the development and sustainability of systems of care in Mississippi. The second phase involved both groups organizing and prioritizing those statements. Group 1 completed these tasks by mail and Group 2 completed them in a group meeting. The Concept System computer software, version 4.118, (Concept Systems, March 2006) was used to perform all analyses and to produce all of the maps and statistical results.

Phase 1 (Generating Statements): Participants of Groups 1 and 2, in separate, live brainstorming sessions, responded to the following focus statement: "**Generate a list of things that need to be done if the system of care is to be developed and sustained successfully throughout the state**." Group 1 produced 67 statements and Group 2, 96 statements. The facilitators carefully reviewed the content of these statements and concluded that they were expressed in a unique manner and could not appropriately be consolidated. Thus, the responses of Groups 1 and 2 yielded a final list of 163 unique statements. These statements are provided in Appendix A. In Phase 1, each participant also completed a checklist that recorded their employment characteristics. The questions on the multiple choice checklist addressed the participant's role at the agency/organization and his/her role in services to children and families.

Phase 2 (Organizing and Prioritizing Statements): Each participant was asked to sort and then to rate the statements in terms of importance and feasibility, as follows:

- *Sorting*. Each participant was presented with a stack of the 163 statements on 2'x3' cards. Each conducted an unstructured sorting (Coxon, 1999; Rosenberg & Kim, 1975; Weller & Romney, 1988) of the statements by grouping them into piles of ideas that were similar to each other. The participants were asked to label the piles with names that described the statements that contained in the piles. The only restrictions in sorting the 163 statements were that participants could not (a) have piles with one statement in each, (b)

[1] The Concept System and Concept System Global software are licensed through Concept Systems Incorporated, Ithaca, New York (http:// www.conceptsystems.com).

have one pile consisting of all the 163 statements, or (c) have any piles that grouped conceptually dissimilar statements (e.g., a "miscellaneous" pile).

- *Ratings*. The 163 statements were listed on two sets of rating sheets. Participants rated each of the 163 statements on two dimensions: importance and feasibility. The ratings were based on a 5-point scale with 5 indicating *extremely important* or *extremely feasible* and 1 indicating *not at all important or not at all feasible*.

Both groups did their brainstorming in face-to-face group settings. Group 2 completed both the sorting and ratings on the day following their brainstorming session, using the statements they generated, plus those generated by Group 1. Of the 15 members of Group 2 in the brainstorming session, 13 (87%) returned and completed the sorting and ratings.

It was necessary to delay Group 1's sorting and rating until after the Group 2 brainstorming session, so that statements generated by both groups could be used. Their sorting and ratings were done by mail, with carefully written instructions. Of the 19 members of Group 1 that participated in the brainstorming session, 12 (63%) completed the sorting and ratings by mail. There was greater attrition in Group 1 between the brainstorming session and the rating session and there was also a greater time lapse. Group 2 did their ratings the next day, but the lapse in time for Group 1 was several months. This lapse occurred because Group 1 waited until Group 2 could meet and add to the brainstorming.

Although the attrition rate for Group 1 was higher than Group 2, there did not seem to be any pattern to those who did not respond to the request to sort and rate by mail. The result was that the two groups were similar in size, after the attrition. However, it seems clear that scheduling the sorting and ratings immediately after the brainstorming in a face-to-face group meeting results in less attrition than having these tasks done by mail. The size of the groups are typical for this methodology, which is often used as an alternative to traditional focus group interview procedures that frequently involve even fewer participants. Trochim (1993), in summarizing 38 projects, reports an average of approximately 14 sorters and raters in each project.

RESULTS

Concept Mapping Analysis

The data generated through concept mapping is derived from the sorting of statements done by the participants. The statements are analyzed using multivariate statistical techniques including multi-dimensional scaling and cluster analysis. A map is created, using the groups' average ratings of the statements as points on the map. Statements perceived to be similar to one another based on the group's sorting are positioned close to each other and statements perceived to be dissimilar are located farther apart. Similar statements are grouped together in non-overlapping categories called clusters based on their proximity to one another.

No simple mathematical criterion is available by which a final number of clusters can be selected. Experience is required to understand which groupings of clusters make the most sense. The facilitators/analysts carefully examined the range of possible cluster solutions, ranging from six to thirteen clusters, which reflect typical cluster solutions. The maximum of thirteen clusters was chosen because clusters beyond that number seemed to be overly detailed and specific. Starting with thirteen clusters, the facilitator/analysts examined successively lower cluster solutions, making a judgment at each stage about whether the merger seemed reasonable or

whether too much information would be lost by combining clusters, resulting in acceptance of the ten-cluster solution. As an example of the decision to use ten clusters, study of the nine-cluster solution showed a merger of “Social Marketing” and “Parent Involvement” into the broader category of “Public Relations.” The facilitators/analysts believed that “Social Marketing” and “Parent Involvement” were sufficiently different conceptually to warrant two separate clusters rather than being placed together under the broader heading of “Public Relations.” Thus a ten-cluster solution, showing both of these, was selected over a nine-cluster solution.

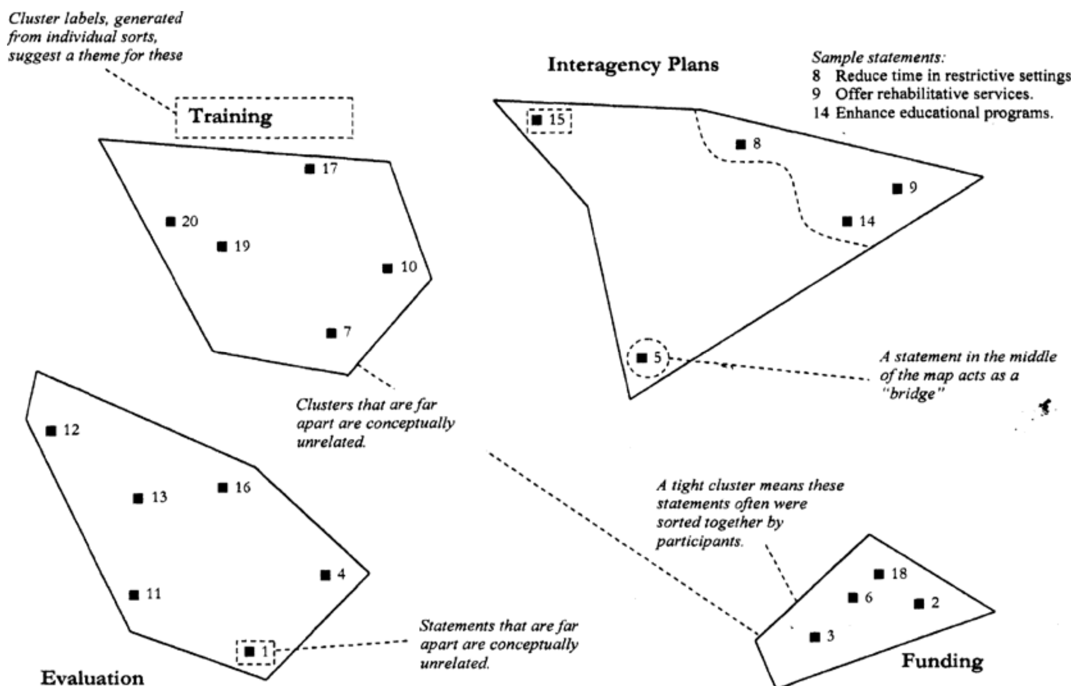
Map Results

The foundation for all maps is the labeled statement-cluster map, which shows all of the statements in relation to each other, based on the statistical analysis. Statements are located closer to each other if more people sorted them together into a group. In general, statements that are closer together are more similar in meaning. Statistical analyses grouped these statements into clusters as shown. In this project, as discussed above, the ten-cluster solution showed the best fit of the data. The analysis also mathematically selects the best-fitting label for each cluster from all of the pile labels generated by all of the sorters. These were examined in relation to the statements in each cluster, and if the analysts determined that the suggested label did not appropriately cover the content, the next best fitting label was examined until an appropriate cluster label was identified.

The guidelines that follow provide an overview of how the maps and supporting data can be read and interpreted. Two tools are provided as aids in understanding concept map data. These are 1) a *Sample Statement and Cluster Map,* and 2) *Guidelines for Interpreting Concept Map Data*.

<u>*Sample*</u> *Statement and Cluster Concept Map*

The map below illustrates the main features of a concept map. It does not include real data; the clusters and statements are used for illustration only and have no relation to the system of care concept mapping process.



Guidelines for Interpreting Concept Map Data

Below is an explanation of the three major components of concept map analysis, which include 1) the statement and cluster map, 2) the statement and cluster ratings, and 3) the consensus pattern match.

Statement (Point) and Cluster Map: As seen above, the statements generated in the brainstorming session have been sorted by the participants and then the results of the sorting process have been analyzed. The analysis produced first a point map and then a cluster map. The point map shows the spatial relationship of the points. Points closer to one another were sorted together most often and should be similar in meaning. Those points far away from each were not sorted together often and should not be conceptually similar. The point map shows the arrangement of statements in terms of proximity to each other. Boundaries are then put around statements that seem to form a grouping, i.e., a cluster. The cluster map provides a more clearly defined picture of the relationship of the items, as they have been sorted (arranged) by the participants. The characteristics of the cluster map are:

- The location of points (statements) on a map is important in relation to other statements.
- The distance between statements is important, but placement at top, bottom, left, right is not relevant (you can flip the map in any direction).
- The relationship of clusters to one another is similar to the relationship of statements.
- Cluster titles are generated from an analysis of participants' sorting labels based on statistical computations.
- In finding the themes of a map, it is helpful to consider how the clusters relate conceptually to one another.
- The size of a cluster does not indicate importance. A small dense cluster indicates that statements were grouped together often.
- When ideas on a map are distinct, the statements may be clustered tightly together and away from other clusters on the map.
- A large cluster often indicates an idea that is broad or that the cluster bridges two related ideas.
- If a large cluster bridges two related ideas, the cluster will sit between the clusters it bridges.
- Clusters in the middle of a map are usually bridging clusters, meaning they include ideas that are linked to multiple regions on the map.
- Clusters that are conceptually clear end up on the edges of the map because participants often sort the statements in them together and sort them with other statements less often.

Statement and Cluster Ratings: After sorting the statements that "go together" into piles, the participants used a list of the statements and rated them for importance of each statement and the feasibility of each statement, using a five-point scale.

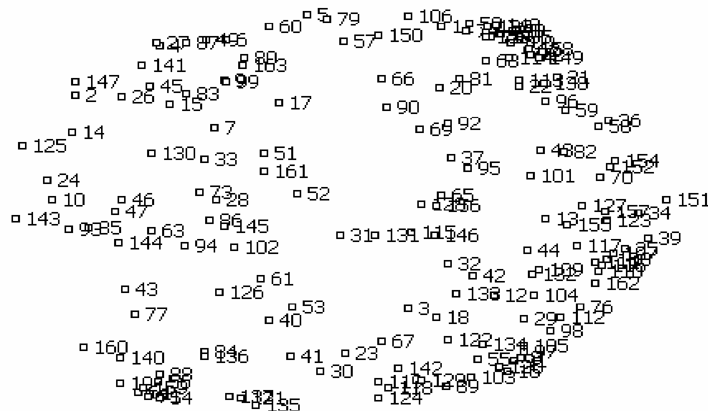
- The tables or maps are used to show the ratings, i.e., average importance and feasibility ratings for each statement across all of the raters or separately for each of the two groups.
- The ratings for importance and feasibility shown in tables or on the rating maps are calculated as an average of the average ratings for statements in those clusters.
- Although one statement in a cluster may have a very high rating, the cluster average will be low if other statements in that cluster are rated low.

Consensus Pattern Match: Consensus pattern matches, represented by the ladder graphs, are used to analyze the ratings of subgroups (e.g. agency staff and administrators or, in this study, the coordinating council members and the community representatives). The ladder graphs compare participant responses on a single rating at a time, either importance or feasibility.

- The rating scale is represented on the vertical lines of the ladder graph. Each of the vertical lines represents a subgroup of participants.
- Because of the narrow range of cluster averages (all averages fell between 2 and 5), the ladder graphs illustrate the rating scale from 2 to 5 rather than the full 1-5 rating. This prevents all of the cluster values from being bunched at the top of the graph and results in a more legible figure.
- The intersections of the cross lines with the vertical lines indicate the rating of that group.
- The cluster titles appear along the vertical lines and can be either evenly spaced or placed near the cluster it represents, depending upon readability.
- If there is agreement in ratings between subgroups, the cross lines will be horizontal.
- The "r" value indicates correlation between the two ratings. +1.0 indicates perfectly positive correlation (ratings are very similar to one another); -1.0 indicates perfectly negative correlation (ratings are very dissimilar); 0 indicates no correlation.

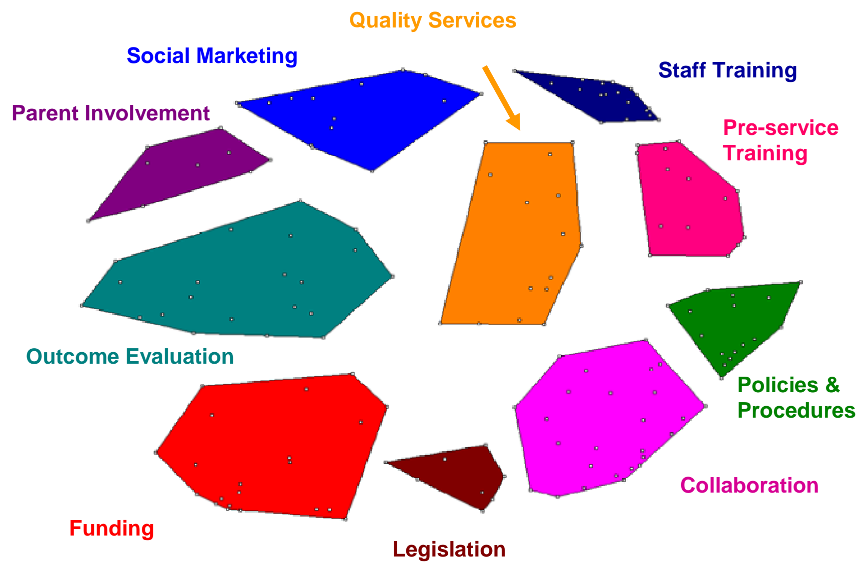
The Point Map and the Cluster Map: The summary of the sorting process by Groups 1 and 2 is presented below, first as a point map and then a cluster map. The point map, Figure 1, shows the arrangement of statements in terms of proximity to each other. Similar items are placed closer together.

Figure 1
Point Map



The cluster map in Figure 2 is derived from the point map by placing statistically determined boundaries around the points (statements) that go together. A ten-cluster solution is shown, as this number of clusters appeared to provide the best description of the data.

Figure 2
Cluster Map with a Ten-Cluster Solution



The four clusters around the top, on the outer rim of the map (i.e., Outcome Evaluation, Parent Involvement, Social Marketing, and Staff Training) refer to systems factors that are often associated with community level activities. The four clusters on the outer rim, at the bottom (i.e., Funding, Legislation, Collaboration, and Policies & Procedures) refer to state level activities. The central location of the Quality Services cluster suggests that this category may serve as the link, i.e., the bridging cluster, between the state level and community level activities. This category, by its placement in the center of the concept map, is considered to have strategic importance in the development and sustainability of systems of care. Described another way, Quality Services seems to represent the central focus of the efforts, with the activities of other clusters serving as supports.

Ratings of Clusters for Importance and Feasibility: It was considered important to have two groups in this study that represented different perspectives concerning the development and sustainability of systems of care across the state. Group 1 (n=12) was comprised of the community interagency team (MAP Team) where the COMPASS Project has been in operation for six and a half years as a system of care demonstration site. Group 2 (n=13) were members of the state level Interagency Coordinating Council for Children and Youth (ICCCY), which has provided guidance and oversight for the development and continuation of systems of care statewide. The two groups, with different perspectives, offered a unique opportunity to construct a more comprehensive plan for systems development.

After the groups sorted the statements into piles that "go together," they rated each statement in terms of importance and feasibility. They used a 5-point scale to rate each statement, with 5 being the highest rating and 1 being the lowest. The average importance or feasibility rating for

a statement is the statistical average of the score given to that statement by each rater. The average importance or feasibility rating for a cluster is the statistical average of the statements within the cluster. In other words, the clusters that contain more statements that have a higher average are the clusters that are rated as more important or feasible.

Tables 1 and 2 below show the ratings of the clusters, in descending order, indicating the highest to the lowest average rating. Table 1 reflects ratings for importance and Table 2, for feasibility. Each table reflects the ratings of Group 1 and 2 combined, and Group 1 (the community level group) and Group 2 (the state level group), separately.

Table 1
Cluster Rating for Importance

Groups 1 and 2 Together		*Group 1 (Community)*		*Group 2 (State)*	
Cluster	**Rating**	**Cluster**	**Rating**	**Cluster**	**Rating**
Legislation	4.04	Social Marketing	4.17	Legislation	4.08
Outcome Evaluation	4.03	Parent Involvement	4.11	Policies & Procedures	4.05
Parent Involvement	4.00	Outcome Evaluation	4.02	Outcome Evaluation	4.04
Policies & Procedures	3.99	Staff Training	4.00	Collaboration	4.02
Social Marketing	3.96	Legislation	4.00	Funding	3.99
Quality Services	3.95	Quality Services	3.96	Quality Services	3.96
Funding	3.95	Policies & Procedures	3.93	Parent Involvement	3.90
Collaboration	3.95	Funding	3.91	Pre-service Training	3.85
Staff Training	3.92	Collaboration	3.87	Staff Training	3.84
Pre-service Training	3.84	Pre-service Training	3.83	Social Marketing	3.75

Table 2
Cluster Rating for Feasibility

Groups 1 and 2 Together		*Group 1 (Community)*		*Group 2 (State)*	
Cluster	**Rating**	**Cluster**	**Rating**	**Cluster**	**Rating**
Parent Involvement	3.45	Parental Involvement	3.57	Social Marketing	3.40
Social Marketing	3.45	Social Marketing	3.51	Parental Involvement	3.34
Policy & Procedures	3.29	Policy & Procedures	3.36	Outcome Evaluation	3.25
Outcome Evaluation	3.26	Quality Services	3.30	Policies & Procedures	3.22
Quality Services	3.25	Outcome Evaluation	3.28	Quality Services	3.21
Staff Training	3.17	Staff Training	3.21	Staff Training	3.12
Legislation	3.15	Pre-service Training	3.20	Legislation	3.12
Pre-service Training	3.11	Legislation	3.18	Collaboration	3.07
Collaboration	3.11	Collaboration	3.15	Pre-service Training	3.03
Funding	2.88	Funding	2.94	Funding	2.83

Table 1 reveals that there is relatively little agreement between the two groups on the dimension of importance. The cluster rated as most important by Group 1 (Social Marketing) is rated as the least important by Group 2. Similarly, Group 1 has rated Parental Involvement quite high and Group 2 has rated it much lower. The areas of importance seem more related to the responsibilities of each group. What is important to the community group (Group 1) is not the same as what is important to the state group (Group 2). Note that these discrepancies are not presented as a negative reflection on the two groups; rather it seems appropriate that each group views what it does or needs to do somewhat differently in the process of developing and sustaining systems of care. It is not unexpected that Group 2 places priority on Legislation and

Policies and Procedures, as those are appropriate and relevant activities for the state level group. Similarly, Social Marketing, Parent Involvement, Outcome Evaluation, and Staff Training seem to be appropriate and relevant activities for the community level group.

The ratings of the clusters on the dimension of feasibility look quite different. Table 2 depicts far more agreement between the two groups on the dimension of feasibility, with the top five clusters being almost the same for both groups. And there is certainly agreement between the groups that an increase in funding is not feasible, that is, not expected to happen in the next few years. Rather, the areas that seem most feasible are 1) Parent Involvement; 2) Social Marketing, 3) Policies & Procedures, 4) Policies & Procedures, and 5) Outcome Evaluation. Both groups have worked on system of care issues for more than five years, and it appears that they have similar perceptions of what is possible, whether the actions are at the state or community level.

This same information concerning the agreement between the two groups can also be clearly presented using a method of the concept mapping data analysis called a consensus pattern match. Consensus pattern matches are represented by ladder graphs. This approach is used to analyze the ratings of subgroups, that is, the community level group and the state level group. The ladder graphs show the results of comparisons between participant responses on a single dimension, either importance or feasibility; they also depict correlations. Correlations (or correlation coefficients) range from -1.00 to +1.00, with the minus scores reflecting degrees of disagreement and the positive scores reflecting amounts of agreement. Figures 3 and 4 reflect the responses of Group 1 and Group 2 on the ratings of importance and feasibility by cluster. These figures reflect the same data as is presented above in Tables 1 and 2.

As shown in Figure 3, the correlation coefficient (r value) for the level of agreement on the importance dimension is negative, at-.40, indicating a 40% negative agreement between the two groups. Statistically, this is considered an extremely low amount of agreement. As noted above, this lack of agreement most likely indicates differences in the priorities of the two groups, based on their roles and responsibilities.

In Figure 4, the amount of correlation on the feasibility dimension is .95, indicating 95% agreement between the two groups. This is considered an extremely high level of agreement. In the discussion above, regarding Table 2, the interpretation of this amount of agreement is that these two groups have worked on system reform for many years and have a realistic and concurring view of what is possible in the near future and what is not. The essential question that the comparisons in Figures 3 and 4 addresses is “How much do the two groups agree or disagree about what is important and what is feasible?”

Figure 3
Cluster Ratings for Importance
Comparison of Group 1 and Group 2

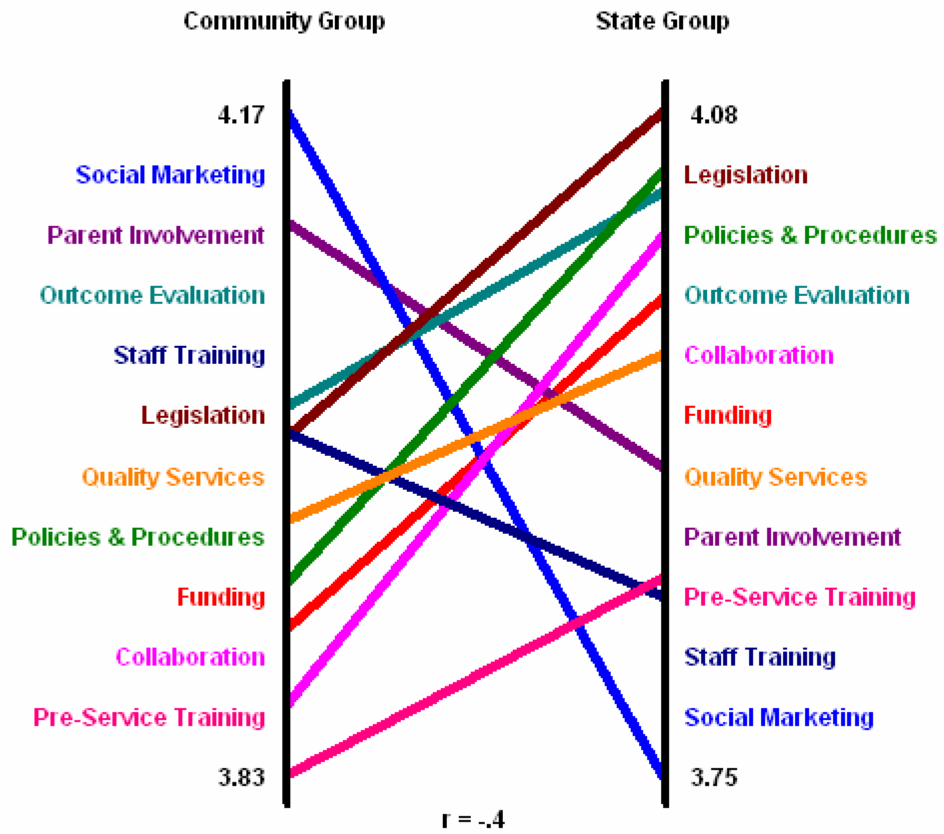
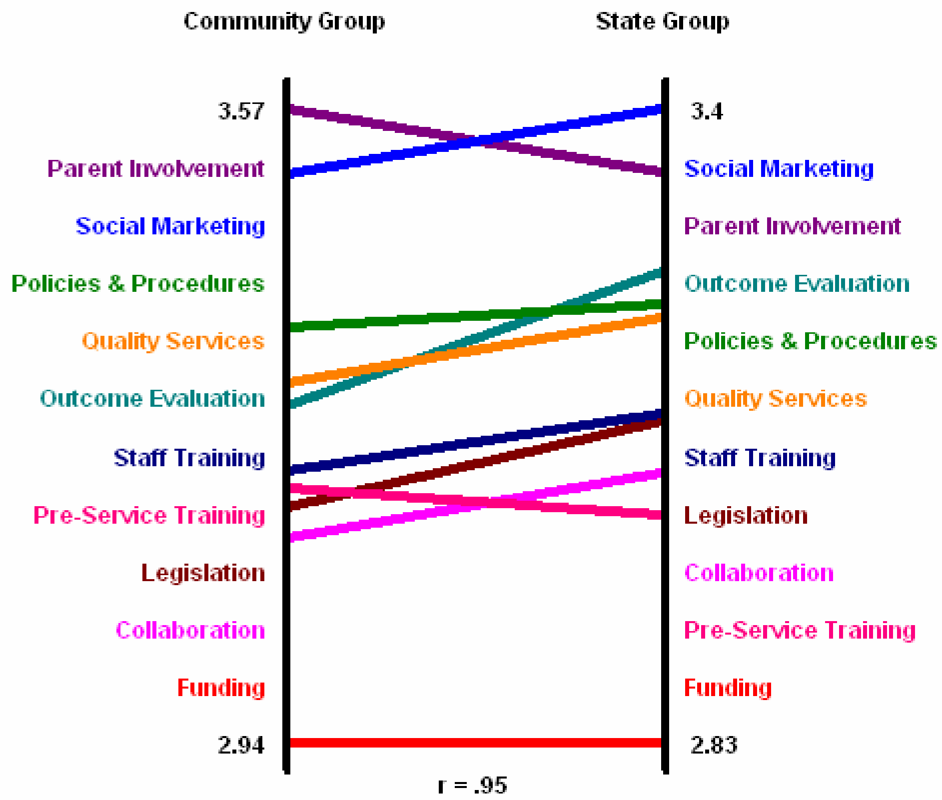


Figure 4
Cluster Ratings for Feasibility
Comparison of Group 1 and Group 2



In order to better understand the interactions of importance and feasibility, comparisons between these two dimensions were made by combining Groups 1 and 2 (Figure 5), and then looking at Group 1 alone (Figure 6) and Group 2 alone (Figure 7).

Figure 5
Comparison of Cluster Ratings for Importance and Feasibility
Group 1 and Group 2, Combined

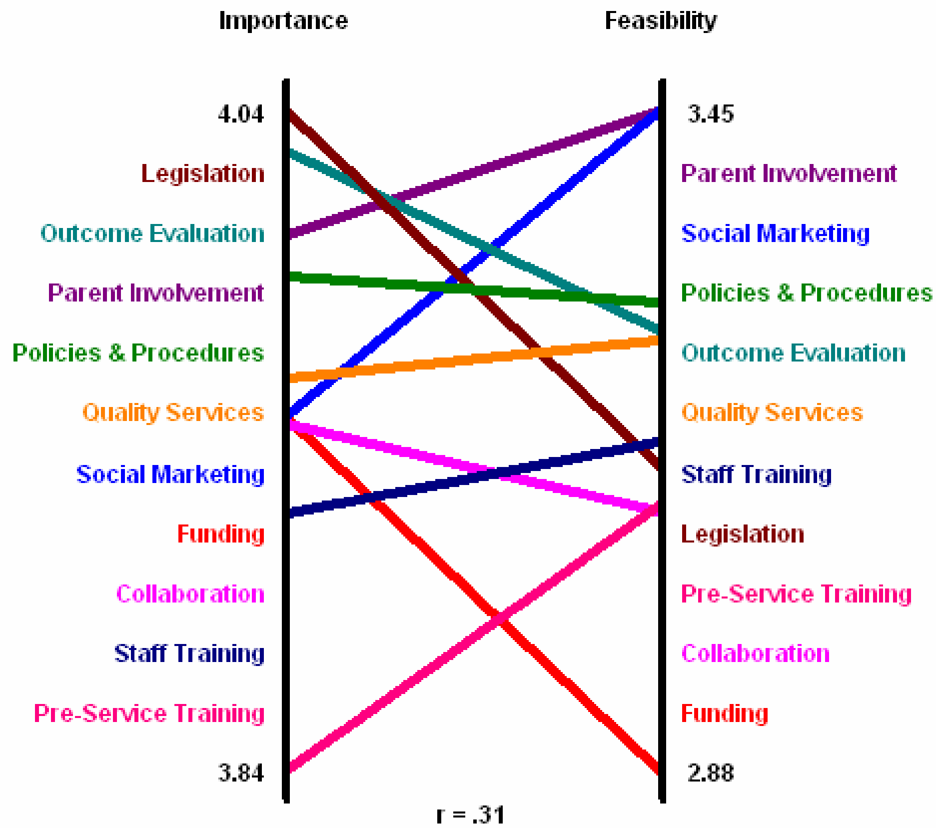


Figure 6
Comparison of Cluster Ratings for Importance and Feasibility
Group 1, Alone

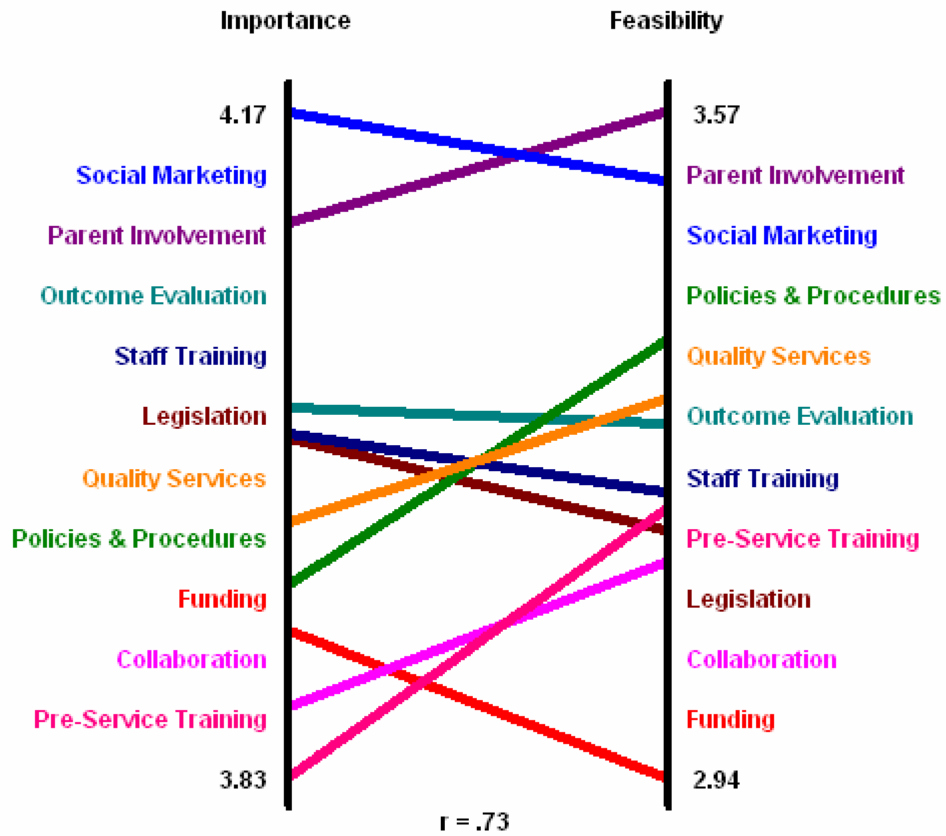
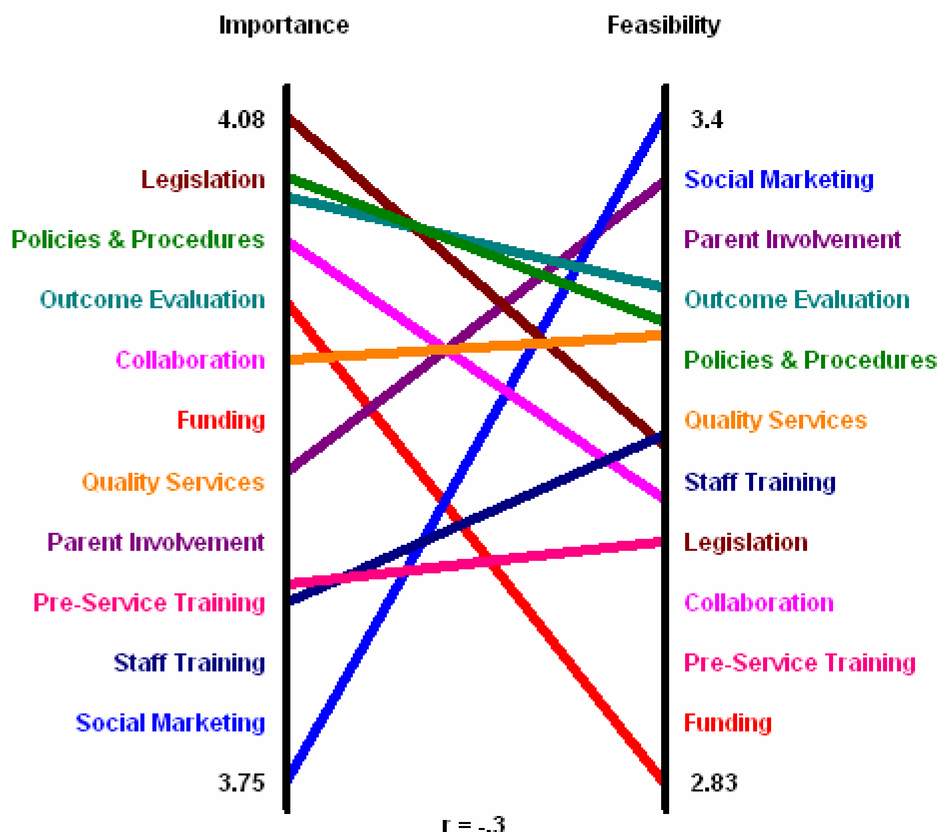


Figure 7
Comparison of Cluster Ratings for Importance and Feasibility
Group 2, Alone



The overall comparison on these two dimensions, by combining Groups 1 and 2, yields a correlation coefficient of .31. This correlation reflects a low level of agreement, indicating that there is little consistency between what is important and what is feasible. More insight into this discrepancy is gained by viewing the ratings between importance and feasibility for Group 1 and Group 2, separately. Group 1 showed a reasonably high level of agreement (r =.73 or 73%) on what is important and what is feasible. Group 2, however, had a correlation (r= -.30 or -30%) which reflects a moderate level of disagreement between what they consider to be important and what they view as feasible. One interpretation of this interaction might be that Group 2 is in a position of knowing that what they consider important will not happen, under current state level realities. Group 1 is more optimistic with 73% agreement between importance and feasibility. Another interpretation might be that important actions are more possible or occur more quickly at the community level, where the priorities are Social Marketing, Parent Involvement, and Outcome Evaluation, and Staff Training. At the state level, the issues of Funding, Legislation, and Policies & Procedures are the priorities and they are considered less likely to occur, under current circumstances. These policy actions may occur more slowly than the implementation actions. As planning for the future continues, it is important to understand that there are differences between how people at the state level and those at the community level view the next steps. Understanding these distinctions is important, as systems change will need to address the responsibilities at both levels for maximum benefit.

Ratings of Statements
As described above, the 163 statements generated in the brainstorming session were rated on a 5-point scale for importance and feasibility. The most highly rated importance statements reflect the priorities for action, that is, what are the most important next steps. However, if the concept of feasibility is brought into the picture, the priorities for action are changed, as they are tempered by what is possible. The areas that would be most fruitful to pursue are those judged both important and feasible.

The seven most highly rated statements for importance and feasibility, by both groups together, are presented in Table 3. The seven most highly rated statements for importance and feasibility, by Group 1 alone, are presented in Table 4. The seven most highly rated statements for importance and feasibility, by Group 2 alone, are listed in Table 5. The statement identification numbers in Tables 3, 4 and 5 are from the listing of the 163 specific statements that were brainstormed by participants. The order reflects the order in which they were introduced by the groups. See Appendix A for the full list of statements. The ratings are in the columns to the right. Note that for all except statement #157 in Table 5, all of the importance ratings are higher than the feasibility ratings, indicating that feasibility is the dimension that is seen to compromise actions.

Table 3
Top Seven Statements Rated for Importance and Feasibility
Groups 1 and 2, Combined

#	*Statement*	*Importance Rating*	*Feasibility Rating*	*Cluster*
2	Develop more or better communication/publicity	4.20	3.88	Social Marketing
5	Teach parents to communicate concerns to educators as early as possible	4.29	3.76	Parent Involvement
7	For families new to SOC, identify all interested agencies & providers	4.28	3.76	Parent Involvement
9	Provide clear explanation to family & child of diagnosis, medication & side effects; clarify whose responsibility is it to make sure the family receives the information	4.33	4.08	Parent Involvement
11	Educate educators on mental health issues for children	4.28	3.76	Staff Training
13	Identify target populations for services	4.20	4.16	Policies and Procedures
16	Develop stronger partnerships between agencies that are part of the SOC	4.38	3.64	Collaboration

Table 4
Top Seven Items Rated for Importance and Feasibility
Group 1, Alone

#	*Statement*	*Importance Rating*	*Feasibility Rating*	*Cluster*
2	Develop more or better communication/publicity	4.20	3.88	Social Marketing
5	Teach parents to communicate concerns to educators as early as possible	4.29	3.76	Parent Involvement
6	Be informative in educating the community about types of care	4.12	3.68	Social Marketing
9	Provide clear explanation to family & child of diagnosis, medication & side effects; clarify whose responsibility is it to make sure the family receives the information	4.33	4.08	Parent Involvement
13	Identify target populations for services	4.20	4.16	Policies & Procedures
41	Have a MAP Team in each county, even if funding is not immediately available	4.12	3.08	Legislation
80	Make educational materials more kid and family friendly so they can learn about their own issues or those of other kids in the class or community	4.00	3.56	Social Marketing

Table 5
Top Seven Items Rated for Importance and Feasibility
Group 2, Alone

#	*Statement*	*Importance Rating*	*Feasibility Rating*	*Cluster*
7	For families new to SOC, identify all interested agencies & providers	4.28	3.26	Parent Involvement
31	Have clear objectives; what are we going to do and how are we going to do it	4.16	3.48	Quality Services
33	Clarify expectations; what the family expects from SOC and we expect from the family	4.25	3.52	Parent Involvement
98	Develop written agreement at local and state levels to carry out best practices associated with system of care	4.16	3.28	Collaboration
102	Involve families and consumers in the design/operation of the system of care	4.12	3.56	Outcome Evaluation
128	Deter institutional placements as opposed to community services	4.16	3.44	Quality Services
157	Develop a mission statement for the overall system of care	4.08	4.16	Policies & Procedures

The tables above provide interesting information, first by showing the overall best action steps, i.e., those that are scored highest on importance and feasibility, by the combined groups (Table

3). However, Tables 4 and 5, which reflect the ratings by the two groups separately, give a better picture of what to do next, that is, what to do that is important and likely to be successful (important and feasible). Although there is no overlap between the two groups in the seven most highly rated importance and feasibility statements; and no statements from one group appear in the list by the other group, the focus on families, although through slightly different statements, is the unifying factor between Group 1 and Group 2. The case for separate action steps at the state and local level is strong, with each group having a different set of tasks to perform to work toward the common goal of developing and sustaining systems of care.

CONCLUSIONS

The mapping process has produced a substantial amount of information that should be useful as the State of Mississippi moves forward to develop and sustain systems of care across the state. The information was obtained through a systematic process involving multiple stakeholders from two levels, the community level and the state level. These stakeholders were experienced in the development and sustainability of systems of care, having addressed these tasks for over five years. The process, designed by Concept Systems, Inc., used standardized methods of data collection and sophisticated statistical analyses. Thus, the information can be considered well founded, credible and relevant, and can provide the guidance to build upon current systems to develop and further translate system of care philosophy into a grounded implementation plan.

The findings can be translated directly into specific objectives to be incorporated into an action plan and subsequently implemented. A summary of the findings includes:

- The clusters that were established by the two groups are consistent, as priority areas, with accepted areas of focus for systems development. They are consistent with Friedman's (2003) essential elements of system of care. The clusters are:
  Legislation
  Outcome Evaluation
  Parent Involvement
  Policies & Procedures
  Social Marketing
  Quality Services
  Funding
  Collaboration
  Staff Training
  Pre-service Training
- When the two groups rate the importance of activities listed in the clusters, there is discrepancy between the groups. The community level group (Group 1) has rated Public Relations and Outcome Measures as most important and the state level group (Group 2) has rated Legislative Focus and Policy & Procedures as most important. These differences in ratings imply that the two groups place different importance on next steps; and this most likely is related to their different roles in the process.
- When the two groups rate the feasibility of the activities listed in the clusters, there is remarkable agreement between the groups. This similarity most likely is related to their understanding of what is possible under current circumstances.
- When importance and feasibility are compared, that is "Is what is important also possible?" the community level group (Group 1) is more optimistic than the state level group (Group 2).

- Within the clusters, the ratings of statements (ideas about next steps) differ between the two groups. The community level group has different priorities about the importance of issues compared to the state level group. There are also differences in how the two groups rate the feasibility of these ideas.
- The seven most important and feasible next steps rated by both groups combined are:

  Develop more or better communication/publicity
  Teach parents to communicate concerns to educators as early as possible
  For families new to SOC, identify all interested agencies & providers
  Provide clear explanation to family & child of diagnosis, medication & side effects; clarify whose responsibility is it to make sure the family receives the information
  Educate educators on mental health issues for children
  Identify target populations for services
  Develop stronger partnerships between agencies that are part of the SOC
- The seven most important and feasible next steps rated by the community level group (Group 1) translate into action steps for a community to implement a system of care. To review, those steps are:

  Develop more or better communication/publicity
  Teach parents to communicate concerns to educators as early as possible
  Be informative in educating the community about types of care
  Provide clear explanation to family & child of diagnosis, medication & side effects; clarify whose responsibility is it to make sure the family receives the information
  Identify target populations for services
  Have a MAP Team in each county, even if funding is not immediately available
  Make educational materials more kid and family friendly so they can learn about their own issues or those of other kids in the class or community
- The seven most important statements rated by the state level stakeholders (Group 2) translate into action steps for the state level council to implement a system of care. To review, those steps are:

  For families new to SOC, identify all interested agencies & providers
  Have clear objectives; what are we going to do and how are we going to do it
  Clarify expectations; what the family expects from SOC and we expect from the family
  Develop written agreement at local and state levels to carry out best practices associated with system of care
  Involve families and consumers in the design/operation of the system of care
  Deter institutional placements as opposed to community services
  Develop a mission statement for the overall system of care

- The unifying factor in planning for next steps is the focus on the family, which cuts across the ratings by both groups.

These findings define a clear picture of how the stakeholders view the next steps to develop and sustain systems of care statewide. Most interesting is the difference between the community level group and the state level group. Each perceives different actions as important and as

feasible, demonstrating that the roles and functions of these two groups are different and call for different action steps.

The study has some possible limitations, particularly the fact that Group 1 did their sorting and rating by mail, while Group 2 did these tasks in a face-to-face group situation. There was greater attrition in Group 1 between the brainstorming session and the rating session and there was also a greater time lapse. Group 2 did their ratings the next day, but the lapse in time for Group 1 was several months. This lapse occurred because Group 1 waited until Group 2 could meet and add to the brainstorming. Both groups did their brainstorming in face-to-face group settings.
It is not apparent what difference these different approaches might make, but it is necessary to point out the difference.

Concept mapping has been used in this setting to identify factors that play a role in formulating a plan for systems of care development and sustainability for Mississippi. It may be anticipated that concept mapping may provide a framework to evaluate progress in implementing systems of care. Follow-up interviews, using s structured interview protocol, could be conducted with the participants and other stakeholders to determine if the steps outlined through the concept mapping process have been implemented. The results from these follow-up interviews can be compared to the current ratings of importance and feasibility, and the concept mapping process can thus serve as an organizing mechanism both for planning and assessment of progress.

In addition to the potential uses for the findings in the State of Mississippi, it is likely that other states and system of care communities could benefit from understanding these issues as they apply to their own settings. The findings are based on at least five years of experience and work at the state and the community levels to establish and sustain a system of care and to expand the concept statewide. Although each state and system of care community is unique, there are cross-cutting themes that apply to all settings engaged in system reform. Of particular interest are the considerations for next steps, in terms of combined importance and feasibility and the distinctions between these as they apply to state and local efforts. The findings in Mississippi clearly indicate that the state and local level efforts might be focused differently, but should be taken in the context of their stage of development, as well as their current circumstances.

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APPENDIX A

Participants' Statements

1. Identify cross-agency financial resources to fund the SOC
2. Develop more or better communication/publicity
3. Extend SOC to other schools and increase providers
4. Increase knowledge base and marketing to the community
5. Teach parents to communicate concerns to educators as early as possible
6. Be informative in educating the community about types of care
7. For families new to SOC, identify all interested agencies & providers
8. Increase systematic focus, collaboration among agencies & providers
9. Provide clear explanation to family & child of diagnosis, medication & side effects; clarify whose responsibility is it to make sure the family receives the information
10. Identify critical performance outcomes after getting feedback from key leaders in the community
11. Educate educators on mental health issues for children
12. Increase the involvement of inpatient facilities and long-term care facilities in the SOC
13. Identify target populations for services
14. Develop a communications network between all resources
15. Find ways to require parent participation without putting services to the child at risk
16. Develop stronger partnerships between agencies that are part of the SOC
17. Improve the way the SOC works with different cultures in order to enhance the overall SOC
18. Adopt principles and practices at a state-level that support SOC; standards that make people do it
19. Fund local MAP teams in each community
20. Provide an ongoing overview so that everybody has the same information about SOC
21. Do periodic orientation to SOC for old and new participants/agencies
22. Mentor new personnel that come into the SOC so that they learn about the resources and principles
23. Build a system for the long haul and make available resources even after current resources may not be available
24. Provide transportation to and from services for the families
25. Clarify and delineate roles
26. Develop a family -friendly checklist for agencies to be sure they are family friendly
27. Increase community awareness of SOC success stories
28. Make sure that services for the child and family are received; holding the agency accountable for making sure
29. Bring in all the partners for SOC, agencies that are part of the children's lives, formal and informal resources; keep it broad
30. Lobby for local government to adopt and support the system of care
31. Have clear objectives; what are we going to do and how are we going to do it
32. Do ongoing review and clarification of goals and objectives for SOC
33. Clarify expectations; what the family expects from SOC and we expect from the family
34. Develop a core set of paperwork to allow services to be more efficient for the families
35. Develop comprehensive training curriculum to take statewide
36. Highlight realism at the same rate as strength-based teaching principles
37. Have an ongoing strength assessment/evaluation to know where we are and to build on the strengths
38. Do cross-training of agencies so one agency is aware of the services another one may offer;

how to connect them

39. Develop procedures for maintenance and planning purposes
40. Continue to identify gaps in services and how to fill those gaps financially
41. Have a MAP Team in each county, even if funding is not immediately available
42. Make sure there is no limit of services that are provided for children and families in the SOC
43. Increase the availability of respite providers and mentors in rural areas
44. Start a SOC resource committee to update the resource manuals to keep everybody abreast of what's available
45. Communicate relevant data on outcomes and other findings
46. Promote accountability for all types of services, so that service providers are accountable
47. Provide more in-home supports and counseling
48. Put core documents on a website so that everyone can access them
49. Make sure that the community sees the multi-cultural approach of SOC, that it's for the whole community
50. Make sure there is multi-cultural sensitivity training for SOC participants
51. Have a SOC database so that SOC providers can access it and know where services are available, what forms to use
52. Recognize and show appreciation to everybody involved
53. Maintain local consortium to evaluate service outcomes
54. Have a mechanism to pay for respite and other family support services, so that they can go statewide—e.g., Medicaid waiver
55. Bring more businesses into the SOC to help kids get jobs; inform the businesses about the abilities of the kids so that they can be transitioned
56. Review and possibly reallocate funds based on need
57. Promote cultural competency in provision of services, e.g., correctly using people from the community to provide services
58. Develop and fund training so that staff could move from billable activities to training without the agency losing funds
59. Have more hospitals and doctors who are trained to work with children who have severe emotional problems and trained to work within the SOC
60. Establish a culturally specific parent peer mentoring programs, for trained people (other parents) to be paired with parents, to deliver services in the home
61. Change the after-hours care to go beyond 5:00 p.m. and include weekends and holidays
62. Identify/train more certified teachers to work with children with EMD; look at pay issues and other incentives
63. Develop a support team within the communities for families that provide respite
64. Pursue private funding sources to support some of the programs/needs within SOC
65. Support, promote, and expand voluntary mental health screening for students
66. Use non-threatening, comprehensible language
67. Expand SOC to more schools
68. Designate a cultural competency and training coordinator to monitor SOC development and implementation
69. Have a full-time staff devoted to SOC development and training—a coordinator and staff
70. Implement non-traditional methods that improve the SOC
71. Identify funding mechanisms so that kids can get needed services—so that child and needed services are covered
72. Train more administrators, school social workers, teachers, and support staff in SOC
73. Develop, as examples, music/art programs ,as creative interventions with funding avenues

to support these interventions, as needed

74. Train those in the community, as well as the churches, to bring back the concept of the village
75. Provide training in mental health issues about children and families in the college curricula/ internships for teachers and administrators
76. Develop new partnerships and collaborate with the Department of Education and institutions of higher learning to create programs to improve teacher education
77. Hire SOC directors at the local level
78. Provide behavior management training for all levels of educators and support staff—whole school system
79. Educate and inform the different parts of the community about mental health issues to decrease the stigma
80. Make educational materials more kid and family friendly so they can learn about their own issues or those of other kids in the class or community
81. Increase the awareness level of youth court judges and workers on SOC principles
82. Create continuity of values and principles and delivery of services when staff change
83. Find ways to motivate/help parents to get kids to services and actively participate in services
84. Hire a grant-writer and/or lobbyist to support SOC
85. Continue national evaluation to monitor child and family outcomes at a local level
86. Focus on kids and families involved with juvenile justice system and adult prisons
87. Use various media to inform families and communities about SOC services
88. Increase focus and funding for dual diagnosis, alcohol/drugs and mental health problems
89. Partner with faith-based and social organizations and businesses to provide services, facilities
90. Encourage school systems to include children in extra-curricular activities, all children—those with severe emotional disturbances, other kids too
91. Include faith-based leadership at the table for SOC planning and development
92. Consider translators and do translation of materials
93. Identify recreational opportunities for families that have no cost associated with them
94. Have a transition person to help children and families as they exit the SOC into the real world, to find a support system, as needed
95. Make sure major ethnic groups participate in SOC
96. Provide education and support to all stakeholders in the transition of youth in their successfulness and to make sure there is a safety net for them
97. Bring all professional organizations (those that have agreement to work together) together in the system of care
98. Develop written agreement at local and state levels to carry out best practices associated with system of care
99. Develop a way to make families and providers aware of services already available
100. Develop a comprehensive training program to be used by each organization to train those who will implement the program
101. Create a flow chart of services available to be combined with a resource manual
102. Involve families and consumers in the design/operation of the system of care
103. Bring key decision makers to the table (e.g. chairs of legislative committees, state officials)
104. Blend services better (e.g. take services from Education and MH and coordinate them) to meet the needs of children and families
105. Encourage the departments/divisions at state and local levels, not at the table, to come to the table

106. Provide training for parents of children with multi disabilities (e.g. children who are deaf and parents need sign language training) so they can better care for their children
107. Develop an infrastructure based on caring about the children and families that produces services and supports available, accessible, and accountable across the state
108. Assure single entry points locally or regionally for strengths based screening, assessment and referral
109. Create an approval process for nontraditional services
110. Identify gaps in services and create services to fill the gaps
111. Create a uniform intake process, (eg. forms, assessments, histories, etc.) to be used across the board to avoid duplication of paperwork
112. Create an interagency agreement process that avoids duplication and allows for sharing of information
113. Create a process for systematic and regular information dissemination and training on dual diagnosis guided by well developed policies and procedures agreed to by all
114. Educate providers/agencies on the holistic approach to service provision, and not just looking at kids/families as segments, but as a "whole" kids/family
115. Have some type of comprehensive tool/ assessment that would link to a comprehensive plan of care
116. Implement an intake process for all kids entering any system, which includes a risk/needs screening to identify areas for further evaluation
117. Develop a "one stop shopping" process for providers to access needed information by interfacing electronic systems and more freely sharing information
118. Identify legislators and public interest groups sensitive to our cause and to make them champions of the cause
119. Investigate state and federal regulations and legislation that allows for and addresses road blocks and avenues for system of care activities, collaboration and parent involvement
120. Expand the stakeholders that we traditionally think of as part of a system of care, in terms of who we bring to the table as partners (e.g., youth groups, community p
121. Increase staff and funding across all agencies
122. Develop a common set of policies, procedures, processes and plans to address finances, data information management, workforce development, identification/assessment, and service delivery
123. Make it a priority and advocate for the development of preventive services with an emphasis on high risk pregnancies follow through the pregnancy thru 1st year of life
124. Develop an interagency agreement and plan for funding the system of care (e.g. dues, contributions) and include non-governmental organizations and some mechanism for them to contribute
125. Improve communication between partners in the system of care
126. Figure out a way to walk the walk (open meetings, funding, stipends) with real, viable consumer involvement from consumers from all walks of life
127. Require research based practices that are proactive and preventive
128. Deter institutional placements as opposed to community services
129. Include all requirements of all agencies, both governmental and non-governmental, in legislation
130. Obtain community buy-in to maintain children in their homes/communities
131. Hire those at the grassroots level, staff who are committed to children with complex needs
132. Develop staff at both state and local levels, to work across agencies to coordinate services
133. Create a separate system of care entity
134. Follow through and focus on existing agreements, plans and legislative charges

135. Require that major state child and family agencies share their budgets, with whom they are contracting, how much they are paying them, and for what they are contracting
136. Reframe what current staff is doing, as needed.
137. Ensure that state, federal and local dollars are identified and that they are drawn down and maximized for high risk children and families
138. Emphasize the credentialing, training and monitoring of individuals who do the screenings and the actual screenings they do
139. Provide training on recognizing and respecting values of others
140. Persuade the MS Department of Education to use a portion of its Educable Child Funds and other IDEA funds for MAP team flex funds
141. Create a communication notebook for families to take to doctor's appointments, other intakes, etc.
142. Facilitate non-profit agencies that provide system of care services getting together
143. Require follow up to measure the effectiveness of our services provided to the families
144. Develop methods to identify recidivism when families return for the same services and use the data to avoid repetition of services that didn't work
145. Improve tracking of the children as they enter the system and follow them
146. Define a refined system of respite for families of SED children or at risk
147. Have a public relations type focus to get the message out, through the media, and cultivate relationships with newspapers and TV
148. Train system providers to be more culturally, socially, and community competent to the needs of families
149. Implement training/workforce development as an ongoing interrelated process rather than a variety of random disconnected events
150. Make sure that people actually know what a wrap plan is and how to make the plan with the family before more money is invested
151. Involve discipline-specific professional organizations (eg. NASW, psychology, etc.) in the development and training for system of care
152. Ensure the professionalization of leadership positions in child serving agencies
153. Re-introduce people on the direct service level to the system of care concept through training, coaching, and supervision
154. Work with community colleges on developing associate degree programs for non-traditional service providers (e.g., respite provider)
155. Improve transition processes across settings (school, institutions, more restrictive to less restrictive settings)
156. Provide services to improve transition from childhood to adulthood
157. Develop a mission statement for the overall system of care
158. Develop a training program for law enforcement to better understand the child and access the system of care
159. Avoid funding that will divert you from your mission and vision to develop system of care statewide
160. Commit dollars and staff for data collection and analysis of outcomes
161. Present the findings and the local system of care concept mapping to the ICCCY
162. Build in opportunities for people to network together
163. Develop regular systematic communication/ social marketing process between local and state levels