System of Care Assessment

2021 Children's Behavioral Health SOC Assessment

Behavioral Health Improvement Institute
Keene State College

On behalf of the Children's Behavioral Health Resource Center

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Executive Summary

The "evidence-based practice" effect

Evidence-based practices (EBPs) are more effective than "services as usual" for children with behavioral health conditions and their families *when implemented to very high standards*. High-quality implementation of EBPs requires additional time, effort, and resources at practitioner, agency, and state levels. The Children's Behavioral Health Resource Center (CBHRC) is contracted by DHHS to support and grow the use and quality of EBPs in NH.

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

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 the inaugural SOC assessment, CBHRC evaluated the delivery of five EBPs by NH's ten Community Mental Health Centers and two Care Management Entities during calendar year 2021 (a total of 29 practice-agency combinations). Together, these practices provide a solid foundation for a coherent, coordinated, and effective children's System of Care.

EBPs Assessed
Wraparound
NAVIGATE/Coordinated Specialty Care
Dialectical Behavior Therapy for Adolescents
Modular Approach Modular Approach to Therapy for Children
Rehabilitation, Empowerment, Natural supports, Education, and Work

Unbillable costs of EBPs leads to trade-offs

The SOC Assessment found that these practices were generally well-supported by research; delivered in a way that was sensitive to youth and family's preferences, cultures, and trauma histories; and occupied a sensible niche in the overall service array. The SOC Assessment also found that workforce shortages, staff turnover, and (especially) non-reimbursable costs limited the availability and/or quality of most of these EBPs. Because they were not delivered to enough children and youth, in the right amount, and/or to a high-enough standard, it is unlikely that they achieved population-level impact. It was especially hard for agencies in rural areas – with smaller staff, bigger catchment areas, and more dispersed populations – to deliver and sustain high-quality EBPs.

> When the costs of implementing EBPs to high standards are not reimbursed, it limits the quantity and/or quality of implementation.

Taking high-quality EBPs to scale in NH's SOC

A prominent exception to this rule was Wraparound (and to a lesser extent, NAVIGATE), which profits from ongoing state support and oversight, pooling of resources, and sufficient funding to support the drivers of high-quality implementation – including ongoing collaboration and infrastructure development, training and coaching, planning and documentation, and performance monitoring and evaluation. This NH SOC bright spot points the way forward for access to high-quality EBPs for all NH children and families that need them.

> We must provide state support and oversight, pool resources, and sustainably reimburse the full cost of high-quality implementation to take children's EBPs to scale in NH

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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 promote the use of, and provide information and training on, evidence-based practices within the Children's Behavioral Health System of Care (SOC). 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 is 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, 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 was required to conduct a "system assessment" within the first ten months of its existence. The purpose of the system assessment is to evaluate 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 inaugural SOC assessment due to their import for the overall service array. Two are wraparound care coordination/planning models: 1) Rehabilitation, Empowerment, Natural supports, Education, and Work (RENEW) and 2) Wraparound (aka FAST Forward, NH Wraparound). Three are clinical treatment models: Dialectical Behavior Therapy for Adolescents (DBT-A), Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH), and NAVIGATE for first-episode psychosis. See below for descriptions of each practice.

Practice descriptions

Practice	Population	Description	Key Components
RENEW[1,2,3]	Transition-aged (16-22) youth with severe emotional disturbance at risk for poor educational and/or occupational outcomes.	A structured school-to-career transition planning process for youth who need help adjusting to transitions; engaging in school, work, and community activities; creating positive interactions with peers and mentors in the community; and finishing their education and/or finding meaningful employment.	Four principles: self-determination, competency-based service, unconditional care, and natural supports and community inclusion. Eight strategies: personal futures planning, alternative education options, school-to career options, naturally supported employment, individually developed teams, mentoring, and sustaining community connections.
DBT-A[4,5]	13-18 year-old chronically suicidal youth with behaviors found in borderline personality disorder (BPD).	DBT-A is an adaptation of a cognitive-behavioral treatment model originally developed to treat chronically suicidal adults diagnosed with borderline personality disorder. The five skills modules include two sets of acceptance-oriented skills (mindfulness and distress tolerance), two sets of change-oriented skills (emotion regulation and interpersonal effectiveness), and one particularly developed for adolescents (walking the middle path).	A skills training group enhances clients' capabilities by teaching them behavioral skills in a class-type setting, using homework to generalize to clients' everyday lives. Groups meet weekly for approximately 2.5 hours for 24 weeks. Once-per week individual therapy, concurrent with the skills group, enhances motivation and help clients apply the skills to their lives. Phone coaching provides in-the-moment coaching on how to use skills to effectively cope with difficult situations. A weekly therapist consultation team supports DBT provider motivation and competence.

Practice	Population	Description	Key Components
MATCH[6,7,8]	Children and adolescents between the ages of 5 and 15 with anxiety, depression, conduct problems, and/or traumatic stress and their caregivers.	Organizes 33 cognitive-behavioral procedures into a single, flexible system to meet a child's needs while fostering individualization to address comorbidity or therapeutic roadblocks. Provides step-by-step instructions, activities, scripts, time-saving tips, monitoring forms, and handouts and worksheets for individual sessions with children/caregivers.	Modules are organized according to expert-driven flowcharts. Providers administer an indicated subset of modules in an individualized format. Caregivers are encouraged to understand and support their child's application of skills. An online platform (TRAC) is used to monitor treatment response and adjust accordingly.
NAVIGATE[9,10]	Adolescents and young adults experiencing first episode psychosis	A team-based, multicomponent treatment implemented in routine mental health treatment settings, aimed at guiding people with a first episode of psychosis (and their families) toward psychological and functional health.	Core services include the family education program (FEP), individual resiliency training (IRT), supported employment and education (SEE), and individualized medication treatment. NAVIGATE embraces a shared decision-making approach with a focus on strengths, resiliency, and collaboration with clients and their families.
Wraparound/FAST Forward[11,12,13]	Children and youth ages 4-17 with severe emotional disturbance, at risk for out-of-home placement, and involved in multiple child and family-serving systems – and their families.	Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build, monitor, implement, and adjust a creative plan of care that responds to child and family underlying needs.	Wraparound should be individualized, family driven, culturally competent and community-based. Wraparound seeks to strengthen interpersonal relationships and utilize other sources of natural support. Wraparound should be strengths-based, helping the child and family recognize, utilize, and build talents, assets, and positive capacities. Youth- and family-peer supports are an integral part of the NH wraparound.

Sites

The foregoing practices are implemented through NH's community-based mental health system, consisting of ten Community Mental Health Centers (CMHCs) and two Care Management Entities (CME's).

Community Mental Health Centers (CMHCs)

NH's Community Mental Health Centers (CMHCs) serve individuals in our state who are living with – and recovering from – mental illness and emotional disorders. The NH CMHC network provides a comprehensive set of ongoing and emergency community-based behavioral health services to all New Hampshire residents, including psychiatric services; individual, group, and family counseling and therapy; case management, and more. The 10 NH CMHCs are: Northern Human Services (NHS), West Central Behavioral Health (WCBH), Lakes Region Mental Health Center (LRMHC), Riverbend Community Mental Health (RCMH), Monadnock Family Services (MFS), Greater Nashua Mental Health (GNMH), Mental Health Center of Greater Manchester (MHCGM), Seacoast Mental Health Center (SMHC), Community Partners (CP), and Center for Life Management (CLM). See next page for a map of the mental health center regions in New Hampshire.

New Hampshire Mental Health Regions

Prepared For:
State of New Hampshire
Department of
Health and Human Services

NH Mental Health Regions

- 1 Northern Human Services
- 2 West Central Behavioral Health
- 3 Lakes Region Mental Heatlh Center
- 4 Riverbend Community Mental Health
- 5 Monadnock Family Services
- 6 Greater Nashua Mental Health
- 7 Mental Health Center of Greater Manchester
- 8 Seacoast Mental Health Center
- 9 Community Partners
- 10 Center For Life Management

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Belknap
1 - Center Harbor

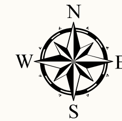
Carroll
2 - Hales Location
3 - Harts Location

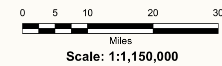
Coos
4 - Hadleys Purchase
5 - Beans Grant
6 - Cutts Grant
7 - Sargents Purchase
8 - Pinkhams Grant
9 - Crawfords Purchase
10 - Chandlers Purchase
11 - Low & Burbanks Grant
12 - Thompson & Meserves Purchase
13 - Greens Grant
14 - Martins Location
15 - Ervings Grant
16 - Wentworth Location
17 - Atkinson & Gilmanton Academy Grant

Hillsborough
18 - Bennington

Rockingham
19 - South Hampton
20 - Seabrook
21 - East Kingston
22 - Kensington
23 - Hampton Falls
24 - Hampton
25 - North Hampton
26 - Rye
27 - Portsmouth
28 - New Castle
29 - Newington

Strafford
30 - Rollinsford
31 - Somersworth





Scale: 1:1,150,000

Prepared by:
NH Department of Safety
Division of Emergency Services
Mapping Section

Care Management Entities (CMEs)

In January 2017, NFI North, Inc. (NFI), a subsidiary of North American Family Institute, Inc., assumed FAST Forward operations as NH's first Care Management Entity. In October 2020, Connected Families NH, a County of Cheshire program, became the state's second CME. The CMEs administrate, staff, and implement FAST Forward and other care coordination models for children, youth, and families across NH. CFNH covers mental health regions 1 and 2 and very thin slice of the western portion of region 4. NFI covers the rest of the state. BCBH provides intake and eligibility determination for FAST Forward as well as oversight of both CMEs, including an annual site review.

Practice by site

RENEW, MATCH, DBT-A, and NAVIGATE are implemented by CMHCs, whereas FAST Forward is implemented by CMEs. See the table below for a break-down of practices offered by site during calendar year 2021.

Practices by site

Practices	CMHCs										CMEs	
	CLM	CP	GNMHC	LRMHC	MFS	MHCGM	NHS	RCMHC	SMHC	WCBH	CFNH	NFI
RENEW	x	x	x			x		x	x			
MATCH	x	x	x	x	x	x	x	x	x	x		
DBT-A	x	x	x		x	x	x	x	x			
NAVIGATE	x		x		x							
FAST Forward											x	x

System assessment tool and data sources

System of Care Assessment Tool (SOCAT)

BHII developed the System of Care Assessment Tool[14] (SOCAT) with inspiration from Glasgow's RE-AIM model for measuring the impact of public health interventions,[15] BHII's related work in this area,[16] 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/understanding. Overall, the SOCAT trades comparability and breadth for depth and specificity, and the resulting findings should thus be viewed as a crude yet hopefully useful approximation of reality.

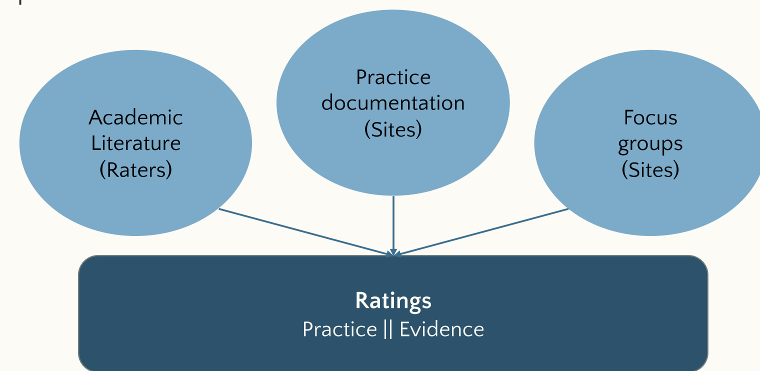
The SOCAT includes 21 items rated against a gold standard on a five-point scale ranging from 1 (not at all) to 5 (completely). The items are organized into five domains: SOC Values, Reach, Implementation, Potency, and Synergy. SOC Values assesses the degree to which community-based practices are implemented 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 and 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 system assessment looks at how the five practice models of interest were implemented during calendar 2021.

Data sources

The SOCAT leverages multiple data sources: academic literature, practice documentation, and focus groups. The latter two required cooperation from the sites, who conscientiously and good naturedly did their best to comply with the requirements of the SOC assessment with little advance warning, submitting the data and documentation they had on hand while releasing staff from potential billable hours to participate in the focus groups for each practice-site combination.



Academic literature

A review of the academic and grey 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.

Practice documentation

Practice documentation and data submitted by quality assurance/evaluation staff was reviewed for each site/practice combination. Despite the short notice, we received documentation from every site/practice combination, thanks the hard work and dedication of these staff. 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. Given the short notice and limited data infrastructure, the amount and quality of data varied by site-practice combination.

Focus groups

Focus groups were conducted for each practice/site combination to get an on-the-ground perspective from those administrating, supervising, coaching, and delivering the practice. This information was used to supplement the site data and documentation and to serve as the primary basis for rating several items in the SOC Values, Implementation, and Synergy domains. We conducted a total of 29 focus groups – 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	Lit review	Site data	Focus groups
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
	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
	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
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	
	6. Timeliness. Practice is able to 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	

Domains/Items		Data Sources		
Domain	Item	Lit review	Site data	Focus groups
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.			X
	10. Organizational alignment & support. Culture is explicitly supportive of the practice; leaderships 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
	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		X	X
	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
	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
	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
	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 RENEW and FAST Forward practice/site combinations (N=8); Dr. Fauth rated DBT-A, MATCH, and NAVIGATE (N=21). This included conducting the academic literature review, reviewing the practice documentation, facilitating the focus groups, and ultimately rating each practice/site combination using the SOCAT. Drs. Haber and Fauth met at least monthly and communicated frequently via email to refine the SOCAT, develop and maintain integrity to the process, and to review and calibrate their ratings.

Descriptive Data

The table below reflects data submitted for each site-practice combination, including the site type (CMHC or CME), the implementation start date (Start), where the practice is offered (Locations), the unduplicated count of youth/families served (Served), the average wait time from referral to first service (Wait), the percentage of youth that received a therapeutic dose (Dose), the number of staff who delivered (Staff) and were certified (Certified) in the practice, the percent fidelity score (Fidelity), data types collected (Data), and cost to revenue ratio (Cost). "Not known" means the site was not able to provide the requested data.

The practice with the longest history is DBT-A, followed by RENEW, MATCH, FAST Forward, and NAVIGATE. Most of the clinical services (MATCH, DBT-A, NAVIGATE) are clinic-based, whereas the care coordination practices are offered in home and community settings. Most practices were delivered to a relatively small number of youth, with a few notable exceptions: RENEW at SMHC (50); DBT-A at RCMH (81); MATCH at SMHC (363), LRMH (148), and CP (119); and FAST Forward at NFI (206). Youth and families generally had to wait at least 30 days from referral to first service for most practices except NAVIGATE and all practices offered at CLM, whose unique intake system enabled them to initiate services more quickly (within about 8-14 days). Other than FAST Forward, only a small percentage of youth received a therapeutic dose, although dose data were often unavailable. The number of staff delivering these practices ranged from 1 (RENEW at CLM) to 46 (FAST Forward at NFI); the number of certified staff ranged from 0 to 29. The only practice for which fidelity and cost to revenue estimates were available was FAST Forward.

The most data-rich practices were FAST Forward and to a lesser extent MATCH, for the few sites still actively using the TRAC data system. Otherwise, basic information about the number of youth served, wait time, and especially fidelity and costs was lacking. Greater lead time and technical assistance will hopefully yield richer site data in future years.

Descriptive data for each practice by site

Site	Type	Start	Locations	Served	Wait	Dose	Staff	Certified	Fidelity	Data	Cost
RENEW											
CLM	CMHC	6/1/2012	Salem, Derry	not known	8-14 days	not known	1	1	not known	not known	not known
CP	CMHC	10/1/2010	Home, community	36	29+ days	0-19%	6	1	not known	not known	not known
GNMHC	CMHC	1/1/2014	Home, community	not known	29+ days	not known	3	8	not known	not known	not known
MHCGM	CMHC	6/30/2010	Manchester	18	0-7 days	not known	9	4	not known	Demographics; Outcomes	not known
RCMH	CMHC	7/1/2018	Concord, Franklin	10	29+ days	not known	7	12	not known	not known	not known
SMHC	CMHC	10/1/2010	Home, community	50	29+ days	not known	15	1	not known	Demographics; Services; Outcomes	not known

Site	Type	Start	Locations	Served	Wait	Dose	Staff	Certified	Fidelity	Data	Cost
DBT-A											
CLM	CMHC	6/1/2017	Derry, Salem	5	8-14 days	not known	4	0	not known	not known	not known
CP	CMHC	9/1/2021	Dover, Rochester	16	22-28 days	0-19%	18	0	not known	not known	not known
GNMHC	CMHC	1/1/1998	Nashua (2 locations)	24	29+ days	not known	16	0	not known	not known	not known
MHCGM	CMHC	1/1/1997	Manchester	not known	29+ days	not known	9	9	not known	not known	not known
MFS	CMHC	not known	Keene, Peterborough	24	8-14 days	not known	3	3	not known	not known	not known
NHS	CMHC	1/15/2011	Colebrook-Groveton, Berlin, Littleton, Conway, Wolfeboro	not known	29+ days	not known	21	2	not known	not known	not known
RCMH	CMHC	1/1/2000	Concord	81	29+ days	not known	11	2	not known	Outcomes	not known
SMHC	CMHC	1/1/2004	Portsmouth, Exeter, Telehealth	not known	15-21 days	not known	6	6	not known	not known	not known
MATCH											
CLM	CMHC	6/1/2014	Salem, Derry	not known	8-14 days	not known	15	5	not known	Services; Outcomes	not known
CP	CMHC	6/1/2018	Dover, Rochester	119	29+ days	0-19%	14	5	not known	not known	not known
GNMHC	CMHC	6/1/2018	Nashua (2 locations)	52	15-21 days	not known	12	0	not known	not known	not known
LRMHC	CMHC	1/1/2019	Laconia, Plymouth	148	29+ days	0-19%	10	10	not known	Services; Outcomes	not known
MHCGM	CMHC	7/1/2017	Manchester	89	21-28 days	not known	11	13	not known	Demographics; Services; Outcomes	not known
MFS	CMHC	not known	Keene, Peterborough	not known	15-21 days	not known	not known	not known	not known	not known	not known
NFI	CMHC	6/26/2017	Colebrook-Groveton, Berlin,	not known	29+ days	not known	8	1	not known	not known	not known

Site	Type	Start	Locations	Served	Wait	Dose	Staff	Certified	Fidelity	Data	Cost
			Littleton, Conway, Wolfeboro								
RCMH	CMHC	7/1/2018	Concord, Franklin	25	29+ days	40-59%	6	2	not known	Outcomes	not known
SMHC	CMHC	6/26/2017	Portsmouth, Exeter	363	29+ days	not known	21	21	not known	Outcomes	not known
WCBH	CMHC	1/14/2021	Newport, Claremont, Lebanon	not known	29+ days	not known	15	8	not known	not known	not known
NAVIGATE											
GNMHC	CMHC	1/1/2016	Nashua, home-based support	56	not known	not known	6	0	not known	Demographics; Services; Experience of cares; Outcomes	not known
MFS	CMHC	7/1/2021	Keene, Peterborough	19	0-7 days	not known	2	2	not known	not known	not known
CLM	CMHC	8/1/2021	Derry, Salem	not known	0-7 days	not known	5	14	not known	not known	not known
FAST Forward											
CFNH	CME	10/1/2020	Home, community, telehealth	81	15-21 days	20-39%	17	4	59%	Demographics; Services; Alliance; Experience of care; Outcomes	Revenues slightly exceed costs
NFI	CME	1/1/2017	Home, community, telehealth	206	29+ days	40-59%	46	29	62%	Demographics; Services; Alliance; Experience of care; Outcomes	Revenues slightly exceed costs

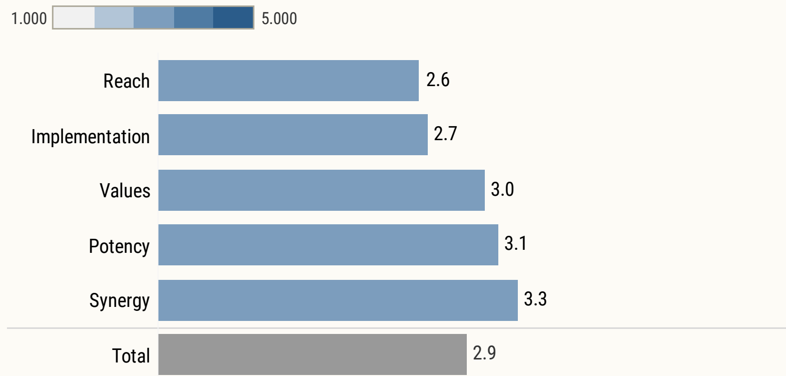
Note. CLM=Center for Life Management; CP=Community Partners; GNMHC=Greater Nashua Mental Health Center; LRMH=Lakes Region Mental Health; MHCGM=Mental Health Center of Greater Manchester; MFS=Monadnock Family Services; NHS=Northern Human Services; RCMH=Riverbend Community Mental Health; SMHC=Seacoast Mental Health Center; WCBH=West Central Behavioral Health

Domain- and item-level findings

This section provides domain and item-level results that cut across practices and sites. The local effectiveness and equitable items, for which we had no or very limited data, were excluded from these analyses.

Domain scores

The dashboard below displays average SOCAT domain scores, providing a high-level perspective of the strengths and weaknesses of these practices overall. The vertical dotted line represents the midpoint ("somewhat in place") of the SOCAT scale. The lowest-scoring domains were Reach (2.6) and Implementation (2.7). In general, the capacity to deliver these practices with fidelity to the populations who need them in a timely manner is limited; these are prime quality improvement targets moving forward. Values and Potency scores were slightly higher, just beyond the midpoint on the scale, suggesting a relatively strong foundation with considerable room for growth. The highest-scoring domain was Synergy – by and large, these practices fit sensibly within the overall service array and can be feasibly implemented with sufficient financing, human resources, and technical assistance.



Item scores

The domain-level scores mask considerable item-level variability, as revealed by the bar chart on page 19.

Reach

Reach item scores ranged widely, from 1.6 (Dose; the overall lowest-rated item) to 3.8 (Fit). These practices are generally delivered to the appropriate population, but only a very small percentage of children and youth who might profit them receive these practices in timely fashion, if at all. And of those that do, very few experience a therapeutic dose.

Implementation

Implementation item scores were more uniform, ranging from 2.1 (Structural Support) to 3.1 (Organizational Support). The system-wide fiscal, financial, policy, and accountability environment was viewed as inhospitable to high-fidelity implementation across most (but not all) practice-site combinations. Home organizational environments were perceived as more supportive, keeping in mind that focus group participants may have been inclined to be supportive of their place of employment. Performance Monitoring – the collection and use of data to learn and improve at the case and practice levels – was a relatively low scoring item; not surprising given the sparse data and documentation submitted by sites. Even in relatively data-rich environments (e.g., CLM, FAST Forward programs), the information is rarely made available or used for case-level feedback or program-level quality improvement. Fidelity and professional development scored in between the other items, just below the midpoint of the scale. Because these two factors are

so closely intertwined, they tend to co-vary by practice-site combination.

Potency

Potency items ranged from 2.1 (Effect Size) to 4.1 (Level of Evidence, the highest-scoring item). Most of these practices have a substantial evidence base – their incremental advantage over services-as-usual when implemented with fidelity in relatively controlled research environments is quite reliable. The limited research on the post-treatment durability of this advantage is limited, but promising. The evidence also suggests, however, that the incremental benefit of these practices is modest, at best – as is the case with most children's evidence-based behavioral health practices. Still, when delivered with fidelity across a large-enough number of youth, the population-level benefit could be substantial.

SOC Values

Values items were relatively high, and less variable. Most of these practices emphasize youth/family collaboration and empowerment (especially RENEW and FAST Forward) and to a slightly lesser extent, trauma-informed principles. Further, many practice staff are so steeped in and committed to these values that they are able to compensate when explicit guidance from the practice model is lacking. Cultural and linguistic competence scored lower; most of the practice models were relatively silent on how to adapt the practice to the cultural and historical context of the client and practice staff seemed less knowledgeable and skilled in this facet of practice.

Synergy

Synergy items hovered around the mid-point of the scale, ranging from 2.9 (Feasibility) to 3.6 (Niche). Environmental factors were the main driver of feasibility, such as the organizational size, resources, and staff; the density and proximity of the client population; the number of trained and credentialed staff; and perhaps most importantly, the presence of expert, influential internal leaders and staff champion(s). The team-based, multi-component nature of several of the practices inherently increases degree-of-difficulty, especially for the high-risk populations they are designed to serve. On the other hand, most of these practices have well-developed toolkits and structured protocols that aid in teaching, learning, and applying the skills. Sustainability – defined as the ability to maintain the practice at the *current* (not necessarily high-fidelity) level – was a bit above the mid-point. The greatest threats to sustainability were retaining a sufficient number of trained and credentialed staff in the face of high turnover, along with the unbillable aspects of these practices. Sustainability assets included the resolve and commitment of the agency and providers to the practice. Proactive and bidirectional collateral contact comes with the territory and some practices (e.g., MATCH) provide useful handouts and other facilitative materials, so communication and coordination with natural (family, friends) and professional (schools, healthcare, other child-serving systems) supports was generally robust. Niche was the highest-rated Synergy item; these practices all targeted relatively unique populations and/or outcomes.

Average scores by domain and item

1.000 5.000

Domain	Item	Score
Reach	Dose	1.6
	Timeliness	2.1
	Capacity	2.4
	Fit	3.8
Implementation	Structural support	2.1
	Perf. monitoring	2.6
	Fidelity	2.9
	Prof. development	2.9
	Org support	3.1
Values	CLC	2.6
	Trauma-informed	3.2
	Family & youth driven	3.4
Potency	Effect size	2.1
	Durability	3.1
	Level of evidence	4.1
Synergy	Feasibility	2.9
	Sustainability	3.2
	Coordinated	3.4
	Niche	3.6

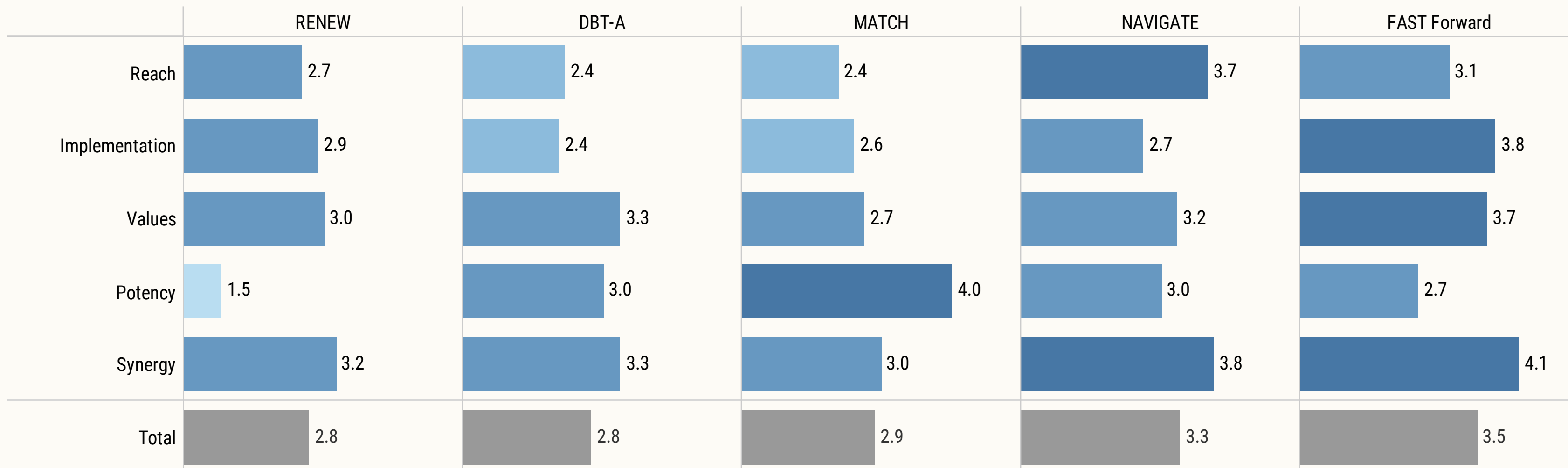
Domain scores by practice, statewide

This section examines domain score variation by practice, statewide. 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. Scanning down columns identifies the relative strengths and weaknesses of each practice. For item-level scores by practice, statewide, see Appendix B.

RENEW, DBT-A, and MATCH had moderately low scores, ranging from 2.8-2.9, but arrived there by different means. RENEW's relatively low score was driven by low Potency ratings against a backdrop of otherwise moderate scores. For DBT-A, it was a consequence of relatively low REACH and Implementation scores paired with middling to moderately high Potency, Values, and Synergy scores. MATCH's low to moderate scores across most domains was counteracted by very high Potency scores, resulting in a middle-of the pack overall score. The overall score of NAVIGATE – the most recent addition to NH's public mental health service array – was a little higher, just above the midpoint on the scale, with domain scores ranging from 2.7 (Implementation) to 3.7 (Reach). This pattern makes sense for a newly-implemented, specialized model for a small target population. The highest-rated practice overall was FAST Forward, which made up for relatively low Potency and middling Reach scores with moderately high Implementation, Values, and Synergy scores.

Average·scores·by·domain·and·practice

1.000 5.000



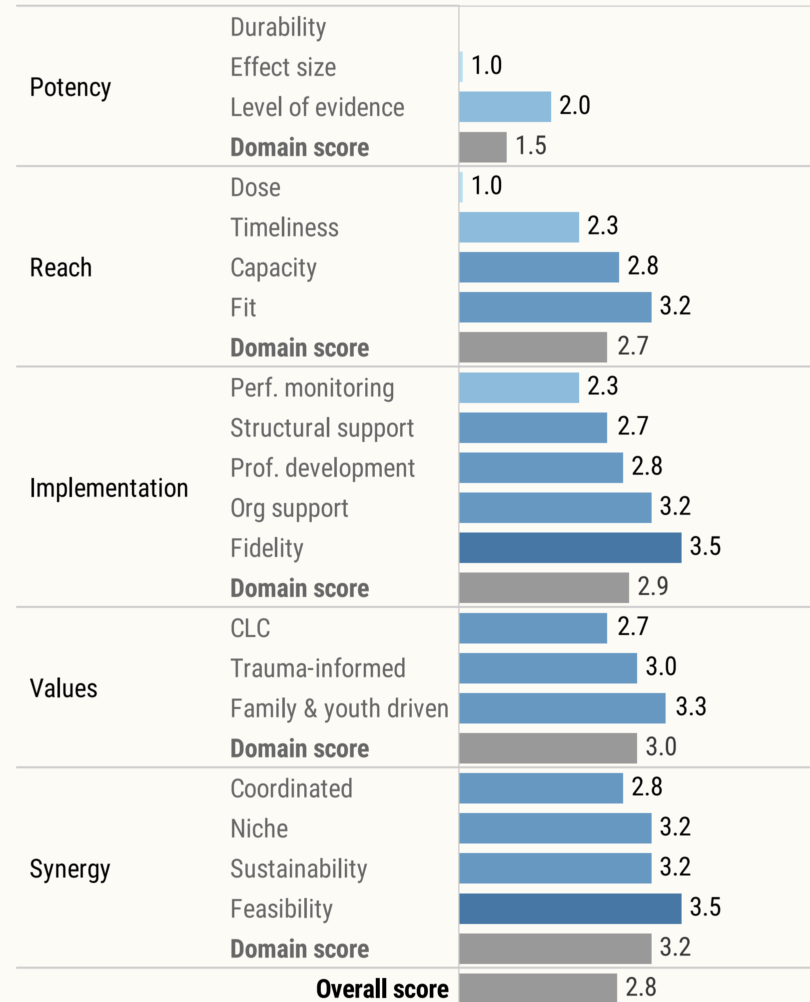
RENEW profile

This section provides more detail on RENEW implementation, first by item, then by site. For the RENEW item by site crosstab, see Appendix C.

Item profile

The chart at right displays the average score per item by domain for RENEW. RENEW's low **Potency** score was driven by the lack of rigorous research on the model. The results of the only RENEW trial of which we are aware were null, most likely due to poor implementation in the school-based settings in which it was tested,[17] and the results of uncontrolled studies[18,19,20] generally showed a small effect. We were unable to score the Durability item due to lack of long-term follow-up studies. **Reach** scores indicate that RENEW is generally provided to appropriate youth, as evidenced by the Fit item. Capacity and Timeliness are less robust, as was the case for most practices. The low Dose score is based on data from only one site, so should be taken with caution, although multiple sites discussed difficulty engaging youth and teams in completing the RENEW process. **Implementation** item scores were evenly dispersed between a low of 2.3 for Performance Monitoring to 3.5 for Fidelity. The latter was the second-highest fidelity rating – practice staff generally find the RENEW protocol enjoyable and relatively easy to implement, despite some difficulty in moving from mapping and graphic facilitation into teaming and planning. The **Values** domain received a moderate rating, with scores ranging from 2.7 (CLC) to 3.3 (Family and Youth driven). RENEW's primary focus on youth voice and choice can sometimes lead to less family involvement. **Synergy** was the strongest RENEW domain, ranging from 2.8 (Coordinated) to 3.5 (Feasibility), reflecting the unique role of RENEW as a coordinating and planning practice for educational and occupational outcomes for high-risk transition-aged youth.

RENEW: Average scores by domain and item



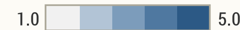
Site profile

The highlight table below displays the average domain score for RENEW, by site. 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 practice, so will always be invariant across sites.

Scores across RENEW sites were highly variable. Although all agencies were supportive of the practice in principle and thought it to be valuable, some RENEW programs were less established or "rebuilding," and administrators and staff for these programs struggled to access necessary resources to support required training and performance monitoring. Much of this variability appeared to be tied to the size of the RENEW program staff and whether programs had established internal coaching. Variation in the Fit item mostly stemmed from the degree to which programs were selectively serving youth within the recommended age range, with some programs delivering RENEW to youth as young as 13 or 14 or, in one case, to adults in supported employment services.

The RENEW site-practice combinations can be classified into three "clusters." Three sites – MHCGM, SMHC, and RCMH – were able to serve larger proportions of their referred youth, had the highest levels of perceived Organizational Support, and achieved the highest levels of Fidelity and Sustainability. Two sites – GNMHC and CLM – face structural challenges as evidenced by lower Organizational Support and Structural Support scores. These sites have struggled to retain a sufficiently sized RENEW staff team at the current rate of training in light of high staff turnover. The small number of staff made distributing implementation responsibilities more difficult. These sites struggled to work with youth in schools and, partially due to this difficulty, convene the educationally and occupationally focused teams for youth that are a hallmark of RENEW. The final site – CP – also had a relatively small staff and at the time of the assessment lacked an internal coach; however, the staff member being groomed for the role was clearly sophisticated and enthusiastic about assuming these responsibilities, and staff participating in the group seemed somewhat more optimistic about building their team and less worried about limitations in state support for doing so. CP has longstanding, strong relationships with area schools, especially Somersworth High School, enabling the program to recruit youth and convene teams more easily.

RENEW: Average domain scores by site

1.0  5.0

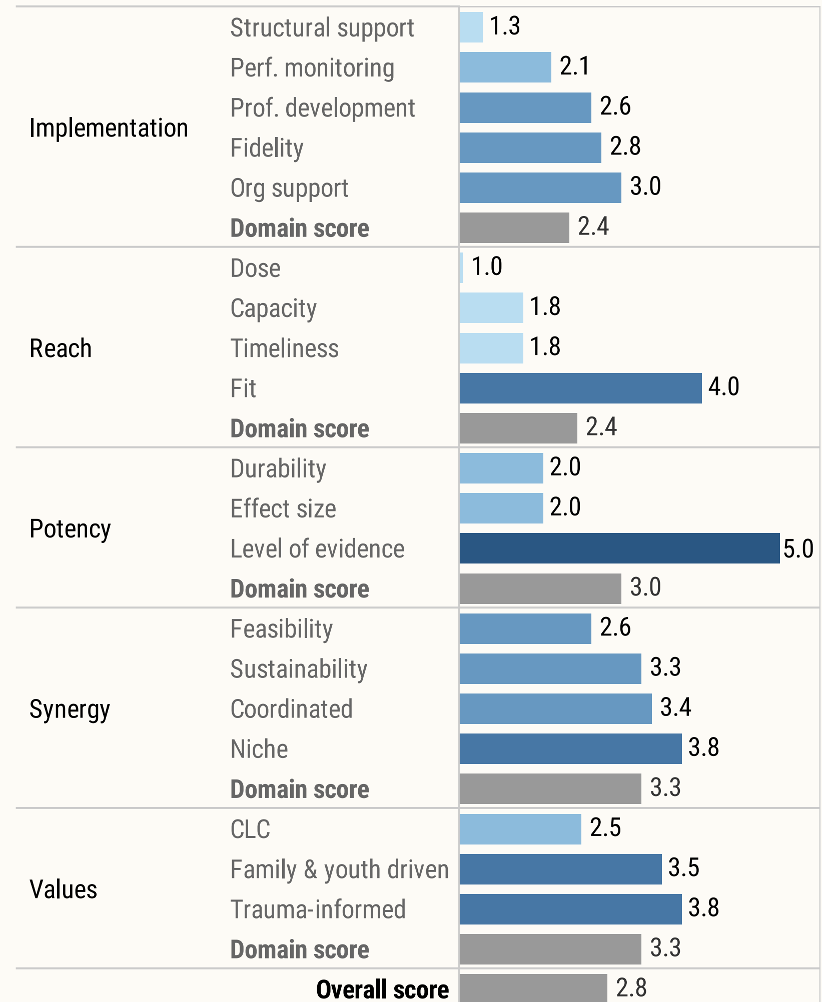
	CLM	GNMHC	CP	RCMH	SMHC	MHCGM	Total
Potency	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Reach	2.7	2.0	1.7	3.0	3.0	3.7	2.7
Implementation	2.4	2.4	2.8	3.4	3.2	3.2	2.9
Values	1.7	3.0	4.0	2.7	3.0	3.7	3.0
Synergy	2.8	2.8	3.0	3.3	4.0	3.3	3.2
Total	2.2	2.3	2.6	2.8	2.9	3.1	2.6

DBT-A profile

Item profile

The overall DBT-A score was hampered by low scores among some of the **Implementation** (e.g., Structural Support, Performance Monitoring) and **Reach** (Dose, Capacity, Timeliness) items. This was a partial consequence of limited state attention and resources devoted to the practice, in combination with the inherent complexities associated with a multi-component, team-based model of care for a high-risk, tough-to-treat population. The DBT-A skills group requires considerable unbillable time (e.g., co-facilitation and preparation for skills groups, inclusion of caregivers in skills group) to implement with fidelity. The DBT-A toolbox is also less robust than some of the other, more recently developed practices, which makes training and professional development effortful and challenging. Providing individual therapy and 24x7 availability for consultation from a trained DBT-A clinician for each youth participant proved infeasible across sites. In terms of **Potency**, the emergent evidence base for DBT-A is promising, especially for decreasing suicidal behavior and self-harm among high-risk adolescents, with the modest effect size and durability characteristics of many child EBPs.[21,22,23,24,25,26] Despite the aforementioned issues with feasibility, DBT-A **Synergy** scores were generally strong. This was in part driven by the perception that DBT-A is an excellent fit for the ever-increasing number of high-risk adolescents populating CMHC caseloads. The model is also well-accepted by many therapists, who appreciate the east-west philosophical blend of the approach. From a **Values** perspective, most staff felt it was relatively easy to infuse DBT-A with a youth- and family-driven, trauma-informed perspective, both of which were seen as particularly critical given the nature of the population. As with all of the practices, cultural and linguistic responsiveness was less robust.

DBT-A: Average scores by domain and item



Site profile

With one notable exception, scores were consistent across DBT-A sites, with seven of the eight scoring between 2.6 and 2.9 overall. These sites, especially those in rural areas, found it difficult to build sufficient internal training capacity given the underdeveloped DBT-A toolbox and struggled to recruit and retain sufficient numbers of adolescents to maintain ongoing, successful skills groups. Bright spots also abound across these sites, including 1) Community Partner's robust Synergy score, bolstered by strong internal care coordination for DBT-A patients and 2) Northern Human Service's and Greater Nashua's strong adherence to system of care values (e.g., tailoring skills group examples to the particular forms of trauma/invalidating environments of group members), and 3) the Implementation scores of MHCGM, MFS, GNMHC, and RCMH.

While in every case some adaptations or modifications of the model were necessary, achieving Implementation scores at this level against the aforementioned head winds is a noteworthy achievement. The heartbeat of these relatively successful DBT-A programs, without exception, was the presence of at least one dedicated, clinically and politically skilled DBT coordinator/trainer who went above and beyond the call of duty. That certainly was the case at RCMH, which has a remarkably robust DBT-A program. This program is led by a doctoral-level Clinical Psychologist expert DBT-A practitioner and trainer. Over time, she has developed what could probably qualify as a graduate-level curriculum in DBT-A. She is surrounded by a very strong and dedicated team that meets regularly, and an organization that supports the release time necessary for her to design and to run the program and keep up to date with new developments in the field.

DBT-A: Average domain scores by site

1.0 – 5.0

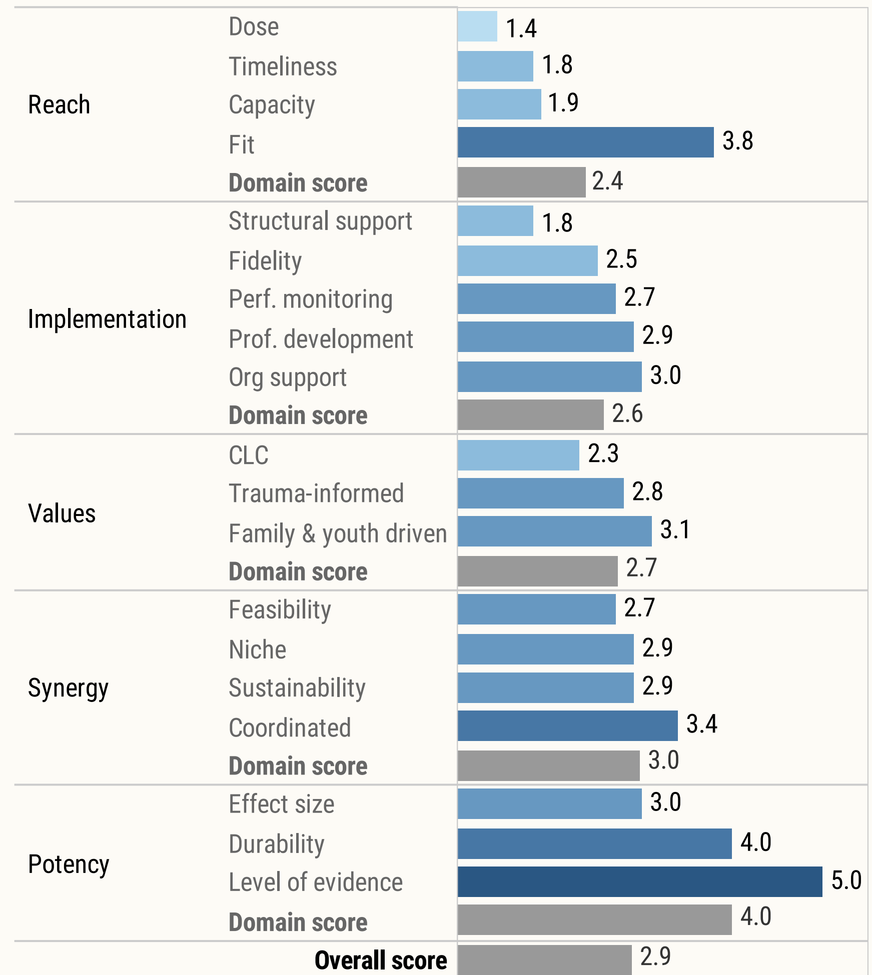
	CP	CLM	SMHC	NHS	MHCGM	MFS	GNMHC	RCMH	Total
Implementation	1.8	1.8	1.8	1.8	2.6	2.8	2.6	3.6	2.4
Reach	1.8	3.0	2.7	2.0	2.7	2.3	2.3	3.0	2.5
Potency	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
Synergy	3.5	3.0	3.0	3.3	3.3	3.0	3.0	4.0	3.3
Values	3.0	2.7	3.0	3.7	2.7	3.0	3.7	4.3	3.3
Total	2.6	2.7	2.7	2.7	2.8	2.8	2.9	3.6	2.9

MATCH profile

Item profile

The state invested significantly in the initial adoption of MATCH, hiring outside experts to provide training, coaching, credentialing, technical assistance, etc. Since then, MATCH has backslid, with most scores in the low to moderate range. In terms of **Reach**, data from MATCH's online data system –TRAC – indicates that only a small percentage of cases receive a therapeutic dose, with treatment frequently terminated due to client drop-out and clinician turnover. MATCH is most appropriate for relatively low-acuity (and thus lower-priority) cases within a threadbare system; that, combined with the need to cap the number of evidence-based practice cases per clinician means that most never receive MATCH or wait a long time to do so. Most participants felt that structural support for **Implementation** has slipped to negligible levels, without the sustainable, structural changes that would allow sites to maintain high-fidelity practice. Most sites described themselves as doing "MATCH-light" or "MATCH-informed" practice, in which clinicians pull elements of the modules into their native therapeutic approach as they see fit. Most have greatly curtailed training and coaching, and use of TRAC has virtually disappeared at all but a few stalwart sites. As a behavioral, clinician- and protocol-driven approach, infusing SOC **Values** requires a level of MATCH mastery in short supply in an ever-changing workforce. Collaborating on defining the youth's "top problems" is the easiest route into Youth and Family-driven practice for most clinicians. MATCH handouts are available in Spanish; otherwise, the model contains little explicit guidance about cultural responsiveness. With the exception of the trauma-protocol, most staff do not perceive MATCH as particularly trauma-informed. In the **Synergy** domain, MATCH is feasible and straightforward to teach and learn, especially for new clinicians and those favorably inclined toward a structured approach. Engaging

MATCH: Average scores by domain and item



families and clinicians in the use of TRAC is viewed – by far – as the least tenable element of MATCH. For some, MATCH's breadth and flexibility makes it an excellent fit for a very large percentage of CMHC patients. The same characteristics are viewed as a liability by others, with MATCH perceived as offering little advantage over their native approach (oftentimes already suffused with CBT strategies) for lower-acuity cases or over specialized practices for more complex, high-acuity youth. MATCH explicitly supports caregiver involvement in treatment and facilitates coordination with other providers and natural supports through an extensive set of handouts, available in Spanish and English. Undoubtedly, MATCH's signature strength is Potency, with strong efficacy, durability, and effect size scores relative to the other practices. Strong MATCH effects have been observed in multiple trials, including with ethnically and racially diverse youth, and over long-term follow-up.[27,28,29,30]

Site profile

MATCH was the most polarizing practice. For younger and less experienced staff, and those with an affinity for cognitive behavioral work, MATCH is embraced. For those staff with a more fluid or dynamic therapeutic style – not a small percentage of clinicians in some CMHC's – the behavioral, scientific, "cookie cutter" MATCH framework is a tougher sell. Some sites have largely abandoned or are preparing to "reset" MATCH, most are "MATCH-informed," but a few have maintained significant integrity to the full model, including the use of TRAC for enrolled cases. Two MATCH bright spots are MHCGM and CLM. MHCGM was in the initial NH MATCH cohort, with very strong support from administrators who received training alongside staff. They continue to use the full MATCH protocol including TRAC, albeit for a relatively small number of cases. CLM also continues to fully use MATCH, providing the full five-day training for staff throughout the children's program along with weekly or biweekly coaching for newly trained or experienced MATCH clinicians, respectively. CLM Community Support Providers that help extend and generalize MATCH skills to the home and Case Managers are also fully trained in MATCH. Even these bright spot practices, however, struggle with diminished state resources for training, and limit MATCH to one to four cases per clinician.

MATCH: Average domain scores by site

1.0 5.0

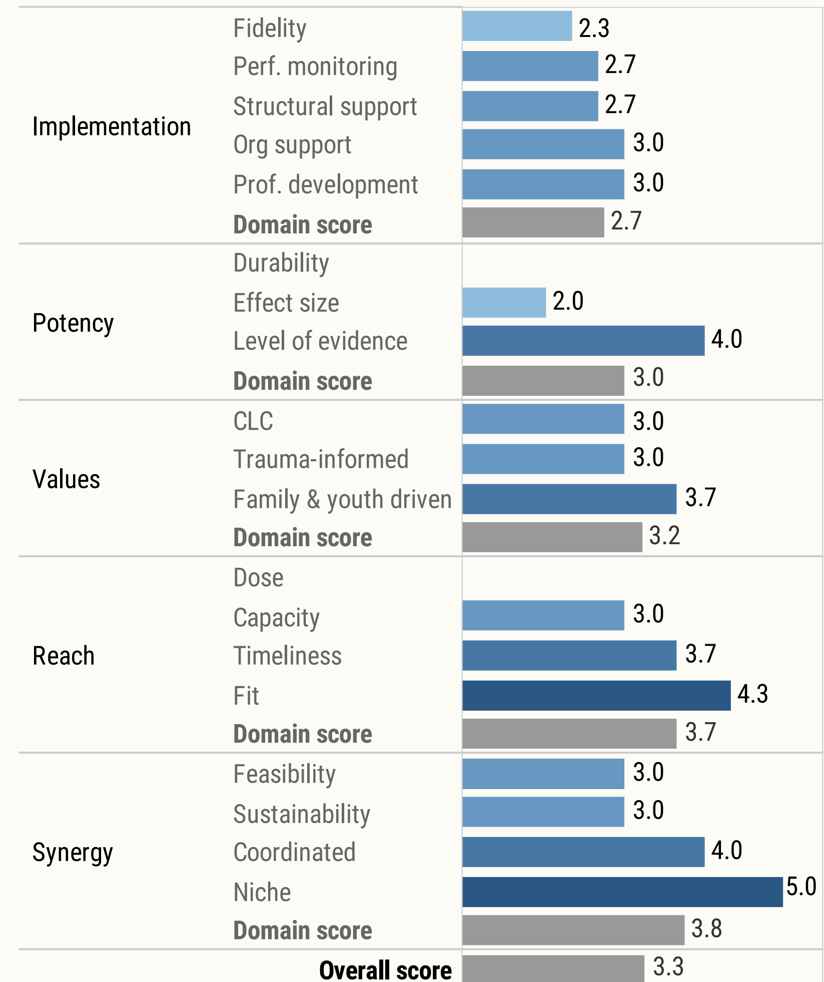
	CP	MFS	LRMHC	NHS	GNMHC	WCBH	RCMH	SMHC	MHCGM	CLM	Total
Reach	2.0	2.0	2.0	2.0	2.3	2.0	2.3	3.0	2.5	3.7	2.4
Implementation	2.0	1.8	2.2	2.2	2.4	2.2	3.4	2.6	3.6	3.4	2.6
Values	2.3	2.7	2.3	2.3	3.0	2.7	2.3	2.7	3.7	3.3	2.7
Synergy	2.3	2.5	2.5	2.5	2.8	3.3	3.3	3.3	3.5	4.0	3.0
Potency	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Total	2.5	2.6	2.6	2.6	2.9	2.8	3.0	3.1	3.5	3.7	2.9

NAVIGATE profile

Item profile

NAVIGATE was the second-highest scoring practice overall. The lowest scoring domain was **Implementation** (2.7), which makes sense for a newly introduced practice. On the other hand, it enjoys considerable state support for training and consultation with external experts – if sustained, we would expect implementation to improve rapidly. The most under-developed aspects of the NAVIGATE model were the Supported Employment and Education and the family outreach and engagement components, both of which were negatively impacted by overall site capacities and staffing shortages. **Potency** was the next highest-scoring domain. The efficacy of NAVIGATE was investigated through the RAISE randomized control trial, which demonstrated positive results, with a modest effect size.[31] The core NAVIGATE model is designed to last about two years, so the lack of long-term post-treatment follow-up data at this point in its history is not surprising. In terms of **Values**, NAVIGATE was seen as inherently youth and family driven, with slightly more work required to infuse CLC and trauma-informed principles into the practice. The two highest-scoring domains were **Synergy** and **Reach**, both of which profited from the nature of the intervention and population itself: a dedicated interprofessional team using a coordinated specialty care model, serving a very small, high-acuity, high priority population. This combination of factors allows participating sites to initiate treatment quickly without taxing overall capacity, leading to relatively high Timeliness, Capacity, Fit, and Niche scores. Interprofessional coordination and outreach to families is baked into the NAVIGATE model, leading to high Coordinated ratings. The specificity of the target population lends itself to high Fit item scores.

NAVIGATE: Average scores by domain and item



Site profile

The three NH NAVIGATE pioneers are GNMHC, MFS, and CLM. The Implementation and Reach gradient between sites is steep, fueled by differing access to and opinions of state support and formal NAVIGATE training. In terms of Implementation, GNMHC is currently patching together training and professional development on their own and would stand to gain from access to the full NAVIGATE training and consultation package. The state recently provided both MFS and CLM with the full NAVIGATE training and consultation package. Both sites have found this professional development opportunity helpful in moving their practice forward, with the exception of the pharmacological portion of the training, which MFS perceives as woefully out-of-date. Beyond training, CLM reports much greater state involvement and support than does MFS, who has been trying to stand up first episode psychosis programming on their own for years. Reach also differs between sites, with greater capacity at CLM and MFS to quickly meet the needs of youth and young adults with first episode psychosis.

NAVIGATE: Average domain scores by site

1.0 5.0

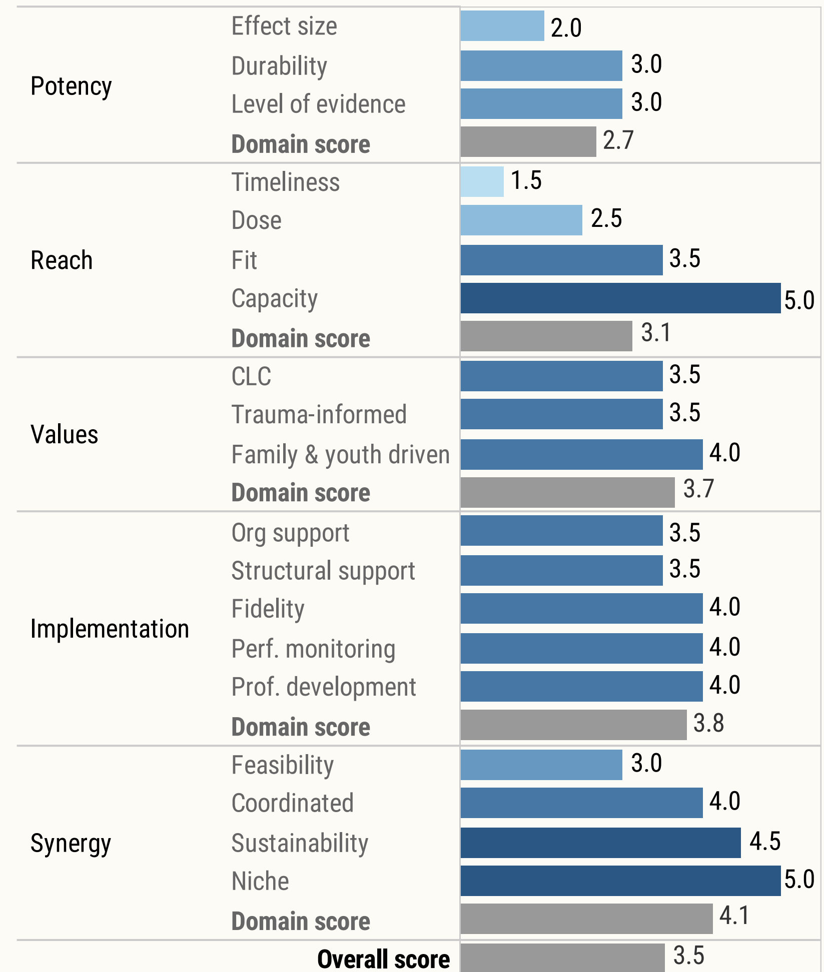
	GNMHC	MFS	CLM	Total
Implementation	2.2	2.4	3.6	2.7
Potency	3.0	3.0	3.0	3.0
Values	2.7	3.3	3.7	3.2
Reach	2.0	4.0	5.0	3.7
Synergy	3.8	3.8	3.8	3.8
Total	2.7	3.3	3.8	3.3

FAST Forward profile

Item profile

FAST Forward was the highest-scoring practice overall. **Potency** was its lowest-scoring domain. The Wraparound evidence-base is nascent but "promising," with no high-quality randomized clinical trials demonstrating a clear advantage over services as usual. The results of naturalistic studies support the effectiveness of wraparound, with modest benefits for child permanency and behavioral and emotional outcomes.[32,33,34] The fidelity with which wraparound has been implemented in several studies has been questioned, which may have attenuated outcomes.[35,36] The lowest-rated **Reach** items were Timeliness (1.5) and Dose (2.5). While the Capacity exists – or more accurately, is constantly being developed – to serve all families who need it, a wait time now exists to initiate the full wraparound model, with family peer support available in the interim. In terms of Dose, many families leave before getting to the first full team meeting and/or reaching six-month enrolled, the therapeutic threshold. The Fit item score was relatively low, as the state sometimes refers youth who may not be a good fit for the model (lower-acuity cases, youth with intellectual disabilities) to make up for deficits elsewhere in the service array. Wraparound originated within the SOC movement, so the high scores in the **Values** domain is to be expected. FAST Forward staff and stakeholders are particularly dedicated to family and youth voice and choice, which is infused throughout the model. FAST Forward was the highest-scoring practice on all five **Implementation** items. Especially promising were high Performance Monitoring, Fidelity, and Professional Development scores, driven by a daily reimbursement rate that supports ongoing external and internal training, coaching, and evaluation. It also supports the small caseloads required for doing high fidelity work with a very high-acuity, complex population. Synergy was the highest-rated

FAST Forward: Average scores by domain and item



domain, reflecting the Fast Forward's unique niche in coordinating care for youth aged 5-18 at risk of out of home placement.

Site profile

The FAST Forward profile was remarkably similar across sites. Both sites are overseen by the NH DHHS BCBH; use the same NH wraparound model, external trainers (the IOD at UNH), and evaluator (BHII); and collaborate closely through an extensive set of statewide meetings and workgroups. The small differences between sites are probably attributable to experience (NFI became a CME in 2017, CFNH began in 2020), organizational context (NFI is a mental health organization whereas CFNH is housed within the County of Cheshire), and thus overall infrastructure and capacity. NFI has largely passed through its growing pains of learning the FAST Forward model, creating organizational alignment and administrative structures to support this non-residential program, and adapting its electronic health record to the model. CFNH is in the middle of that process within the constraints of a County governance system, at the same time the state has experienced a massive surge in referrals. Both programs raised inadequate accessibility to high quality services, especially mental health treatment, in the communities they serve as a major constraint on the effectiveness of care coordination. They also indicated that the "by unit" reimbursement structure for family peers was creating problems for implementation, as it fails to account for necessary effort outside of face-to-face time – in particular, travel. The consequences for services are less capacity to serve families in a financially sustainable manner, in turn reducing the capacity for peer supports to participate consistently on family teams.

FAST Forward: Average domain scores by site

	CFNH	NFI	Total
Potency	2.7	2.7	2.7
Reach	3.0	3.3	3.1
Values	3.7	3.7	3.7
Implementation	3.6	4.0	3.8
Synergy	4.0	4.3	4.1
Total	3.4	3.6	3.5

Lessons learned and next steps

This section describes some initial ideas and potential next steps from this inaugural SOC assessment.

Toward a small, diverse array of complementary services

In an ideal world, the five practices selected for this year's SOC assessment would anchor a comprehensive and coherent children's service array. Each practice would occupy a unique and important niche, as these do, with the most expensive and intensive models reserved for the highest need, most complex populations. In this world, MATCH, a structured, scientifically based treatment, would be used as a first-line clinical treatment for most youth presenting for treatment, with DBT-A and NAVIGATE reserved for youth with self-harming tendencies and first episode psychosis, respectively. RENEW would be used as an adjunct to clinical treatments and as a way of engaging hard-to-reach transition-aged youth in a creative, team-based process to meet their educational and occupational needs. FAST Forward would be reserved for a relatively small number of multi-system-involved youth at immanent risk of out-of-home placement who either have not responded to – or are overwhelmed by – the traditional service array. This image of a relatively small, diverse, and synergistic set of behavioral health services for children and their families is worth holding on to.

Reach x implementation x effectiveness = population impact

Of course, strategic selection of practices is only the starting point – if not widely adopted, implemented with fidelity, or delivered with sufficient intensity to a large-enough proportion of the population in need, the incremental benefit of a strategically selected set of practices will be minimal.[37] That is the current status of these practices, and likely other evidence-based practices in the NH children's service array as well. Families experience long-wait times, evidence-based models are minimally deployed, and a therapeutic dose is rarely received. One exception may be FAST Forward, which shows promising reach and implementation characteristics, though it too is buffeted and constrained by the lack of availability of high-quality services in the rest of the service array, as detailed on the preceding page. The recent infusion of resources into the system will need to continue well into the future to adequately address the workforce shortage and unbillable aspects of evidence-based practice implementation, to elevate the reach and quality of EBPs through the CMHCs. This could take the form of additional increases to the Medicaid rate, benchmarking per member per month expenditures rates to those of gold model peer states, applying for mission-aligned external funding, incremental reimbursement or other value-based funding models for high-quality delivery of EBPs, or other related strategies.

In the absence of ongoing infusion of external energy, entropy reigns

As implementation science has compellingly demonstrated,[38] up-front investment in the installation of new practices – even with the deep dedication to client care so evident in our focus groups – is insufficient for enduring high-quality evidence-based practice. The decline of MATCH is a good example of what happens when external support for training, coaching, data, and other unbillable aspects of implementation are withdrawn before sustaining funding and implementation structures are fully in place. Another case in point is the relative success of FAST Forward – unique among these

practices in having a reimbursement mechanism that 1) allows for small caseloads and 2) covers the typically unbillable costs of high-quality implementation, including ongoing collaboration and infrastructure development, training and coaching, and performance monitoring and evaluation. Not only does this improve implementation quality and client care, it also supports the hiring, retention, and well-being of staff. As a system, we need to resist the urge to provide initial training and support, then quickly turn toward the next pressing matter or practice du jour. A long-term commitment to and support for the envisioned small portfolio of high-quality, synergistic practices, together with sustainable sources of funding (see preceding paragraph), will be required to truly enhance the NH service array.

Context matters: Geographic reach, population density, staff size and diversity

With all these challenges and complexities, now imagine the degree of difficulty in standing up several evidence-based practices simultaneously, in a rural area with multiple sites scattered over a wide geographic region, with a highly dispersed staff (often only one or two per office) who must meet the mental health needs of the entire age spectrum. No surprise, then, that the most successful CMHC practice-site combinations tend to reside in higher-density population environments, presumably because it ultimately increases and concentrates resources. These resources support development and maintenance of more sophisticated administrative and technical structures, enable more creative and flexible productivity and release-time models, and allows for a larger, more diverse workforce. More staff teams, in turn, mean increased opportunities for learning and collaboration, reduced isolation, increased dispersion of the burdens and responsibilities associated with implementation, and greater buffers against the constant threat of staff turnover. One strategy for overcoming some of these problems of scale, especially in the more rural areas of the state, are to pool and share resources across the CMHCs.

More data, more learning, more better

With few exceptions, these practices exist in relatively data-poor environments. Even in sites with relatively sophisticated measurement systems, data are rarely accessible to front-line staff and seldom used at the case- or program-levels for quality improvement purposes. This hampers not only transparency and accountability, but client care, data-based decision-making, and organizational learning. Indeed, providing regular feedback on client progress to practitioners is itself evidence-based, with effect sizes at least commensurate with those of most evidence-based practices.[39] Increasing the amount, integrity, and use of data at all levels of the system should be among the technical assistance priorities moving forward.

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	
Reach	**4. Fit** The practice is an ideal fit for the target population/intended outcomes; it is delivered to the population and for the	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	

Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
	purpose/outcomes it was designed for/tested on						
	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 is able to 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; leaderships 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 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 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 fairly 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/considera ble 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 item scores by domain and practice

1.000 5.000

Domain	Item	RENEW	DBT-A	MATCH	NAVIGATE	FAST Forward
Reach	Dose	1.0	1.0	1.4		2.5
	Timeliness	2.3	1.8	1.8	3.7	1.5
	Capacity	2.8	1.8	1.9	3.0	5.0
	Fit	3.2	4.0	3.8	4.3	3.5
	Domain score	2.7	2.4	2.4	3.7	3.1
Implementation	Structural support	2.7	1.3	1.8	2.7	4.0
	Perf. monitoring	2.3	2.1	2.7	2.7	4.0
	Fidelity	3.5	2.8	2.5	2.3	4.0
	Prof. development	2.8	2.6	2.9	3.0	4.0
	Org support	3.2	3.0	3.0	3.0	3.5
	Domain score	2.9	2.4	2.6	2.7	3.9
Values	CLC	2.7	2.5	2.3	3.0	3.5
	Trauma-informed	3.0	3.8	2.8	3.0	3.5
	Family & youth driven	3.3	3.5	3.1	3.7	4.0
	Domain score	3.0	3.3	2.7	3.2	3.7
Potency	Effect size	1.0	2.0	3.0	2.0	2.0
	Durability		2.0	4.0		3.0
	Level of evidence	2.0	5.0	5.0	4.0	3.0
	Domain score	1.5	3.0	4.0	3.0	2.7
Synergy	Feasibility	3.5	2.6	2.7	3.0	3.0
	Sustainability	3.2	3.3	2.9	3.0	4.5
	Coordinated	2.8	3.4	3.4	4.0	4.0
	Niche	3.2	3.8	2.9	5.0	5.0
	Domain score	3.2	3.3	3.0	3.8	4.1
	Overall score	2.8	2.8	2.9	3.3	3.6

Appendix C: Practice-item-site crosstabs

RENEW: Average scores by domain, item, and site

Domain	Item	CLM	GNMHC	CP	RCMH	SMHC	MHCGM	Total
Potency	Durability							
	Effectiveness							
	Effect size	1.0	1.0	1.0	1.0	1.0	1.0	1.0
	Level of evidence	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Reach	Equitable							
	Dose			1.0				1.0
	Timeliness	5.0	1.0	1.0	1.0	1.0	5.0	2.3
	Capacity	1.0	1.0		5.0	4.0	3.0	2.8
	Fit	2.0	4.0	3.0	3.0	4.0	3.0	3.2
Implementation	Perf. monitoring	2.0	2.0	2.0	3.0	3.0	2.0	2.3
	Structural support	2.0	2.0	3.0	3.0	3.0	3.0	2.7
	Prof. development	3.0	3.0	3.0	3.0	2.0	3.0	2.8
	Org support	2.0	2.0	3.0	4.0	4.0	4.0	3.2
	Fidelity	3.0	3.0	3.0	4.0	4.0	4.0	3.5
Values	CLC	2.0	2.0	4.0	2.0	3.0	3.0	2.7
	Trauma-informed	1.0	3.0	5.0	2.0	3.0	4.0	3.0
	Family & youth driven	2.0	4.0	3.0	4.0	3.0	4.0	3.3
Synergy	Coordinated	2.0	2.0	3.0	3.0	4.0	3.0	2.8
	Niche	3.0	3.0	3.0	3.0	4.0	3.0	3.2
	Sustainability	3.0	2.0	3.0	3.0	4.0	4.0	3.2
	Feasibility	3.0	4.0	3.0	4.0	4.0	3.0	3.5
	Total	2.3	2.4	2.7	2.9	3.1	3.2	2.8

DBT-A: Average scores by domain, item, and site

Domain	Item	CP	CLM	SMHC	NHS	MHCGM	MFS	GNMHC	RCMH	Total
Implementation	Structural support	1.0	1.0	1.0	1.0	1.0	1.0	2.0	2.0	1.3
	Perf. monitoring	2.0	3.0	2.0	2.0	2.0	2.0	1.0	3.0	2.1
	Prof. development	2.0	1.0	1.0	2.0	3.0	4.0	3.0	5.0	2.6
	Fidelity	2.0	2.0	2.0	1.0	3.0	4.0	4.0	4.0	2.8
	Org support	2.0	2.0	3.0	3.0	4.0	3.0	3.0	4.0	3.0
Reach	Equitable									
	Dose	1.0								1.0
	Capacity	1.0	1.0	1.0	2.0	3.0	1.0	2.0	3.0	1.8
	Timeliness	1.0	4.0	3.0	1.0	1.0	2.0	1.0	1.0	1.8
	Fit	4.0	4.0	4.0	3.0	4.0	4.0	4.0	5.0	4.0
Potency	Effectiveness									
	Durability	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
	Effect size	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
	Level of evidence	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
Synergy	Feasibility	3.0	3.0	2.0	2.0	3.0	2.0	2.0	4.0	2.6
	Sustainability	3.0	3.0	3.0	4.0	3.0	3.0	3.0	4.0	3.3
	Coordinated	4.0	4.0	3.0	3.0	3.0	3.0	3.0	4.0	3.4
	Niche	4.0	2.0	4.0	4.0	4.0	4.0	4.0	4.0	3.8
Values	CLC	3.0	2.0	2.0	3.0	2.0	2.0	3.0	3.0	2.5
	Family & youth driven	3.0	3.0	3.0	4.0	3.0	3.0	4.0	5.0	3.5
	Trauma-informed	3.0	3.0	4.0	4.0	3.0	4.0	4.0	5.0	3.8
	Total	2.5	2.6	2.6	2.7	2.8	2.8	2.9	3.6	2.8

MATCH: Average scores by domain, item, and site

Domain	Item	CP	MFS	LRMHC	NHS	WCBH	GNMHC	RCMH	SMHC	MHCGM	CLM	Total
Reach	Dose	1.0		2.0			1.0	1.0		2.0		1.4
	Timeliness	1.0	3.0	1.0	1.0	1.0	3.0	1.0	1.0	2.0	4.0	1.8
	Capacity		1.0	1.0	1.0		1.0	3.0	4.0	1.0	3.0	1.9
	Fit	4.0	2.0	4.0	4.0	3.0	4.0	4.0	4.0	5.0	4.0	3.8
	Equitable						5.0	2.0		5.0		4.0
Implementati..	Structural su..	2.0	1.0	2.0	2.0	1.0	2.0	2.0	2.0	2.0	2.0	1.8
	Fidelity	2.0	2.0	2.0	2.0	2.0	2.0	4.0	2.0	4.0	3.0	2.5
	Perf. monitor..	2.0	2.0	3.0	2.0	2.0	3.0	3.0	2.0	4.0	4.0	2.7
	Prof. develop..	2.0	2.0	2.0	2.0	4.0	2.0	4.0	3.0	4.0	4.0	2.9
	Org support	2.0	2.0	2.0	3.0	2.0	3.0	4.0	4.0	4.0	4.0	3.0
Values	CLC	2.0	3.0	2.0	2.0	2.0	3.0	2.0	2.0	3.0	2.0	2.3
	Trauma-infor..	3.0	2.0	2.0	2.0	3.0	3.0	2.0	3.0	4.0	4.0	2.8
	Family & you..	2.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	4.0	4.0	3.1
Synergy	Feasibility	2.0	3.0	2.0	3.0	3.0	2.0	3.0	3.0	3.0	3.0	2.7
	Niche	2.0	2.0	2.0	2.0	4.0	3.0	3.0	4.0	3.0	4.0	2.9
	Sustainability	3.0	2.0	3.0	2.0	2.0	3.0	3.0	3.0	4.0	4.0	2.9
	Coordinated	2.0	3.0	3.0	3.0	4.0	3.0	4.0	3.0	4.0	5.0	3.4
Potency	Effectiveness											
	Effect size	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
	Durability	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
	Level of evid..	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
	Total	2.4	2.5	2.5	2.6	2.8	2.9	3.0	3.1	3.5	3.7	2.9

NAVIGATE: Average scores by domain, item, and site

	GNMHC	MFS	CLM	Total
Implementation	2.2	2.4	3.6	2.7
Potency	3.0	3.0	3.0	3.0
Values	2.7	3.3	3.7	3.2
Reach	2.0	4.0	5.0	3.7
Synergy	3.8	3.8	3.8	3.8
Total	2.7	3.3	3.8	3.3

FAST Forward: Average scores by domain, item, and site

1.0 – 5.0

Domain	Item	CFNH	NFI	Total
Potency	Effectiveness			
	Effect size	2.0	2.0	2.0
	Durability	3.0	3.0	3.0
	Level of evidence	3.0	3.0	3.0
Reach	Timeliness	2.0	1.0	1.5
	Dose	2.0	3.0	2.5
	Equitable	3.0	3.0	3.0
	Fit	3.0	4.0	3.5
	Capacity	5.0	5.0	5.0
Values	CLC	3.0	4.0	3.5
	Trauma-informed	4.0	3.0	3.5
	Family & youth driven	4.0	4.0	4.0
Implementation	Org support	3.0	4.0	3.5
	Fidelity	4.0	4.0	4.0
	Perf. monitoring	4.0	4.0	4.0
	Prof. development	4.0	4.0	4.0
	Structural support	4.0	4.0	4.0
Synergy	Feasibility	3.0	3.0	3.0
	Coordinated	4.0	4.0	4.0
	Sustainability	4.0	5.0	4.5
	Niche	5.0	5.0	5.0
	Total	3.5	3.6	3.5

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