System of Care Assessment

2022 Children's Behavioral Health SOC Assessment

Behavioral Health Improvement Institute
Keene State College

On behalf of the Children's Behavioral Health Resource Center

October 2023

Behavioral Health Improvement Institute | Keene State College

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Contributors

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Center for Life Management, Community Partners, Greater Nashua Mental Health Center, Lakes Regional Mental Health, Mental Health Center of Greater Manchester, Monadnock Family Services, Northern Human Services, Riverbend Community Mental Health, Seacoast Mental Health Center, West Central Behavioral Health

Care Management Entities

Connected Families New Hampshire, NFI North

Intensive Service Option/Home-Based Providers

Easter Seals, Home Base, Independent Services Network, Northeast Family Services, Waypoint

Residential Treatment Providers

Chase Home, Dover Children's Home, Orion House, Pine Haven Boys Center, Spaulding, Webster House

Substance Use Disorder Providers

Live Free Recovery

Subcontractor

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Executive Summary

Assessing the EBPs in NH's children's System of Care

The Children's Behavioral Health Resource Center (CBHRC) is contracted by DHHS to assess, support, and improve the children's behavioral health continuum of care, including expanding the uptake and quality of EBPs. The CBHRC conducts an annual System of Care (SOC) assessment to evaluate the status of EBPs delivered through NH's public mental health system. In this second SOC assessment, CBHRC evaluated the delivery of five EBPs by NH's Care Management Entities, Community Mental Health Centers (CMHC), Residential Treatment Centers (RTCs), and Substance Use Disorder (SUD) providers during calendar year 2022.

Statewide themes

Adherence to SOC values is strong throughout the system. On the other hand, when the unbillable aspects of these practices are not accounted for the reach and quality of services suffer; small agencies in rural areas are hard pressed to support the full complement of EBPs; and data infrastructure is weak, limiting our ability to learn and improve. We need to further address these problems to build a fully functioning SOC.

Evidence-Based and Promising Practices Assessed

Child Parent Psychotherapy
Seven Challenges
Transitional Enhanced Care Coordination
Trauma-Focused Cognitive Behavioral Therapy
Trust-Based Relational Intervention

Practice-specific themes

Child Parent Psychotherapy (CPP) is the gold standard treatment for young children affected by Adverse Childhood experiences. CPP has an excellent foundation in NH and recent federal and state investments should allow for increased access to high-quality CPP in the coming years. **Seven Challenges** is a flexible, youth-driven model for helping adolescents explore and change their relationship with substances but demand for this practice is currently negligible, at least in CMHCs. Further exploration of the utility of Seven Challenges among SUD providers is warranted. **Transitional Enhanced Care Coordination** (TrECC) is a NH-developed model for helping youth transition in and out of residential treatment. TrECC does not yet have a substantial evidence-base but fills a critical gap in the service array. NH's two Care Management Entities are dedicated to further developing, evaluating, and improving this model going forward. **Trauma-Focused Cognitive Behavioral Therapy** (TFCBT) is the gold standard trauma treatment for youth and adolescents – but other trauma-treatment options for this population also exist. A decision about whether a more concerted effort to support this practice is needed. **Trust-Based Relational Intervention** (TBRI) is a milieu-type therapeutic approach that is being implemented in Residential Treatment Centers. TBRI lacks a substantial evidence-base but fills a critical niche and appears to be an ideal fit for NH residential treatment settings. We recommend further expansion of TBRI – and SOC Values – throughout the residential treatment and related systems.

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SOC assessment context

The Children's Behavioral Health Resource Center

The New Hampshire (NH) Department of Health and Human Services (DHHS) established the Children's Behavioral Health Resource Center (CBHRC) in October 2021 to provide data- and training-related technical assistance to promote a high-quality children's behavioral health continuum of care. The CBHRC contract was awarded to the Institute on Disability (IOD; JoAnne Malloy and Kelly Nye-Lengerman, co-Directors) at the University of New Hampshire (UNH), in partnership with Dartmouth and the NH chapter of the National Alliance for Mental Illness (training and technical assistance in First Episode Psychosis), the Institute for Health Policy and Practice (IHPP) at UNH (website development), and the Behavioral Health Improvement Institute (BHII) at Keene State College (data-related technical assistance).

October 2021
NH Children's Behavioral Health Resource Center established

NH children's System of Care

In May 2016, the passage of Senate Bill 534 committed the State of New Hampshire to develop a comprehensive SOC for children's behavioral health services. A SOC is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and is responsive to their cultural and linguistic needs to support well-being and functioning at home, school, community, and throughout life. NH's children's SOC guiding principles:

- **Effective, evidence-informed service**
- **Individualized Wraparound service planning and service delivery**
- **Least restrictive environments**
- **Youth and families as full partners**
- **Integrated care**
- **Care management for service coordination**
- **Developmentally appropriate services**
- **Prevention, early identification, and intervention**
- **Promoting advocacy and quality**
- **Non-discrimination**

These principles are enacted through NH SOC's common value framework:

Family and Youth Driven: Family and Youth voice and choice are at the core of the work. Their strengths and needs determine the types and mix of services and supports provided. Youth and families take a leadership role in their own service team as well as at policy, planning and system levels.

Community Based: services are provided in the least restrictive settings possible, with the youth and family remaining within a supportive environment of structures, processes, and relationships in their home community.

Culturally and Linguistically Competent: Services and service delivery that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve. Full understanding of a family's values and culture is required to develop a trusting partnership and supportive relationship with families.

Trauma Informed: The SOC fosters attuned, caring and supportive relationships that acknowledge the adverse environments that many distressed youth and families have experienced, and that place them at risk for emotional, behavioral, and other health challenges throughout life. Services are delivered in a manner that embodies trauma-informed principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

NH SOC assessment

The CBHRC's system assessment evaluates the reach, adoption, quality, effectiveness, and systems characteristics of key evidence-based and promising behavioral health practices delivered to children and their families through the public mental health system in NH. As such, it serves as a NH children's behavioral health needs assessment, identifying strengths, needs, and gaps in the service array that can be leveraged and addressed through CBHRC technical assistance. Approximately one-third of the key behavioral health practices will be assessed annually, on a rotating basis, thus providing a comprehensive picture over time.

Practices and sites

Practices

Five children's behavioral health practices were selected for the second SOC assessment due to their import for the overall service array. Child-Parent Psychotherapy (CPP) is an attachment-based, trauma-informed clinical model for very young children and their caregiver(s). Seven Challenges (7C) is an outpatient substance-misuse intervention. Transitional Enhanced Care Coordination (TrECC) is a care management process for youth transitioning into and out of residential treatment settings. Trauma-focused Cognitive Behavioral Therapy (TFCBT) is a clinical model for youth and adolescents with trauma-based symptoms. Trust-Based Relational Intervention (TBRI) is a milieu treatment appropriate for residential and other congregate care settings.

Practice descriptions

Practice	Population	Description	Key Components
CPP[1]	Children aged 0-5 who have experienced trauma and their caregivers	A long-term (~1 year) dyadic treatment that examines how trauma and caregiver history affect the caregiver-child relationship and the child's development. Supports and strengthens the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship	Focuses on the parent-child relationship as the primary target of intervention. Targets caregivers' and children' maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulation
7C[2]	Adolescents and young adults aged 13-25 with substance misuse, co-occurring mental health issues, trauma, and family issues	The Seven Challenges® program is designed to motivate a decision and commitment to change and to support success in implementing the desired changes to address substance misuse. The program simultaneously aims to help young people address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems. The challenges provide a framework for helping youth think through their own decisions about their lives and their use of alcohol and other drugs. Counselors use the program to teach youth to identify and work on the issues most relevant to them. 7C makes extensive use of journaling.	As the youth discusses what matters most to them, the counselor integrates the seven challenges: 1) We decided to open up and talk honestly about ourselves and about alcohol and other drugs (AOD); 2) We looked at what we liked about AOD, and why we were using them; 3) We looked at our use of AOD to see if it has/could cause harm; 4) We looked at our responsibility and the responsibility of others for our problems; 5) We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish; 6) We made thoughtful decisions about our lives and about our use of AOD; 7) We followed through on our decisions about our lives and AOD;. If we saw problems, we went back to earlier challenges and mastered them.

Practice	Population	Description	Key Components
TrECC	Children and youth ages 6-21 experiencing psychiatric crisis episodes that require inpatient or residential care and their families	TrECC is a time-limited care coordination model to facilitate transitions into and out of inpatient or RTCs into the community. TrECC case management activities include structured and standardized youth and family-centered assessment, case management, and planning	The model builds upon wraparound principles and focuses on 1) monitoring to ensure that the right types and levels of care are provided during and following crisis episodes, and 2) planning so that transitions out of care are seamless and coordinated with an appropriate mix of supports to ensure stabilization and promote positive development and recovery
TFCBT[3]	Children 3-18 with a known trauma history who are experiencing significant posttraumatic stress disorder (PTSD) symptoms and/or depression, anxiety, and/or shame related to their traumatic exposure	TF-CBT is a conjoint child and parent therapy model for children experiencing significant emotional and behavioral difficulties related to traumatic life events. It incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles to improve child functioning and wellbeing, reduce child/youth PTSD and other mental health symptoms, and enhance parenting skills and the parent-child relationship	The essential components of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) include Psychoeducation and parenting skills; Relaxation techniques, Affective expression and regulation, Cognitive coping, Trauma narrative and processing, In vivo exposure, Conjoint parent/child sessions, Enhancing personal safety and future growth. Gradual exposure is included in all components to help children gain mastery in how to use skills when trauma reminders or cues occur
TBRI[4,5,6,7]	Youth with complex developmental trauma, especially those who have experienced foster care or institutionalization of all ages and risk levels	A milieu model consisting of three core principles (Empowerment, Connection, and Correction) to provide effective support and treatment for at-risk children through parent-caregiver trainings and milieu-based intervention in institutional settings	TBRI Empowering principles address environment and physical needs, setting the stage for the Connecting and Correcting principles. The Connecting principles address relational and attachment needs. The Correcting principles teach self-regulation and maintaining appropriate boundaries and behavior

Sites

These practices are implemented through NH's public mental health system, consisting of Community Mental Health Centers (CMHCs), Care Management Entities (CME's), Intensive Service Option/Home-Based Therapy (ISO/HBT) providers, Residential Treatment Centers (RTC), and Substance Use Disorder (SUD) providers. NH's 10 CMHCs provide a comprehensive set of ongoing and emergency community-based behavioral health services. NH's two CMEs provide intensive care coordination youth who are either in, or at high risk of, out-of-home treatment placements. ISO/HBT providers tailor high intensity, multi-faceted services to create a safe, stable, and positive home environment for children and their families who are referred through the courts or DCYF. RTCs are live-in health care facilities of varying levels that provide multi-faceted treatment for substance use disorders, mental illness, or other behavioral problems. Three agencies declined to participate.

Practices by site

See the table below for a break-down of practices offered by site during calendar year 2021.

Type	Site	Practice				
		CPP	7C	TrECC	TFCBT	TBRI
CME	Connected Families New Hampshire (CFNH)			x		
	NFI North			x		
CMHC	Center for Life Management (CLM)				X	
	Community Partners (CP)	X			X	
	Greater Nashua Mental Health Center (GNMHC)	X	X		X	
	Lakes Region Mental Health Center (LRMHC)	X	X		X	
	Mental Health Center of Greater Manchester (MHCGM)	X	X		X	
	Monadnock Family Services (MFS)	X			X	
	Northern Human Services (NHS)	X			X	
	Riverbend Community Mental Health (RCMH)	X			X	
	Seacoast Mental Health Center (SMHC)	X	X		X	
	West Central Behavioral Health (WCBH)	X			X	
ISO	Easter Seals	X				
	Home Base	X				
	Independent Services Network (ISN)	X				
	Northeast Family Services (NEFS)	X				
	Waypoint	X			X	
RTC	Chase Home					X
	Dover Children's Home					X
	Orion House					X
	Pine Haven Boys Center					X
	Spaulding					X
	Webster House					X
SUD	Live Free Recovery		X			

System assessment tool and data sources

System of Care Assessment Tool (SOCAT)

BHII developed the System of Care Assessment Tool[8] (SOCAT) with inspiration from Glasgow's RE-AIM model for measuring the impact of public health interventions,[9] BHII's related work in this area,[10] and support from CBHRC evaluation workgroup members. The SOCAT was designed to place the qualities of behavioral health practices as delivered in naturalistic settings on a common metric, fostering comparability, transparency, and common language and understanding. The SOCAT trades comparability and breadth for depth and specificity – the resulting findings should be viewed as a crude yet useful approximation of reality.

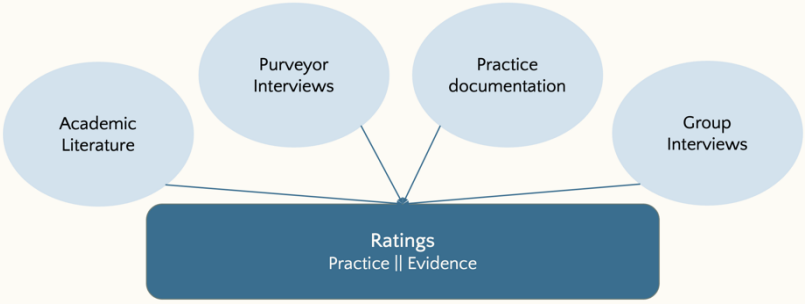
The SOCAT includes 21 items rated against a gold standard on a five-point scale ranging from 1 (not at all) to 5 (completely). The items are organized into five domains: SOC Values, Reach, Implementation, Potency, and Synergy. SOC Values assesses the degree to which community-based practices are implemented in a way that is family/youth driven, culturally and linguistically competent, and trauma-informed. Reach assesses the scope, accessibility, timing, size, and characteristics of the population a practice is delivered to. Implementation has to do with fidelity – the degree to which a practice is delivered in a way that is consistent with the practice model and implementation science principles. Potency estimates the potential of a practice based on scientific research and its observed effectiveness in the settings in which it is delivered. Synergy assesses the degree to which practices are sustainable, feasible, and fill an important niche in the overall service array. The combination of Reach, Implementation, and Potency are the best estimates of a practice's public health impact; Values is a proxy for youth and family experience of care; and Synergy approximates the value-added of a particular practice within the overall service array. See Appendix A for the SOCAT domains, items, and anchored rating scale.

Timeframe

This SOC assessment examined five practice models implemented during calendar year 2022.

Data sources

The SOCAT leverages multiple data sources: academic literature, purveyor interviews, practice documentation, and group interviews. The latter two required cooperation from the sites, who submit readily available data and documentation while releasing staff from potential billable hours to participate in the group interviews for each practice-site combination.



Academic literature

A review of the academic literature was conducted to familiarize the raters with the core elements of the practice and as a primary or secondary source for rating several items in the reach, potency, and synergy domains. The literature review focused on 1) descriptions of the practice model, 2) practice manuals, and 3) the most rigorous (e.g., randomized controlled trials, meta-analytic reviews) research on each practice.

Purveyor interviews

Purveyors are individuals or organizations with specialized expertise in a practice model. Purveyors work to disseminate and support high-quality implementation of the model through activities such as training and certification, coaching and consultation, and monitoring and oversight. They are external to the agencies implementing the practice and may or may not be the developer of the model. In NH, the primary purveyors of each practice are/have been:

CPP – Center for Trauma-Responsive Practice Change (CTRPC)[11]

7C – Seven Challenges[12]

TrECC – No external purveyor, developed and supported by NFI[13] and CFNH[14]

TFCBT – Originally, Dartmouth Trauma Interventions Research Center (DTIRC)[15], now various entities

TBRI – Karyn Purvis Institute of Child Development[16]

Practice documentation

Practice documentation and data submitted by quality assurance/evaluation staff was reviewed for each site/practice combination. The practice documentation provided descriptive information about who, how, and to whom each site delivered each practice, as well as to rate multiple SOCAT items in the Reach, Implementation, Potency, and Synergy domains. The comprehensiveness and quality of data varied given the limited data infrastructure at many sites.

Group interviews

Group interviews were conducted for each practice/site combination to get an on-the-ground perspective from those administrating, supervising, and delivering the practice. This information supplemented the site data and documentation and served as the primary basis for rating several items in the SOC Values, Implementation, and Synergy domains. We conducted a total of 38 group interviews – one for every site/practice combination.

For an overview of the data sources used to rate each of the SOCAT items, see the table below.

SOCAT domains and items by data source

Domains/Items		Data Sources			
Domain	Item	Literature review	Purveyor interviews	Site data	Group interviews
SOC Values	1. Family/youth driven. The youth/family are considered experts on their own needs, goals, and life circumstances; youth/family voice/choice incorporated into all aspects of the practice including their plan of care/treatment; all key decisions are youth/family driven	X	X		X
	2. Culturally & linguistically competent. The model/practice are appropriately responsive and adapted to the culture, values, norms, and language of the youth/family	X	X		X
	3. Trauma-informed. The practice effectively incorporates all six principles of trauma-informed care: 1) safety; 2) trustworthiness & transparency; 3) peer support & mutual self-help; 4) collaboration & mutuality; 5) empowerment, voice, & choice; and 6) cultural, historical, and gender issues	X	X		X
Reach	4. Fit. The practice is an ideal fit for the target population/intended outcomes; it is delivered to the population and for the purpose/outcomes it was designed for/tested on	X		X	X
	5. Capacity. The organization has the capacity to deliver the practice to youth/families who meet eligibility criteria (i.e., the target population) at intake			X	X
	6. Timeliness. Practice can be initiated for those who need it within one week of referral			X	
	7. Dose. Most/all who enroll in the practice receive what an adequate dose of the practice to have a positive effect	X		X	
	8. Equitable. Access, process, and outcomes are equitable across ethnic, racial, geographic, other relevant groups			X	
Implement -ation	9. Structural support. State systems fully support and resource high-fidelity implementation of the practice through its policies and procedures, contracts, reimbursement rates, oversight mechanisms, administrative requirements, data platforms, etc.		X		X
	10. Organizational alignment & support. Culture is explicitly supportive of the practice; leadership buys into, champions, resources the practice; data platform helps scaffold the practice; physical environment conducive to practice; staff have the tools, technology, resources they need				X
	11. Professional development. Ongoing (initial + at least annual) training of all staff delivering the practice by certified trainer/expert(s); weekly coaching -- observation, feedback, reinforcement, and shaping of practice at point of performance -- by a certified/expert coach; access to additional trainings and professional development opportunities as needed		X	X	X
	12. Performance monitoring. Ongoing, frequent, rigorous, and comprehensive monitoring of demographics, service delivery, alliance/experience of care, fidelity, and outcomes; regular,		X	X	X

Domains/Items		Data Sources			
Domain	Item	Literature review	Purveyor interviews	Site data	Group interviews
	structured use of data for data-based decision-making at case, practitioner, and practice levels; regular PDSA cycles to improve practice				
	13. Fidelity. The practice is delivered with integrity, faithful to the conceptual/guiding model and theory, as demonstrated by regularly monitored scores from a well-established fidelity tool			X	X
Potency	**14. Level of evidence.** Sufficient evidence (peer-reviewed studies) to meet evidence-based practice standards (at least two independent, randomized controlled trials)	X			
	15. Effect size. The practice, when implemented with fidelity in research environments, demonstrates a large effect size relative to treatment as usual	X			
	16. Durability/maintenance of gains. The practice, when implemented with fidelity in research environments, shows strong durability/maintenance of gains at least one-year post-treatment	X			
	17. Local effectiveness. The practice -- as routinely implemented in their organizational environment -- achieves similar effects/outcomes as those demonstrated in rigorous research studies (i.e., local effectiveness = efficacy)			X	
Synergy	**18. Coordination.** Substantial, bi-directional, and proactive communication & coordination with natural (e.g., friends and families) and professional supports (e.g., other providers, teachers)		X		X
	19. Sustainability. The organization can sustain the practice for at least two more years; has (or will have) the financial, political, and human resources needed to continue to deliver the practice at the current level of implementation		X	X	X
	20. Feasibility. The practice is straightforward and simple to deliver with fidelity: low in complexity, low costs/overhead to operate, no special skills, easy-to-meet expectations re: youth/family participation, etc.	X	X	X	X
	21. Ecological niche. The practice fills a unique AND important niche or gap in the overall array of services/system of care environment; does not substantially overlap with other practices				X

Raters

The SOC assessment was conducted by two doctoral-level psychologists: Mason Haber and Jim Fauth. Dr. Haber reviewed TBRI and TrECC practice/site combinations (N=8); Dr. Fauth rated CPP, 7C, and TFCBT practice/site combinations (N=30). This included conducting the academic literature review, reviewing the site data, facilitating the purveyor and group interviews, and rating each practice/site combination using the SOCAT. Drs. Haber and Fauth met monthly and communicated via email to maintain integrity to the process and to review and calibrate ratings.

Descriptive Data

The table below reflects data submitted for each site-practice combination, including the site type (Type), implementation start date (Start), unduplicated count of youth/families served (Served), average wait time from referral to first service (Wait), number of staff who delivered (Staff) and were certified (Certified) in the practice, and cost to revenue ratio (Cost). ND ("no data) indicate that the requested data was not provided.

The practice with the longest history in NH is TFCBT, followed by CPP, and much more recently, 7C, TrECC, and TBRI. Most practices were delivered to a relatively small number of youths with a few notable exceptions: CPP at NHS (60); TrECC at CFNH (76) and NFI (118); TFCBT at CP (54) and MHCGM (52); and TBRI at Spaulding (185) and Pine Haven (90). Youth and families generally had to wait at least 30 days from referral to first service for most practices except those delivered by ISO providers, CLM, and WCBH. The number of staff delivering these practices ranged from 1 (multiple site-practice combinations) to 166 (TBRI at Spaulding). The number of certified staff ranged from 0 (multiple site-practice combinations; note, there is no certification for TrECC at this time) to 35 (TBRI at Webster House). The small number of sites that provided an estimate indicated that costs exceeded revenue.

Descriptive data for each practice by site

Site	Type	Start	Served	Wait	Staff	Certified	Cost
CPP							
CP	CMHC	6/1/14	6	29+ days	1	1	No data
GNMH	CMHC	9/1/19	No data	29+ days	10	2	No data
LRMHC	CMHC	1/1/18	No data	22-28 days	1	1	No data
MHCGM	CMHC	4/1/16	17	29+ days	7	5	No data
MFS	CMHC	5/1/17	23	29+ days	16	5	No data
NHS	CMHC	10/10/22	60	29+ days	7	7	No data
RCMH	CMHC	1/1/08	No data	29+ days	9	No data	Costs greatly exceed revenues
SMHC	CMHC	9/1/18	30	29+ days	5	2	No data
WCBH	CMHC	No data	No data	8-14 days	4	0	No data
Easter Seals	ISO	No data	No data	No data	No data	No data	No data
Home Base	ISO	10/30/20	4	15-21 days	3	1	No data
ISN	ISO	3/25/22	3	8-14 days	1	1	No data
Norcross	ISO	No data	No data	No data	No data	No data	No data
NEFS	ISO	1/28/22	5	8-14 days	2	No data	No data
Waypoint	ISO	11/1/16	4	No data	3	0	No data
7 Challenges							
GNMHC	CMHC	7/1/19	No data	29+ days	15	No data	No data
LRMCH	CMHC	1/1/21	No data	22-28 days	2	0	No data

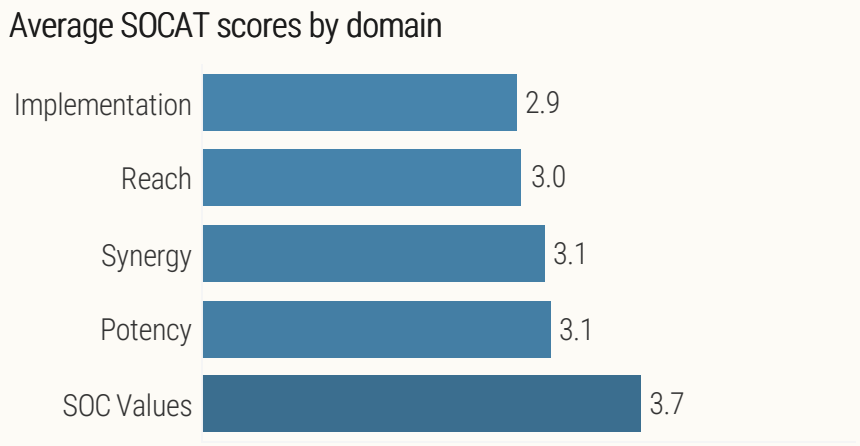
Site	Type	Start	Served	Wait	Staff	Certified	Cost
MHCGM	CMHC	6/9/21	16	15-21 days	7	7	No data
SMHC	CMHC	5/2/22	No data	No data	7	7	No data
Live Free Recovery	SUD	6/1/22	23	0-7 days	2	6	Costs greatly exceed revenues
TrECC							
CFNH	CME	6/1/20	76	29+ days	25	0	Costs greatly exceed revenues
NFI	CME	5/1/20	118	29+ days	25	0	No data
TFCBT							
CLM	CMHC	1/1/13	No data	0-7 days	5	0	No data
CP	CMHC	6/1/07	54	29+ days	12	12	No data
GNMHC	CMHC	1/1/10	No data	29+ days	12	No data	No data
LRMCH	CMHC	1/1/09	No data	22-28 days	5	0	No data
MHCGM	CMHC	9/1/07	52	29+ days	15	15	No data
MFS	CMHC	5/1/13	No data	29+ days	6	3	No data
NHS	CMHC	8/5/19	24	29+ days	4	4	No data
RCMH	CMHC	1/1/06	No data	29+ days	9	No data	Costs slightly exceed revenues
SMHC	CMHC	1/1/18	No data	29+ days	11	3	No data
WCBH	CMHC	No data	No data	8-14 days	4	1	No data
Waypoint	ISO	11/1/16	3	No data	2	1	No data
TBRI							
Chase Home	Residential	5/1/20	No data	29+ days	19	19	No data
Dover Children's	Residential	10/31/20	14	29+ days	1	1	No data
Orion House	Residential	8/20/20	30	29+ days	12	12	No data
Pine Haven	Residential	10/24/18	90	29+ days	35	3	No data
Spaulding	Residential	4/20/18	185	29+ days	166	3	No data
Webster House	Residential	3/23/22	21	29+ days	35	35	Costs slightly exceed revenues

Note. CFNH = Connected Families New Hampshire; CLM=Center for Life Management; CP=Community Partners; GNMHC=Greater Nashua Mental Health Center; ISN = Independent Services Network; LRMH=Lakes Region Mental Health; MHCGM=Mental Health Center of Greater Manchester; MFS=Monadnock Family Services; NEFS = Northeast Family Services; NHS=Northern Human Services; RCMH=Riverbend Community Mental Health; SMHC=Seacoast Mental Health Center; WCBH=West Central Behavioral Health

Domain- and item-level findings

Domain scores

The dashboard below displays average SOCAT domain scores, providing a high-level perspective of the collective strengths and weaknesses of these practices across the SOC. The vertical dotted line represents the midpoint ("somewhat in place") of the SOCAT scale. The lowest-scoring domains were Implementation (2.9) and Reach (3.0), closely followed by Synergy and Potency (3.1). The scores of these domains clustered around the midpoint on the scale, suggesting some foundation with considerable room for growth. SOC values (3.7) was the highest-scoring domain by a considerable margin – these practices are generally delivered in a manner that is highly consistent with SOC values.



Item scores

The domain-level scores mask considerable item-level variability, as revealed by the dashboard on the next page.

Implementation

Implementation item scores ranged from 2.6 (Performance Monitoring and Structural Support) to 3.2 (Organizational Alignment). The system-wide fiscal, financial, policy, and accountability environment was viewed as challenging across most practice-site combinations. The infrastructure and capacity to collect and report and use data to monitor and improve practice at the case and practice levels is rudimentary. Providing sufficient professional development was a bit more robust, but short of the midpoint of the scale. Fidelity to the practice model and home organizational environments were rated just beyond the mid-point of the scale.

Reach

Reach item scores ranged widely from 2.0 (Timeliness; the overall lowest-rated item) to 3.8 (Fit). The bad news is that only a small number of children and youth receive a therapeutic dose of these practices in timely fashion. The good news is that sites recognize those youth/families who would most likely profit from these practices. And in time, they have the capacity to deliver these practices to most of the children and youth who need them. The data provided by sites did not allow us to rate the Equity item.

Synergy

Synergy items ranged from 2.8 (Sustainability) to 3.5 (Niche). The greatest threats to sustainability were workforce and the unbillable aspects of these practices. Sustainability assets included the resolve and commitment of the purveyors, sites, and providers to these practices. Feasibility was affected by the complexity of the target population and intervention; the level of development of the practice toolkit and availability of training; and organizational size,

resources, and staff. Proactive and bidirectional collateral contact comes with the territory when working with kids, so communication and coordination with natural and professional supports was generally adequate. Niche was the highest-rated Synergy item; with perhaps a couple of notable exceptions, these practices generally make sense within the overall system array.

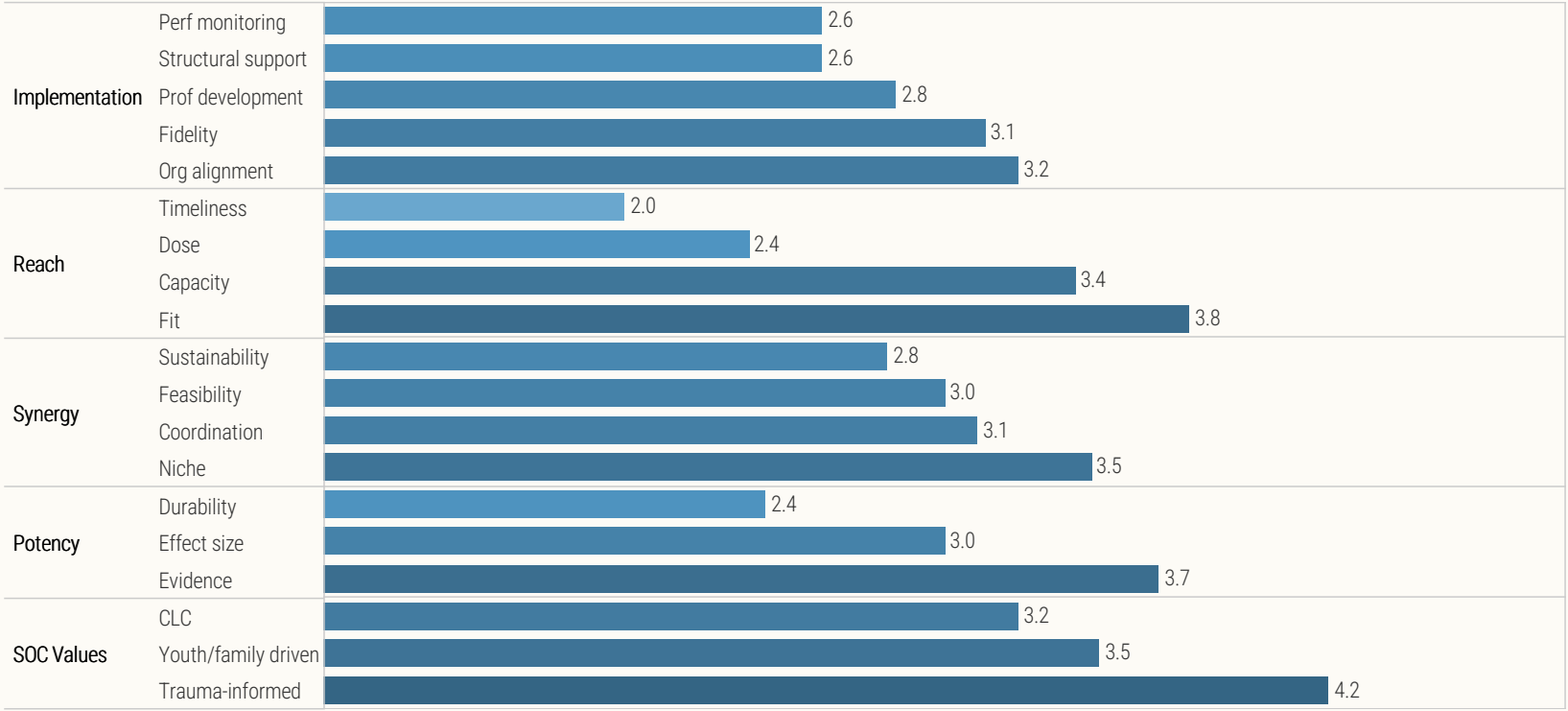
Potency

Potency item scores ranged from 2.4 (Durability) to 3.7 (Level of Evidence). TFCBT and CPP are well-supported by research, the evidence-base on TBRI and 7 Challenges is nascent, and no rigorous research exists for TrECC. Research studies examining the long-term maintenance/durability of gains beyond the period of active treatment for these practices are rare.

SOC Values

Values item scores ranged from 3.2 (Cultural and Linguistic Competence) to 4.2 (Trauma-informed; the single highest-scoring item). These practices are grounded in trauma-informed principles and youth/family collaboration and empowerment. Cultural and linguistic competence scored lower but still above the midpoint. The degree to which these practice models explicitly attend to sociocultural issues varies, and foundational knowledge and skill in applying these principles to their work with clients is less well developed.

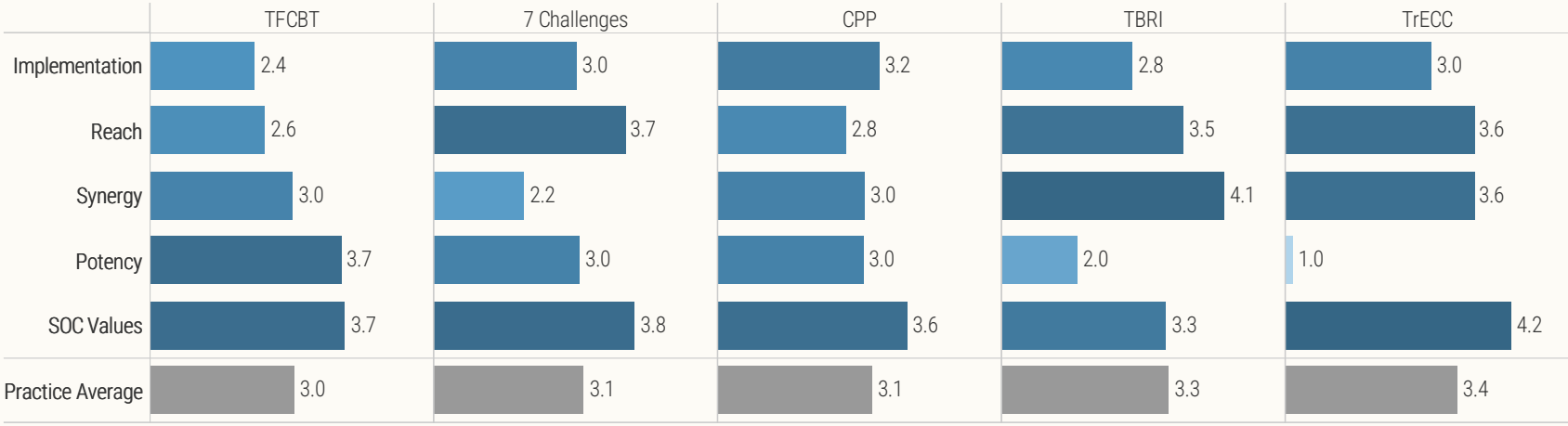
Average SOCAT scores by domain and item



Domain scores by practice

The dashboard below provides domain (blue bars) and overall scores (brown bar at bottom) for each practice (columns). The dotted line represents the midpoint of the 5-point scale. All five practices scored at or just above the midpoint ("somewhat in place") of the five-point SOCAT scale. TFCBT was the lowest-scoring practice (3.0), followed by 7C (3.1), CPP (3.1), TBRI (3.3), and TrECC (3.4). TFCBT's strong Potency and SOC Values scores were counteracted by relatively low Implementation and Reach. 7C, on the other hand, had strong Reach and SOC Values, middling Implementation and Potency, but low Synergy scores. CPP had very strong SOC Values scores; other domains hovered around the midpoint of the scale, though the CPP score profile varied significantly by site type (see below for more detail). TBRI's domain profile included high Synergy scores, relatively robust Reach and SOC Values scores, middling Implementation, and low Potency. TrECC had high SOC Values and Synergy, middling Implementation and Reach, but very low Potency scores (TrECC is a newly developed practice without an evidence base). For item-level scores by practice, see Appendix B.

Average SOCAT scores by domain and practice



CPP profile

This section provides more detail on the SOCAT profile of CPP, first by item, then by site, with both broken out by site type (i.e., ISO/HBT or CMHC). For the CPP item by site crosstab, see Appendix C.

Item profile

The chart below displays the average score for each SOCAT item for CPP, broken out by site type (i.e., CMHC or ISO/HBT provider).

Reach. ISO/HBT providers initiate CPP relatively quickly for the right kinds of children and families. On the other hand, they don't have enough trained and rostered clinicians to serve the sizable number of young children who would most benefit from CPP. ISO/HBT cases contracted through DCYF are often unilaterally closed, effectively terminating CPP services early in the process. The *best-case* in this scenario is "warm handoff" to a community-based provider, requiring the family to re-tell their story and establish trust with a new provider, a significant hardship and disruption for these children and their families. CMHCs, on the other hand, can provide CPP to most of the young children referred to them for as long as they need it, but struggle to initiate CPP in a timely fashion.

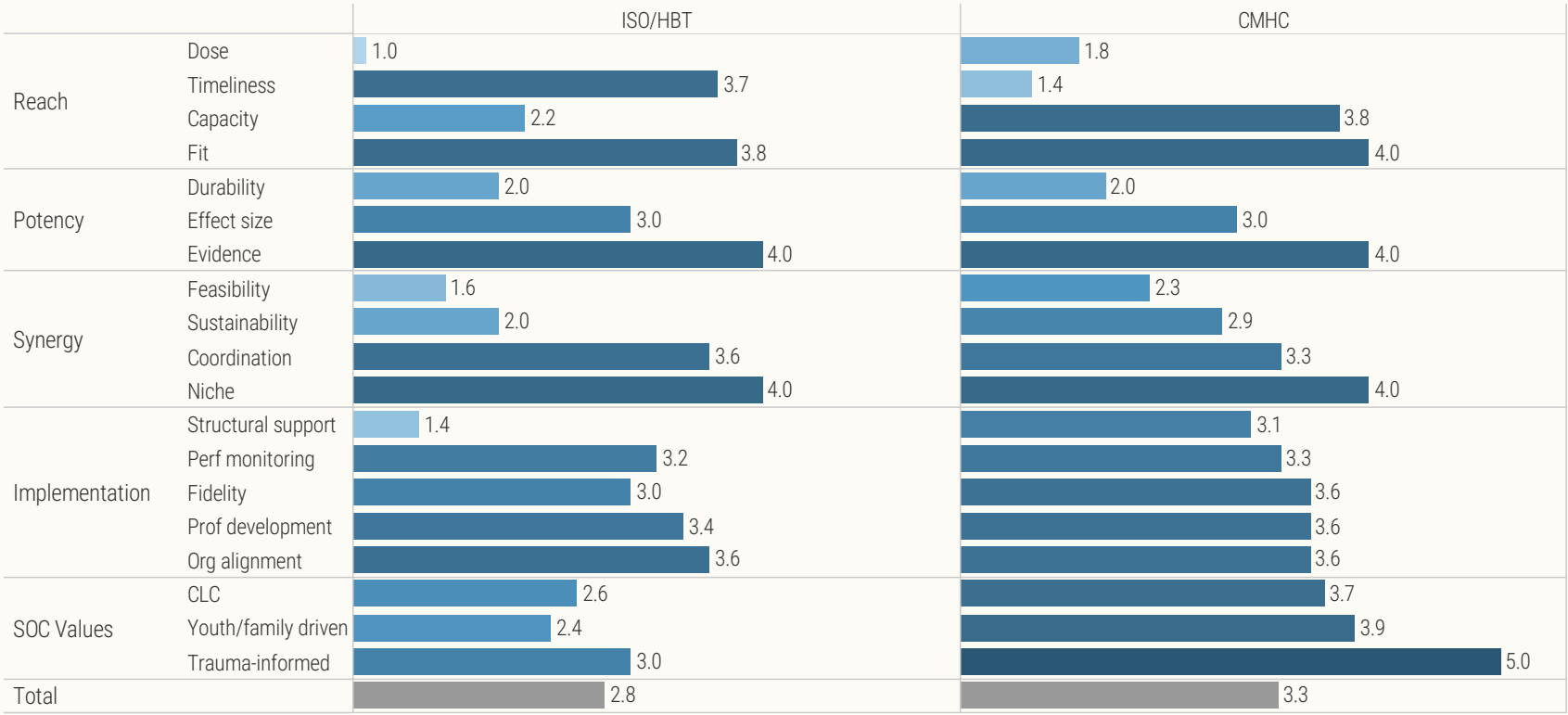
Potency is a characteristic of the evidence-base, so does not vary by site type. Research indicates that CPP reliably and moderately outperforms "treatment as usual" when delivered with fidelity to the target population. Little rigorous research exists on the long-term, post-treatment impact of CPP.

Synergy. CPP is viewed as the "gold standard" for most young children and their families in both ISO/HBT and CMHC contexts. The feasibility and sustainability of CPP is more fragile among ISO/HBT agencies than their CMHC peers.

Implementation. Both ISO/HBT and CMHC providers are highly enthusiastic and committed to CPP. This unparalleled enthusiasm was attributed by providers to the passion, dedication, support, and training provided by CTRPC and their willingness to go above and beyond to meet the needs of our youngest and most vulnerable children. CPP implementation was consistently more robust in CMHC than in ISO/HBT agencies, primarily due to the challenges associated with DCYF involvement in these cases and the more robust administrative and professional development infrastructure and larger size/workforce of CMHCs.

SOC Values. The CPP practice model inherently embodies SOC values, as reflected in SOCAT profile for CMHCs. Further, CTRPC has recently extended additional professional development to sites to further enhance cultural and linguistic competence. In the ISO/HBT context, however, families sometimes feel "voluntold" to engage in CPP, which is often suddenly and prematurely terminated when a DCYF case is closed – it is hard to argue that processes such as these are youth and family driven or trauma-informed.

CPP: Average SOCAT item scores by site type



Site profile – ISO/HBT providers

The highlight table below displays the average domain score for CPP by ISO/HBT provider. Total scores for each domain are displayed at the far right; total scores by site are displayed at the bottom. Potency scores are a property of the evidence-based for the practice, so are invariant across sites. ISN had little capacity to support CPP beyond one clinician enrolled in a training cohort who was uncertain about remaining in her position at the time of the interview. Waypoint has been involved with CPP from the first cohort and maintains strong internal supervision capacity. The number of trained people who can deliver CPP has diminished, and they no longer have the luxury of being able to shift CPP cases that are closed prematurely to their outpatient mental health services department, which has been shuttered. Home Base scored well in terms of performance monitoring – unlike many sites, they continue with all CPP assessment tools beyond the training cases for which they are required. Easter Seals can provide CPP for most of the youth who need it and have strong internal training and performance monitoring capacity. NEFS excels in terms of coordinating with natural and professional supports, internal supervision capacity, and organizational alignment.

CPP: Average SOCAT domain scores for ISO/HBT providers

	ISN	Waypoint	Home Base	Easter Seals	NEFS	Domain Average
Reach	2.3	2.3	2.5	3.0	2.8	2.6
SOC Values	2.7	2.3	3.0	2.3	3.0	2.7
Synergy	2.8	2.8	3.0	2.8	2.8	2.8
Implementation	2.0	2.6	3.0	3.4	3.6	2.9
Potency	3.0	3.0	3.0	3.0	3.0	3.0
Site Average	2.5	2.6	2.9	2.9	3.1	2.8

Site profile – CMHCs

The highlight table below displays the average domain score for CPP by CMHC. CP and LRMHC implement CPP in a way that is strongly adherent to SOC Values, but both struggle with the developing and maintaining sufficient capacity to deliver it in a timely fashion for all that need it. NHS, MHCGM, and GNMHC are at a similar level of implementation with CPP. SMHC, WCBH, and RCMHC have the strongest CPP programs; SMHC is especially strong in terms of SOC Values, WCBH with the capacity to serve everyone who needs CPP relatively quickly, and RCMHC with implementation and fidelity to the practice.

CPP: Average SOCAT domain scores for CMHCs

	CP	LRMHC	NHS	MHCGM	GNMHC	MFS	SMHC	WCBH	RCMHC	Domain Average
Reach	1.8	1.8	2.5	2.8	3.3	3.7	3.0	4.3	3.5	2.9
Potency	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
Synergy	2.8	2.5	3.5	3.5	3.0	3.3	3.5	3.3	3.0	3.1
Implementation	2.4	2.8	3.6	3.8	3.6	3.6	3.6	3.4	4.0	3.4
SOC Values	4.3	4.3	4.0	3.7	4.0	4.3	4.7	4.0	4.3	4.2
Site Average	2.7	2.8	3.3	3.4	3.4	3.6	3.6	3.6	3.6	3.3

Seven Challenges Profile

This section provides more detail on the SOCAT profile of 7C, first by item, then by site. For the 7C item by site crosstab, see Appendix C.

Item profile

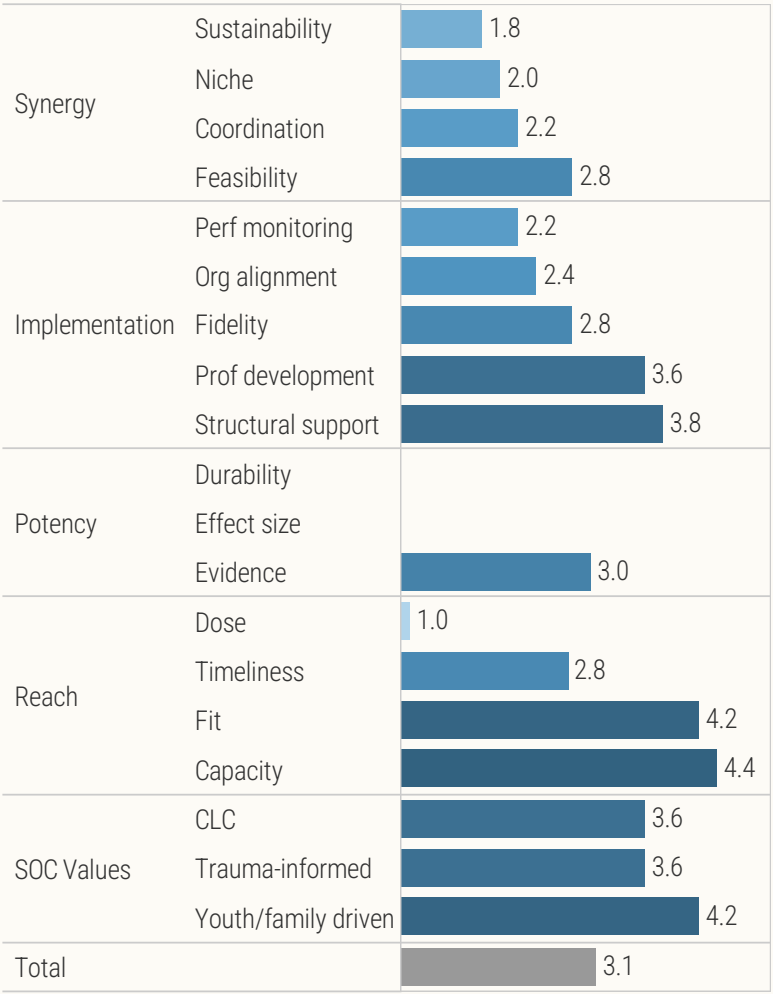
The chart at right displays the average score for each SOCAT item for 7C, across sites.

Synergy. The central challenge with 7C has been finding enough of the "right" youth who wish to engage in the practice. Low Synergy scores were also driven by the challenges of coordinating and communicating with natural and professional supports given the constraints of 42CFR. The flexibility in how 7C can be implemented was a double-edged sword, leaving sites with many choices in the absence of a ready-made "formula." Sites also worry about the unbillable expenses associated with the extensive use of journaling in 7C, including staff time outside of sessions and purchasing a separate set of journals for each client beyond the initial period of state support.

Implementation. Sites have enjoyed strong state/structural support and access to high quality training and coaching from the 7C purveyor. At the clinical and operations level, the extensive use of journaling in 7C is difficult to pull off in a fee for service/productivity-based financial model. 7C does not have any built-in assessments or performance measures which inhibited performance monitoring. The lack of client demand and concerns about sustainability dampened organizational commitment and alignment, which in turn, limited the fidelity with which the model was implemented.

Potency. The California Clearinghouse indicates that the level of evidence for 7C is "promising," based on a randomized controlled

7C: Average SOCAT item scores



trial in which 7C performed similarly to another active treatment. No rigorous studies comparing 7C to "treatment as usual" or investigating long-term outcomes beyond the initial period of treatment have been conducted, so the "effect size" and "durability" items could not be scored.

Reach. Most sites have the capacity to provide 7C for the small number of youths that are appropriate for and willing to engage in the practice. Sites have had difficulty keeping youth engaged in the practice, along with the ubiquitous issues with delivering the practice quickly enough, leading to low dose and timeliness scores.

SOC Values. 7C is inherently youth-driven and embodies most of the principles of trauma-informed care, leading to relatively high ratings for those items. CLC is less built-in to the model; as such, it relies on sites and practitioners to use their foundational knowledge and skills to implement the model in a culturally responsive manner.

Site profile

LRMHC does not view 7C as having a substantial niche in the CMHC context in their region and thus has not invested heavily in 7C beyond the initial training. Live Free Recovery – the lone SUD provider that participated in the SOC Assessment – has discontinued the practice based on staff ambivalence and difficulty engaging youth in the practice, despite ready access to an appropriate client population through their school-based group programming. Data they provided indicated that, when given the choice, youth overwhelmingly preferred Live Free Recovery's standard Choice Theory-based practice model, which is less expensive and easier to operate. MHCGM and SMHC are having the prototypical experience with 7C – they appreciate the flexibility of the model, like being able to provide integrated SUD services, and find the skills easy to learn and practice. Yet they struggle with the lack of built-in client demand, the unbillable time and (future) expense of journaling and have doubts about long-term feasibility and sustainability. GNMHC is enthusiastic about the support provided by the state and the 7C purveyor and have put in considerable effort figuring out how to implement 7C in a CMHC context. While they believe 7C fills an important niche, they too struggle with the lack of built-in demand (going so far as offering 7C to neighboring CMHC regions) and unbillable aspects of the practice (journaling).

7C: Average SOCAT domain scores by site

	LRMHC	Live Free Recovery	MHCGM	SMHC	GNMHC	Domain Average
Synergy	1.5	1.5	2.3	2.3	3.5	2.2
Implementation	2.0	3.0	3.2	3.0	3.6	3.0
Potency	3.0	3.0	3.0	3.0	3.0	3.0
Reach	3.0	3.5	4.0	5.0	3.3	3.7
SOC Values	4.0	3.7	3.7	4.0	3.7	3.8
Site Average	2.5	2.9	3.2	3.3	3.5	3.1

TrECC profile

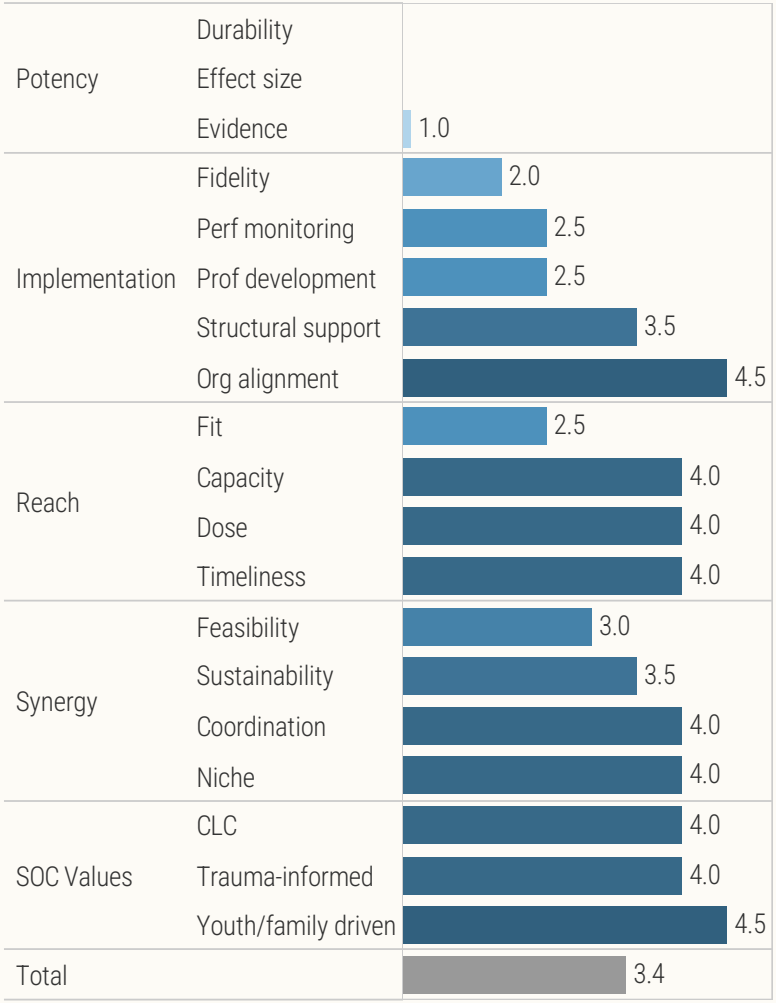
Item profile

Potency. A downside of a being a newly developed practice – even one modeled after promising and evidence-based practices like Critical Time Intervention and Wraparound – is that no rigorous research or uncontrolled outcome evaluations had been conducted on TrECC as of calendar year 2022. As such, the Durability and Effect Size items could not be scored, and the level of Evidence item received the lowest possible score on the SOCAT scale.

Implementation. The newness of the model also impacted implementation scores, with TrECC's practice manual, practice tools, and fidelity and outcome assessments still very much under development in calendar year 2022. While generally grateful for a variety of types of helpful support that they receive from the state, TrECC respondents felt that the state was not doing enough to address – and may not fully appreciate – the nature or extent of the "Fit" problem (see below). Nonetheless, CMEs have been working hard at developing the infrastructure for TrECC, resulting in strong organizational alignment scores.

Reach scores were generally robust. The state requirement that CMEs initiate TrECC for all cases without resort to a waiting list ensures high Timeliness and Capacity ratings. Indeed, the lag time from a referral to BCBH and subsequent assignment of and initiation of TrECC by a CME averaged about ten days. Youth and families transitioning in and out of residential treatment have proven very receptive to the support and coordination TrECC provides, leading to strong engagement in the practice and a high Dose score. The major challenge in the Reach domain is Fit – the perception among CME leaders and staff is that the original purpose and target population has been diluted to the point that it serves as a "stopgap" whenever a youth and family do not have

TrECC: Average SOCAT item scores



funding, or for situations in which a family is "burnt out" and wanting to use residential treatment of the youth as respite or even a way of ending their guardianship.

Synergy. TrECC's Synergy scores were also strong. Coordination with natural and community supports is a hallmark of TrECC and the practice is viewed as filling an important service gap – or niche – within the system of care by all involved. Feasibility and sustainably scores were a bit lower. In comparison to FAST Forward (the other primary CME-based intervention), TrECC has proven to be an intense, complex, and "expensive" practice to operate while getting reimbursed at a lower rate.

SOC Values. The upside of TrECC being a new, locally-developed practice is that it was designed – and is practiced – in a way that embraces and embodies SOC Values. As such, it received high marks for Cultural and Linguistic Competence, Trauma-informed, and (especially) Youth and Family-driven.

Site profile

TrECC scores were slightly higher for NFI than for CFNH. NFI's implementation of TrECC has been relatively advantaged by 1) being the primary developers of TrECC, 2) having a smaller proportion of TrECC cases relative to FAST Forward; and 3) having more mental health-specific programming experience and organizational infrastructure. CFNH is especially concerned – as are BCBH and NFI – about the costs, complexities, sustainability, and perceived "drift" in TrECC's purpose and patient population.

TrECC: Average SOCAT domain scores by site

	CFNH	NFI	Domain Average
Potency	1.0	1.0	1.0
Implementation	2.8	3.2	3.0
Reach	3.5	3.8	3.6
Synergy	3.5	3.8	3.6
SOC Values	4.0	4.3	4.2
Site Average	3.2	3.5	3.4

TFCBT profile

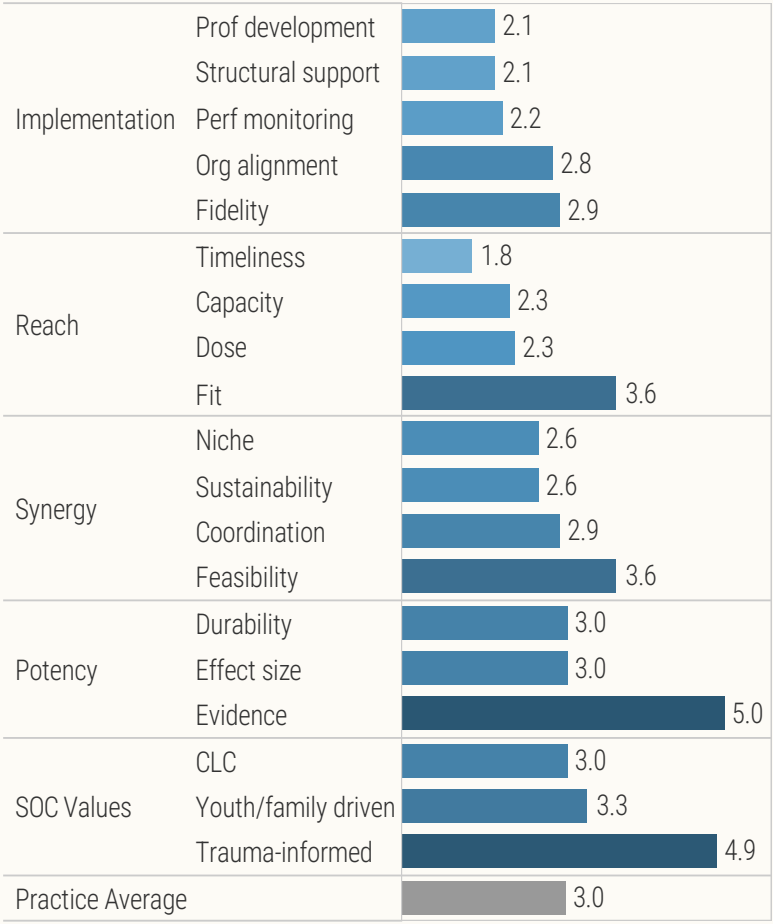
Item profile

Implementation was the lowest scoring domain for TFCBT. The practice was introduced to the CMHCs and other mental health agencies over a decade ago by DTIRC through a series of federal grants; historically, the state has neither required nor resourced TFCBT implementation. As the years have gone by and grant-funded projects ended, access to training and coaching has eroded. TFCBT does not require a specific set of assessments, so sites generally rely on their usual data collection and monitoring routines (e.g., quarterly reviews), supplemented at times by a trauma-specific screener at baseline and/or termination. Despite thin state support, fidelity to the model generally remains strong in the most dedicated sites, except for the in-vivo exposure element of the practice, which is rarely if ever applied.

Reach. TFCBT suffers from the system-wide issues with timeliness and dose. In addition, inconsistent access to external support and training, and lack of a train-the-trainer component, have limited site's ability to develop and maintain sufficient capacity. Nonetheless, sites do a good job screening/assessing for trauma at intake, which helps them recognize and offer TFCBT to those who need it.

Synergy. TFCBT Synergy scores were depressed by concerns about sustainability and niche. The sustainability concerns were driven by the historically thin state support for TFCBT and the lack of a train-the-trainer component. In terms of niche, TFCBT and the MATCH trauma module overlap – most sites use TFCBT as their trauma module, but the most ardent supporters of MATCH tend to de-emphasize TFCBT. Coordination with natural and professional supports within TFCBT was standard – the TFCBT model

TFCBT: Average SOCAT item scores



incorporates conjoint sessions with caregivers that rarely happen because many youths drop out prior to that phase of treatment, it is difficult to engage caregivers in conjoint sessions, and on depending on the age and trauma history of the youth, it may even be clinically contraindicated.

Potency. The evidence base for TFCBT is impressive. Extensive rigorous research including many clinical trials support the efficacy of the model; as such it received the highest possible score on level of Evidence. The existing research indicates that TFCBT is moderately more effective than treatment as usual and that youth outcomes are durable beyond the period of active treatment.

SOC Values scores were bolstered by its obvious strength as a trauma-responsive model. The Youth and Family-driven items was rated a bit lower; clinical practices such as TFCBT tend to take a bit more of an expert-driven stance than those approaches explicitly developed around SOC values. Historically, the TFCBT model and trainings did not incorporate a lot of guidance around culturally responsive care, though that seems to be improving.

Site profile

Site-level scores for TFCBT ranged from 2.6 to 3.7. The sites at the lower end of that range (2.6 to 2.8) have found it hard to sustain a strong TFCBT practice considering limited state support, inconsistent access to external training, and competing priorities (such as other EBPs that are required, perceived as more important, and/or overlap to some extent). The scores of sites in the middle of the distribution (3.0–3.2) were bolstered by one or more relatively specific bright spots (e.g., Reach for CLM and WCBH, Synergy for GNMHC and SMHC). At the high end of the distribution, SMHC and MHCGM have broadly strong TFCBT programs. Both emphasize TFCBT at an organizational level, find the practice quite feasible relative to other EBPs, and have found ways to continue providing access to external training and maintain in-house bi-monthly consult groups.

TFCBT: Average SOCAT domain scores by site

	LRMHC	Waypoint	NHS	CP	MFS	CLM	GNMHC	WCBH	RCMHC	SMHC	MHCGM	Domain Aver..
Implementation	1.6	2.2	1.6	2.0	1.8	2.0	2.6	2.6	3.0	3.6	3.6	2.4
Reach	2.3	1.7	1.8	2.3	2.3	3.7	2.3	3.3	2.8	3.0	3.0	2.6
Synergy	2.3	2.8	3.3	2.5	2.8	2.8	3.3	2.8	3.3	3.3	3.8	3.0
Potency	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7
SOC Values	3.7	2.7	3.3	4.0	4.3	3.7	3.3	4.0	3.7	4.0	4.3	3.7
Site Average	2.6	2.6	2.6	2.8	2.8	3.0	3.0	3.2	3.2	3.5	3.7	3.0

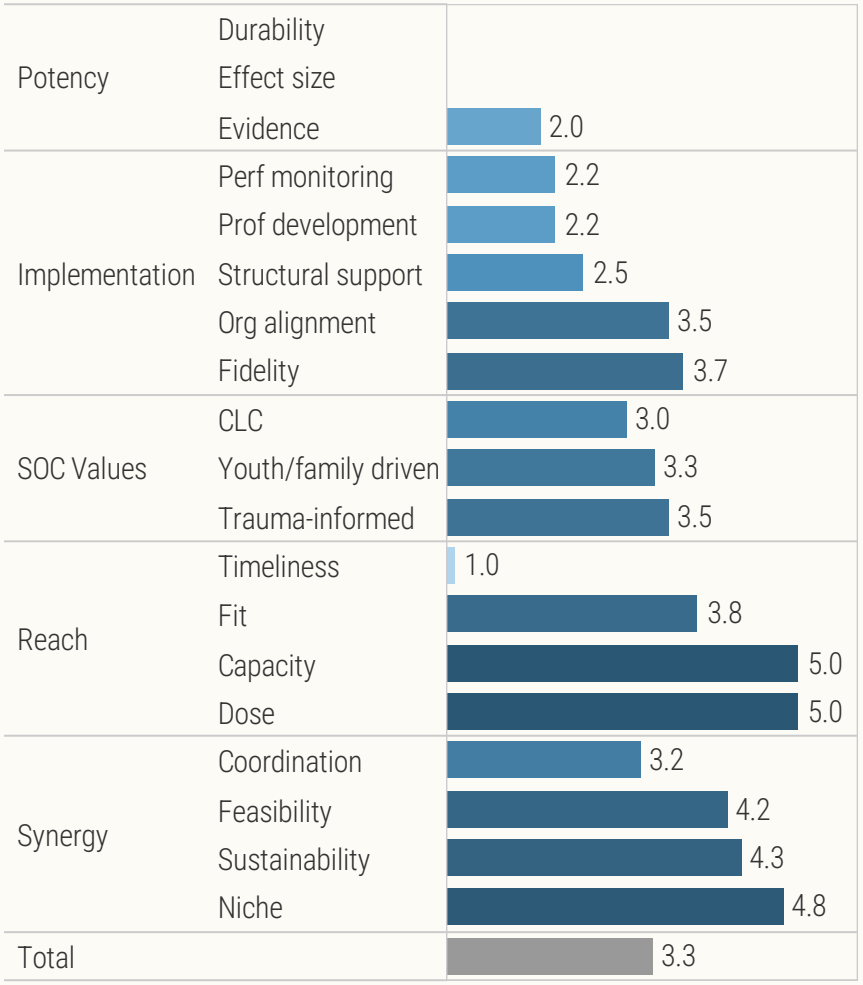
TBRI profile

Item profile

Potency was the lowest-scoring domain for TBRI. The practice is best described as "evidence-informed" based on the research to date, as reflected in the Evidence score. No rigorous studies comparing TBRI to "treatment as usual" or investigating long-term outcomes beyond the initial period of treatment have been conducted, so the "effect size" and "durability" items could not be scored.

Implementation. Performance monitoring at most sites is rudimentary and restricted to required treatment planning and reviews. TBRI has an observational tool for assessing fidelity, but it is not in use at any of the sites. Access to TBRI training for staff has been relatively strong, but many sites don't have a plan or capacity to continue to support fidelity to the model internally through ongoing TBRI-focused supervision and coaching. Structural support in terms of access to trainings and support from the purveyor and beautification funds for creating an aligned physical environment were noted and appreciated. The major challenge regarding structural support was the perception that understanding and commitment to SOC values (e.g., youth and family-driven) does not extend beyond TBRI-implementing sites to the many other state systems with which these youth most commonly interface (e.g., DCYF). In addition, sites were concerned about inappropriate referrals (referring level 3 youth to level 2 programs) and inadequate reimbursement rates to cover costs of training and other resources, even with state support. The primary form of ongoing technical assistance from the purveyor – the practitioner group – was also discontinued. Organizational alignment for TBRI and Fidelity were generally strong. TBRI is described across the board as very flexible and highly complementary with existing agency practices. In general, the professional development

TBRI: Average SOCAT item scores



infrastructure at most RTCs is limited. The biggest stretch for some RTCs appears to be getting practitioner-level training for lead staff; for a large agency, this can amount to a significant logistical and financial hurdle.

SOC Values were rated as strong for TBRI-implementing sites. This was especially the case for youth voice and choice, but less so for family driven. As with all other practices, applied knowledge of CLC seems a bit less robust than the other values, with noteworthy exceptions (see below).

Reach. TBRI Reach scores were pulled down by a low Timeliness rating due to the significant amount of time it takes from the point of referral for residential care to go through the Comprehensive Assessment for Treatment then successfully find an open bed at an appropriate RTC. As a milieu model, by definition, TBRI is provided for all youth in RTC, and average lengths of stay are sufficient for a therapeutic dose.

Synergy. Coordination with natural and professional supports – the lowest-scoring item in this domain – could certainly be better within NH RTCs. TBRI was widely viewed as feasible, sustainable, and filling a critical niche within RTC settings. TBRI principles and strategies touch on many aspects of treatment and are seen as aligned with organizations' existing values and practices and highly feasible across the board. The common argument among practitioners interviewed for the assessment that TBRI helps residential treatment facilities do what they are already doing – but better – appears well justified.

Site profile

Variation in TBRI scores, which ranged from 3.1 to 3.6, was minimal compared to other practices. The sites on the lower end of the distribution were finding it difficult to promptly train staff with the resources that were currently available, especially practitioner-level training for lead staff. Beyond that, TBRI bright spots abounded. Chase Home values TBRI and is strongly adherent to SOC Values. Pine Haven feels that TBRI has increased the fit of their agency and programming with the level 3 youth they serve. They have two on-site TBRI practitioners that provide internal training to all new staff, plus annual trainings to all staff. Dover Children's Home is strongly "youth-driven;" they offered multiple excellent examples of how youth are given control over their environment. Webster House excels at performance monitoring, cultural and linguistic competence, and working in a youth/family-driven manner. Reports on all cases are delivered to all Webster House staff as well as parents monthly to describe progress using a point system. Webster House's TBRI practice was culturally responsive, not just in individual terms for the youth, but also in the broader milieu to celebrate youth culture and stimulate culturally responsive mutual support. Spaulding's organizational alignment and trauma-informed practice were very strong, as was the fit with patient population and feasibility/sustainability of the approach. Leadership champions and prioritizes the practice, and the agency seems to be continually ramping up its professional development and infrastructure to support TBRI more fully. Staff see the practice as highly aligned with agency culture and other practices. Spaulding remains connected with outside TBRI expertise and see themselves as a resource for other agencies implementing TBRI.

TBRI: Average SOCAT domain scores by site

	Orion House	Chase Home	Pine Haven Boys Center	Dover Children's Home	Webster House	Spaulding	Domain Average
Potency	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Implementation	2.2	1.8	3.0	3.2	3.2	3.4	2.8
SOC Values	3.0	3.7	2.3	3.7	3.7	3.3	3.3
Reach	3.5	3.7	3.3	3.0	3.8	3.8	3.5
Synergy	4.0	4.3	4.3	4.0	4.0	4.3	4.1
Site Average	3.1	3.1	3.2	3.4	3.5	3.6	3.3

Lessons learned and next steps

Echoes from the last SOC assessment

Several themes from the inaugural SOC Assessment apply to this year's as well. First, **geography and context matters** – it is inherently more difficult to support a full array of evidence-based and promising practices in smaller agencies and in rural areas serving highly dispersed populations. We need to more realistically appraise the EBP carrying capacities. Those in rural areas should be supported in focusing on the smallest possible number of highly flexible EBPs appropriate for the broadest possible swath of their patient population. We then need to find strategies to flow more specialized interventions from more to less populated regions to ensure equitable access throughout the state.

Second, **you get what you pay for** – when resources are readily available to support the "unbillable" aspects of EBP you get better reach and implementation. That requires a stable/ongoing source of revenue to enhance and retain the workforce and offset the currently unbillable aspects of the full complement of mandated EBPs. Options include enhanced reimbursement rates for delivery of high-quality EBPs, supplemental grants or contract enhancements provided by the state, or other means.

Third, you can **never take your foot off the gas** – up-front investment in the installation of new practices is insufficient for enduring high-quality evidence-based practice. We need to budget for ongoing investments in training, coaching, performance monitoring, and other implementation drivers for all priority EBPs.

Fourth, we continue to operate in a **data-poor environment**, which hampers client care, transparency and accountability, and our ability to learn and grow as a system. Increasing the amount, integrity, and use of data at all levels of the system should be among the technical assistance priorities moving forward. The first order of business in this regard will be ensuring that all sites have the appropriate fields and reports built into their EHRs so that they can use and provide demographic and service data disaggregated by practice. In the longer-term, we need to guide investments in reporting infrastructure that decouple quality reporting and billing.

CPP: a tale of two worlds

Sites view CPP as the gold standard model for a very high-priority population – young children with trauma and attachment difficulties and their caregivers. CTRPC has done amazing work disseminating and supporting CPP. Sites were highly enthusiastic about the cohort-based training and rostering process and other supports provided by CTRPC. Commitment to CPP surpassed that of any of the other practices we have ever assessed – despite the lack of state funding until very recently, the clinical sophistication and complexity of the model, the need for highly skilled clinical workforce, the hefty time commitment associated with learning and fully using the model, and the potential for vicarious trauma and burnout potential from working with this population.

The challenges – and potential solutions – for CPP in CMHCs are the same as those for the other EBPs. Workforce shortages and churn and the unbillable aspects of the practice limit the timeliness and reach of CPP (e.g., the time associated with the training and rostering process and completing CPP-specific assessments). Recent investments by the state via SB 444 and a SAMHSA grant awarded to CTRPC should go a long way toward enhancing the CPP infrastructure, referral pathways, access, and quality throughout the state.

ISO/HBT providers would *seem* to be in prime position to bolster the reach of CPP in NH – they have access to large numbers of young children and families who could benefit from CPP, are able This CPP potential of ISO/HBT providers, however, is being undermined by insufficient workforce and state processes that risk disillusioning and re-traumatizing very vulnerable children and families. CPP in the ISO/HBT context will only be viable when 1) family voice and choice about whether and when to engage in CPP and 2) continuity of care when they do can be assured.

Seven Challenges in search of a niche

The CMHCs implementing 7C have encountered an unfamiliar problem – limited demand for the practice. Few CMHCs are known for offering substance misuse services, so referrals for mild to moderate substance misuse are few and far between. Youth that are referred to CMHCs for mental health or behavioral issues are unlikely to view mild/moderate substance misuse as a significant problem or choose to discuss it openly at intake if it is. The most likely scenario that results in identification of youth in need of 7C in CMHCs is one in which substance concerns arise over the course of therapy for some other condition(s). While 7C can accommodate being used as an adjunctive model in such cases, unless the original/primary therapist is trained in the model it raises pragmatic and logistical problems – do they switch therapists or add a second intervention (i.e., individual or group 7C)? The ideal scenario would involve training most/all CMHC practitioners in 7C so they can seamlessly incorporate substance misuse exploration as needed on a case-by-case basis. That, of course, would take a massive investment for what appears to be a relatively high-cost/low-demand intervention. Until CMHCs can respond fully to the many currently unmet demands in the system, further expansion of 7C in CMHCs may be unwarranted.

The experience of the one SUD provider in this year's sample was not promising: staff were not convinced 7C offered incremental value beyond their standard ("choice theory") approach, it was perceived as being overly expensive and clunky (i.e., journaling) relative to its perceived value and alternatives, and was rejected at a high rate by both mandated and voluntary students in school-based SUD groups. As a next step, we recommend consulting with other SUD providers about the feasibility and viability of 7C prior to any additional dissemination of the model.

Baseline TrECC assessment offers hope – and concern

For a home-grown, newly developed practice, TrECC got off to an impressive start during calendar year '22. The need and niche for the practice was clear and organizational commitment was strong. Internal training and coaching infrastructure were being built and numerous practice and evaluation tools were under development, all of which should strengthen the practice. The most pressing concern for TrECC is to explicitly address the perceived "drift" in the purpose of and population served by the model. Doing so should enhance the state-CME partnership and allow the practice can be better codified and operationalized (e.g., tighter inclusion/exclusion criteria) and ultimately, practiced. The lack of evidence supporting the efficacy and effectiveness of TrECC should also be addressed. The first step should be examining pre-post evaluation outcomes. If those results are positive, grant funding could be pursued to conduct more rigorous and controlled research on the practice. Finally, the fact that TrECC is being developed, trained, and coached internally via the CMEs – without an external purveyor or technical assistance partner – bears watching. Will this internal-only strategy be as effective at developing the model and toolkit and establishing and maintaining quality control and fidelity as one involving at external purveyor?

To TFCBT or not to TFCBT – that is the question

TFCBT has an interesting history in NH, having been introduced and disseminated through the grant-funded efforts of DTIRC. The fact

that TFCBT practice remains as strong at several sites is a testament to the excellent foundation laid by DTIRC, the dedication and commitment of sites, and the feasibility and demonstrated effectiveness of the model. Nonetheless, the "trauma treatment" space for youth and adolescents is growing crowded. The state continues to invest in MATCH, which includes a trauma module. Although that module is widely viewed as TFCBT "light," it is an open question whether the incremental value of substituting the full TFCBT model would be worth the investment. In addition, some sites are experimenting with Eye Movement Desensitization and Reprocessing (EMDR), which anecdotally, they view as easier for youth to engage in (less need to talk about the trauma) and at least as effective in potentially a shorter amount of time that TFCBT (the extant research is mixed on those latter two points).[17,18] Nonetheless, TFCBT is still considered the gold standard trauma treatment for youth and adolescents, has an impressive evidence-base, and its mechanism of change is better understood than that of EMDR. Now is the time for the state, CMHCs, and other system partners to make explicit decisions about what trauma models will be required and supported, when, how, and for whom. If TFCBT is among them, it should be supported more heavily by the state, especially in terms of improving regular access to external training and consultation and building internal training and supervision capacity.

Take TBRI to scale

While other milieu-based interventions have been tried in youth residential treatment settings, none seem to be as formalized or as supported by accessible technical assistance as TBRI. Considerable free technical assistance and online implementation resources for TBRI are available to all practitioners. Although evidence for TBRI's effectiveness in residential settings at this point is extremely limited, it appears to conform to best practices for behavior management, provide a framework that seems to discourage pathologizing and enhance empathy for youth in residential care, and offer many types of resources to improve implementation, all important objectives for residential facilities. No ready to hand milieu-based intervention would seem to compete with these advantages of TBRI. The recommendation is to take TBRI to scale in three ways: 1) continue to support and enhance the work of the current cohort of RTCs that are implementing TBRI to demonstrate the feasibility and promise of the approach, 2) expand TBRI to additional RTCs with the eventual goal of installing TBRI throughout the state, and 3) engage in system-wide education, training, and coaching to ensure that SOC values extend beyond the TBRI-implementing RTCs to all the other systems with which these youth regularly interface.

Appendix A: Children's System of Care Assessment Tool items

Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
SOC Values	**1. Family/youth driven** The youth/family are considered experts on their own needs, goals, and life circumstances; youth/family voice/choice incorporated into all aspects of the practice including their plan of care/treatment; all key decisions are youth/family driven	1 No youth/family voice/choice	2 A little youth/family voice/choice	3 Some youth/family voice/choice	4 Considerable youth/family voice/choice	5 Full/complete youth/family voice/choice	
	2. Culturally & linguistically competent The model/practice are appropriately responsive and adapted to the culture, values, norms, and language of the youth/family	1 Not responsive to culture, norms, language of youth/family	2 A little responsive to culture, values/norms, language of the youth/family	3 Somewhat responsive to culture, values/norms, language of the youth/family	4 Considerably responsive to culture, values/norms, language of the youth/family	5 Fully responsive to culture, values/norms, language of the youth/family	
	3. Trauma-informed The practice effectively incorporates all six principles of trauma-informed care: 1) safety; 2) trustworthiness & transparency; 3) peer support & mutual self-help; 4) collaboration & mutuality; 5) empowerment, voice, & choice; and 6) cultural, historical, and gender issues	1 Not trauma-informed	2 A little trauma-informed	3 Somewhat trauma-informed	4 Considerably trauma-informed	5 Completely trauma-informed	

Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
Reach	**4. Fit** The practice is an ideal fit for the target population/intended outcomes; it is delivered to the population and for the purpose/outcomes it was designed for/tested on	1 No fit between actual and ideal target population & outcomes	2 A little fit between actual and ideal target population & outcomes	3 Some fit between actual and ideal target population & outcomes	4 Considerable fit between actual and ideal target population & outcomes	5 Complete fit between actual and ideal target population & outcomes	
	5. Capacity The organization has the capacity to deliver the practice to youth/families who meet eligibility criteria (i.e., the target population) at intake	1 No capacity - able to serve 1-20% of the target population	2 Little capacity - able to serve 21-40% of the target population	3 Some capacity - able to serve 41-60% of target population	4 Considerable capacity - able to serve 61-80% of target population	5 Complete capacity - able to deliver to 81-100% of target population	
	6. Timeliness Practice can be initiated for those who need it within one week of referral	1 Not timely - 29+ days to first service	2 Minimally timely - 22-28 days to first service	3 Somewhat timely - 15-21 days to first service	4 Considerably timely - 8-14 days to first service	5 Completely timely - 1-7 days to first service	
	7. Dose Most/all who enroll in the practice receive what is considered an adequate dose of the practice to have a positive effect	1 No dosage (1-19% adequate dose)	2 A little dosage (22-39% adequate dose)	3 Some dosage (41-59% adequate dose)	4 Considerable dosage (61-79% adequate dose)	5 Complete dosage (81+% adequate dose)	Not able to rate (no practice data)
	8. Equitable Access, process, and outcomes are equitable across ethnic, racial, geographic, other relevant groups	1 Not equitable - access and/or outcomes greatly favors advantaged	2 A little equitable - access and/or outcomes favors advantaged	3 Somewhat equitable - access and/or outcomes somewhat favors advantaged	4 Considerably equitable - access and/or outcomes slightly favors advantaged	5 Completely equitable - access and/or outcomes do not favor advantaged	Not able to rate (no practice data)

Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
Implementation	**9. Structural support** State systems fully support and resource high-fidelity implementation of the practice through its policies and procedures, contracts, reimbursement rates, oversight mechanisms, administrative requirements, data platforms, etc.	1 No structural support - state systems do not support high fidelity implementation	2 A little structural support - state systems minimally support high-fidelity practice	3 Some structural support - state systems somewhat support high-fidelity practice	4 Considerable structural support - state systems support high-fidelity practice	5 Complete structural support - state systems fully support high-fidelity practice	
	10. Organizational alignment & support Culture is explicitly supportive of the practice; leadership buys into, champions, resources the practice; data platform helps scaffold the practice; physical environment conducive to practice; staff have the tools, technology, resources they need	1 No organizational support for high fidelity implementation	2 A little organizational support for high fidelity implementation	3 Some organizational support for high fidelity implementation	4 Considerable organizational support for high fidelity implementation	5 Complete organizational support for high fidelity implementation	
	11. Professional development Ongoing (initial + at least annual) training of all staff delivering the practice by certified trainer/expert(s); weekly coaching -- observation, feedback, reinforcement, and shaping of practice at point of performance -- by a certified/expert coach; access to additional trainings and professional development opportunities as needed	1 No ongoing training and coaching by an expert in the practice model	2 A little ongoing training and coaching by an expert in the practice model	3 Some ongoing training and coaching by an expert in the practice model	4 Considerable ongoing training and coaching by an expert in the practice model	5 Complete ongoing training and coaching by an expert in the practice model	

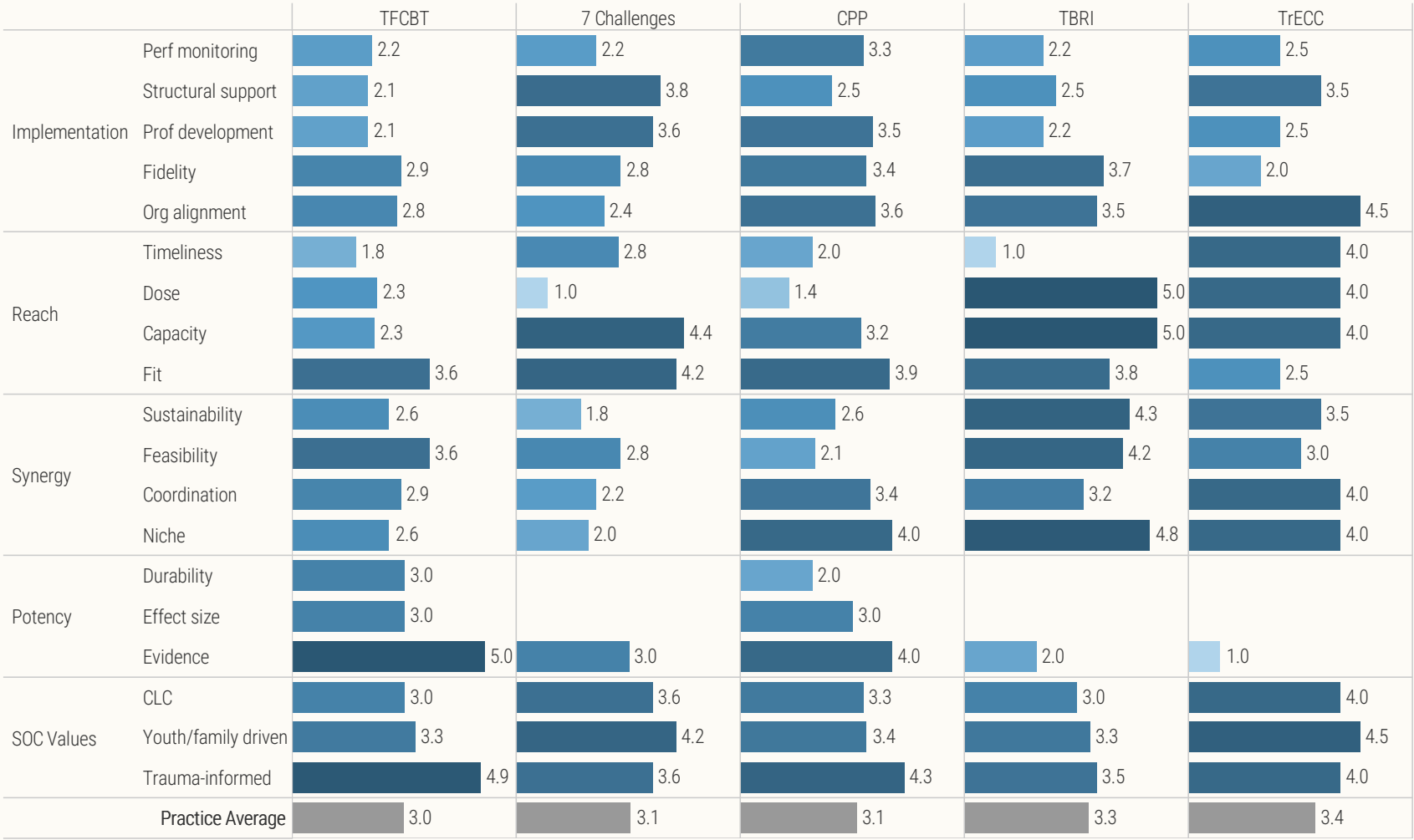
Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
	12. Performance monitoring Ongoing, frequent, rigorous, and comprehensive monitoring of demographics, service delivery, alliance/experience of care, fidelity, and outcomes; regular, structured use of data for data-based decision-making at case, practitioner, and practice levels; regular PDSA cycles to improve practice	1 No collection and use of data to inform and improve practice	2 A little collection and use of data to inform and improve practice	3 Some collection and use of data to inform and improve practice	4 Considerable collection and use of data to inform and improve practice	5 Comprehensive collection and systematic use of data to inform and improve practice	
	13. Fidelity The practice is delivered with integrity, faithful to the conceptual/guiding model and theory, as demonstrated by regularly monitored scores from a well-established fidelity tool	1 No fidelity (no model)	2 A little fidelity (fidelity < 25%)	3 Some fidelity (fidelity 35-49%)	4 Considerable fidelity (fidelity 51-74%)	5 Complete fidelity (fidelity >=75%)	
Potency	**14. Level of evidence** Sufficient evidence (peer-reviewed studies) to meet evidence-based practice standards (at least two independent, randomized controlled trials)	1 No evidence, evidence fails to support, or negative evidence "Not supported by evidence"	2 Empirical rationale, 2+ uncontrolled (e.g., pre-post, observational) studies or evaluations "Evidence-informed"	3 At least one quasi-experimental study with comparison group "Promising research evidence"	4 At least one randomized controlled trial "Supported by research evidence"	5 At least two independent, randomized controlled trials "Well-supported by research evidence"	
	15. Effect size The practice, when implemented with fidelity in research environments, demonstrates a large effect size relative to treatment as usual	1 No effect (d<.21)	2 Small effect (.22-.49)	3 Medium effect (d =.51-.79)	4 Large effect (d=.81-1.19)	5 Very large effect (d>1.21)	Not able to rate (no relevant research)

Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
	16. Durability/maintenance of gains The practice, when implemented with fidelity in research environments, shows strong durability/maintenance of gains at least one-year post-treatment	1 No durability of gains for at least six months post-treatment	2 A little durability of gains for at least six months post-treatment	3 Some durability of gains for at least one-year post-treatment	4 Considerable durability of gains for at least one-year post-treatment	5 Complete durability of gains for at least one-year post-treatment	Not able to rate (no relevant research)
	17. Local effectiveness The practice -- as routinely implemented in their organizational environment -- achieves similar effects/outcomes as those demonstrated in rigorous research studies (i.e., local effectiveness = efficacy)	1 No effectiveness (<71% relative effectiveness)	2 A little effectiveness (72-79% relative effectiveness)	3 Some effectiveness (81-89% relative effectiveness)	4 Considerable effectiveness (91-99% relative effectiveness)	5 Complete effectiveness (111%+ relative effectiveness)	Not able to rate (no relevant data and/or benchmark)
Synergy	**18. Coordination** Substantial, bi-directional, and proactive communication & coordination with natural (e.g., friends and families) and professional supports (e.g., other providers, teachers)	1 No bidirectional, proactive coordination with natural & professional supports	2 A little bidirectional, proactive coordination with natural & professional supports	3 Some bidirectional, proactive coordination with natural & professional supports	4 Considerable bidirectional, proactive coordination with natural & professional supports	5 Complete bidirectional, proactive coordination with natural & professional supports	
	19. Sustainability The organization can sustain the practice for at least two more years; has (or will have) the financial, political, and human resources needed to continue to deliver the practice at least the current level of implementation	1 Not at all sustainable at current level of implementation for next two years	2 A little sustainable at current level of implementation for next two years	3 Somewhat sustainable at current level of implementation for next two years	4 Considerably sustainable at current level of implementation for next two years	5 Completely sustainable at current level of implementation for next two years	

Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
	20. Feasibility The practice is straightforward and simple to deliver with fidelity: low in complexity, low costs/overhead to operate, no special skills, easy-to-meet expectations re: youth/family participation, etc.	1 Not feasible - practice is very complex & resource intensive; high fidelity implementation unattainable	2 A little feasible - practice is complex and fairly resource intensive; high fidelity implementation unlikely	3 Somewhat feasible - practice is moderately complex and resource intensive; high fidelity implementation a stretch	4 Considerably feasible - Practice is simple, not that resource intensive; high fidelity implementation within reach	5 Completely feasible - Practice is simple, can be implemented with resources already on hand; high fidelity implementation within easy reach	
	21. Ecological niche The practice fills a unique AND important niche or gap in the overall array of services/system of care environment; does not substantially overlap with other practices	1 No niche -- no need/complete overlap with at least one other intervention	2 Small niche - little need/considerable overlap with at least one other intervention	3 Moderate niche - some need/overlap with at least one other intervention	4 Considerable niche - considerable need/minimal overlap with any other intervention	5 Complete niche - large need/no overlap with any other intervention	

Appendix B: Domain- and item-level practice profiles

Average SOCAT item scores by domain and practice



Appendix C: Practice-item-site crosstabs

CPP: SOCAT item scores by domain and CMHC site

		CP	LRMHC	NHS	MHCGM	GNMHC	MFS	SMHC	WCBH	RCMHC	Item Average
Reach	Timeliness	1	2	1	1	1	1	1	4	1	1.4
	Dose	1	1	1	2					4	1.8
	Capacity	1	1	4	4	5	5	4	5	5	3.8
	Fit	4	3	4	4	4	5	4	4	4	4.0
Potency	Durability	2	2	2	2	2	2	2	2	2	2.0
	Effect size	3	3	3	3	3	3	3	3	3	3.0
	Evidence	4	4	4	4	4	4	4	4	4	4.0
Synergy	Feasibility	2	2	3	3	2	3	2	2	2	2.3
	Sustainability	2	2	3	3	3	3	4	3	3	2.9
	Coordination	3	2	4	4	3	3	4	4	3	3.3
	Niche	4	4	4	4	4	4	4	4	4	4.0
Implementation	Structural support	3	3	3	4	3	3	3	3	3	3.1
	Perf monitoring	2	4	3	4	3	3	3	4	4	3.3
	Fidelity	3	2	4	4	4	4	4	3	4	3.6
	Org alignment	2	3	4	3	4	4	4	4	4	3.6
	Prof development	2	2	4	4	4	4	4	3	5	3.6
SOC Values	CLC	4	4	3	3	4	4	4	3	4	3.7
	Youth/family driven	4	4	4	3	3	4	5	4	4	3.9
	Trauma-informed	5	5	5	5	5	5	5	5	5	5.0
	Site Average	2.7	2.8	3.3	3.4	3.4	3.6	3.6	3.6	3.6	3.3

CPP: SOCAT item scores by domain and ISO/HBT site

		ISN	Waypoint	Home Base	Easter Seals	NEFS	Item Average
Reach	Dose	1	1	1	1	1	1.0
	Capacity	1	2	2	4	2	2.2
	Timeliness	4		3		4	3.7
	Fit	3	4	4	4	4	3.8
SOC Values	Youth/family driven	2	2	3	2	3	2.4
	CLC	3	2	3	2	3	2.6
	Trauma-informed	3	3	3	3	3	3.0
Synergy	Feasibility	1	1	2	3	1	1.6
	Sustainability	2	2	2	2	2	2.0
	Coordination	4	4	4	2	4	3.6
	Niche	4	4	4	4	4	4.0
Implementation	Structural support	1	1	1	2	2	1.4
	Fidelity	3	2	3	3	4	3.0
	Perf monitoring	3	2	4	4	3	3.2
	Prof development	1	4	3	4	5	3.4
	Org alignment	2	4	4	4	4	3.6
Potency	Durability	2	2	2	2	2	2.0
	Effect size	3	3	3	3	3	3.0
	Evidence	4	4	4	4	4	4.0
	Site Average	2.5	2.6	2.9	2.9	3.1	2.8

7C: SOCAT item scores by domain and site

		LRMHC	Live Free Recovery	MHCGM	SMHC	GNMHC	Item Average
Synergy	Sustainability	1	1	2	2	3	1.8
	Niche	1	1	2	2	4	2.0
	Coordination	1	3	2	2	3	2.2
	Feasibility	3	1	3	3	4	2.8
Implementation	Perf monitoring	2	3	2	2	2	2.2
	Org alignment	1	1	3	3	4	2.4
	Fidelity	2	3	3	3	3	2.8
	Prof development	1	4	4	4	5	3.6
	Structural support	4	4	4	3	4	3.8
Potency	Durability						
	Effect size						
	Evidence	3	3	3	3	3	3.0
Reach	Dose		1				1.0
	Timeliness	2	5	3		1	2.8
	Fit	4	4	4	5	4	4.2
	Capacity	3	4	5	5	5	4.4
SOC Values	CLC	4	4	4	4	2	3.6
	Trauma-informed	4	3	3	4	4	3.6
	Youth/family driven	4	4	4	4	5	4.2
	Site Average	2.5	2.9	3.2	3.3	3.5	3.1

TrECC: SOCAT item scores by domain and site

		CFNH	NFI	Item Average
Potency	Durability			
	Effect size			
	Evidence	1	1	1.0
Implementation	Fidelity	2	2	2.0
	Perf monitoring	3	2	2.5
	Prof development	2	3	2.5
	Structural support	3	4	3.5
	Org alignment	4	5	4.5
Reach	Fit	2	3	2.5
	Capacity	4	4	4.0
	Dose	4	4	4.0
	Timeliness	4	4	4.0
Synergy	Feasibility	3	3	3.0
	Sustainability	3	4	3.5
	Coordination	4	4	4.0
	Niche	4	4	4.0
SOC Values	CLC	4	4	4.0
	Trauma-informed	4	4	4.0
	Youth/family driven	4	5	4.5
	Site Average	3.2	3.5	3.4

TFCBT: SOCAT item scores by domain and site

		LRMHC	Waypoint	NHS	CP	MFS	CLM	GNMHC	WCBH	RCMHC	SMHC	MHCGM	Item Avera..
Implementation	Prof development	1	2	1	1	1	1	3	1	4	4	4	2.1
	Structural support	1	2	1	2	2	2	2	3	2	4	2	2.1
	Perf monitoring	2	2	2	2	2	2	2	3	2	2	3	2.2
	Org alignment	2	3	2	2	2	2	3	3	3	4	5	2.8
	Fidelity	2	2	2	3	2	3	3	3	4	4	4	2.9
Reach	Timeliness	2		1	1	1	5	1	4	1	1	1	1.8
	Capacity	1	1	2	2	2	2	3	2	2	4	4	2.3
	Dose		1	1						5			2.3
	Fit	4	3	3	4	4	4	3	4	3	4	4	3.6
Synergy	Niche	2	2	3	2	3	2	4	2	3	3	3	2.6
	Sustainability	2	3	2	2	2	2	2	3	3	4	4	2.6
	Coordination	2	4	4	2	2	3	3	3	3	2	4	2.9
	Feasibility	3	2	4	4	4	4	4	3	4	4	4	3.6
Potency	Durability	3	3	3	3	3	3	3	3	3	3	3	3.0
	Effect size	3	3	3	3	3	3	3	3	3	3	3	3.0
	Evidence	5	5	5	5	5	5	5	5	5	5	5	5.0
SOC Values	CLC	3	2	2	3	4	3	2	3	3	4	4	3.0
	Youth/family driven	3	2	3	4	4	3	3	4	3	3	4	3.3
	Trauma-informed	5	4	5	5	5	5	5	5	5	5	5	4.9
	Site Average	2.6	2.6	2.6	2.8	2.8	3.0	3.0	3.2	3.2	3.5	3.7	3.0

TBRI SOCAT item scores by domain and site

		Orion House	Chase Home	Pine Haven Boys Center	Dover Children's Home	Webster House	Spaulding	Item Average
Potency	Durability							
	Effect size							
	Evidence	2	2	2	2	2	2	2.0
Implementation	Perf monitoring	2	1	1	3	4	2	2.2
	Prof development	2	1	3	2	2	3	2.2
	Structural support	2	1	3	3	3	3	2.5
	Org alignment	2	3	4	4	3	5	3.5
	Fidelity	3	3	4	4	4	4	3.7
SOC Values	CLC	3	3	2	3	4	3	3.0
	Youth/family driven	3	4	2	4	4	3	3.3
	Trauma-informed	3	4	3	4	3	4	3.5
Reach	Timeliness	1	1	1	1	1	1	1.0
	Fit	3	5	4	3	4	4	3.8
	Capacity	5	5	5	5	5	5	5.0
	Dose	5				5	5	5.0
Synergy	Coordination	4	3	3	3	3	3	3.2
	Feasibility	4	4	4	5	4	4	4.2
	Sustainability	3	5	5	4	4	5	4.3
	Niche	5	5	5	4	5	5	4.8
	Site Average	3.1	3.1	3.2	3.4	3.5	3.6	3.3

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