System of Care Assessment

2023 Children's Behavioral Health SOC Assessment

Behavioral Health Improvement Institute
Keene State College

On behalf of the Children's Behavioral Health Resource Center

December 2024

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Care Management Entities

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Intensive Service Option/Home-Based Providers

Community Solutions Institute, NFI North, Waypoint, Youth Villages

Residential Treatment Providers

Dover Children's Home, Home for Little Wanderers, Mount Prospect Academy, Nashua Children's Home, Orion House

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Executive Summary

Assessing 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 system of care. CBHRC conducts annual System of Care (SOC) assessments to evaluate practices delivered through NH's public mental health system. In this third SOC assessment, CBHRC evaluated five practices delivered by NH's Care Management Entities, Community Mental Health Centers, Intensive In-Home Providers, and Residential Treatment Programs.

Evidence-Based & Promising Practices Assessed
Cognitive Behavioral Therapy
Early Childhood Wraparound
Eye Movement Desensitization & Reprocessing
Intercept
Multisystemic Therapy

Statewide themes

The ability to specialize and deeply embed implementation supports in practice settings leads to the highest quality services, which is challenging for small generalist agencies, such as those in rural areas. In addition, greater investments in data infrastructure would improve system learning and functioning.

Practice-specific themes

Cognitive Behavioral Therapy (CBT) is short-term, present-focused, goal-driven form of therapy focused on changing thoughts and behaviors to alter feelings and symptoms. Within NH's SOC, CBT is a loosely defined but highly adaptable and user-friendly practice. As a result, it has become the standard form of care. We need to define and improve CBT in ways that preserve its flexibility and feasibility.

Early Childhood Wraparound (ECW) is a youth- and family driven, team-based care coordination model for young children and their families. Wraparound for this age group does not yet have a substantial research base but fills a critical gap in the service array by intervening at the earliest ages and stages of development. ECW's referral base would benefit from additional efforts to build and integrate the early childhood system within the overall SOC.

Eye Movement Desensitization and Reprocessing (EMDR) is a therapy that relieves trauma-related feelings and symptoms by sequentially reprocessing traumatic memories while attending to a neutral stimulus. EMDR has an impressive research base and may be less demanding on clients than other trauma treatments. EMDR has arisen organically and recently. The state should decide if it will endorse and support EMDR moving forward.

Intercept is an intensive, evidence-based in-home therapy program to safely limit out-of-home placement for high-risk youth. The research evidence for Intercept is strong and implementation in NH by Youth Villages is excellent. Increased clarity about when and for whom to use Intercept would be helpful.

Multisystemic Therapy (MST) is a clinical intervention that reduces family- and systems-level risk factors driving delinquent behavior among juvenile justice-involved youth. MST has an impressive research base. Implementation in NH by Community Solutions Incorporated is also excellent. The main problem right now is limited knowledge and understanding about MST among potential referring partners; continued outreach and education from a variety of actors using multiple methods is warranted.

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SOC assessment context

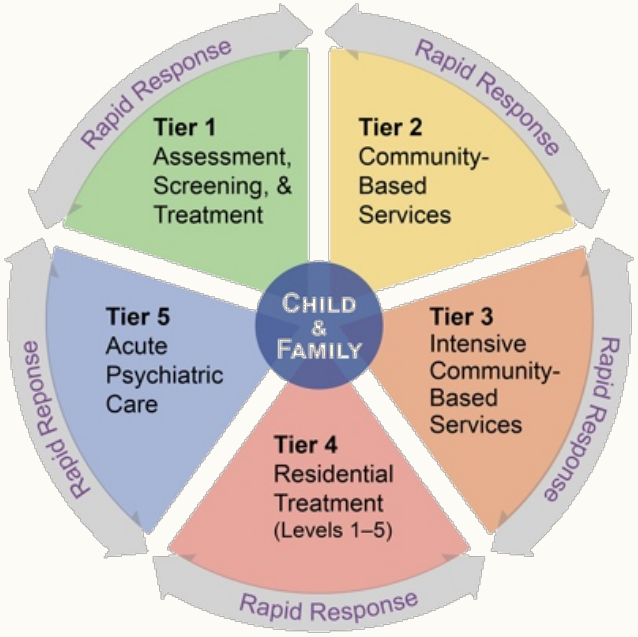
The Children's Behavioral Health Resource Center

In 2021, the New Hampshire (NH) Department of Health and Human Services (DHHS) established the Children's Behavioral Health Resource Center (CBHRC) to improve access to high-quality practices within the children's behavioral health System 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 at UNH (website), and the Behavioral Health Improvement Institute (BHII) at Keene State College (data and evaluation).

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 System of Care (SOC) for children's behavioral health services. A SOC is a spectrum of effective, 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. The NH SOC service array is organized around five tiers ranging from the least (Tier 1's preventative approaches) to the most intensive (Tier 5's acute psychiatric hospitalization) – see right.



Across Tiers, NH's children's SOC guiding principles are:

- **Effective, evidence-informed service**
- **Individualized Wraparound service planning and 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 third SOC assessment due to their importance to the overall service array. **Cognitive Behavioral Therapy** (CBT; Tiers 2–5) is a versatile clinical intervention suitable for various behavioral health conditions, therapy modalities (individual, group, family), and ages. CBT is short-term, present-focused, goal-driven, and focuses on changing thoughts and behaviors to alter feelings and symptoms. **Early Childhood Wraparound** (ECW; Tier 3) is an application of the wraparound approach for families with young children (birth to 5) with or at risk of serious emotional disturbance. Wraparound programs provide care coordination through family-driven teams, which develop and implement strength-based, individualized plans of care. These plans leverage professional and natural supports to address the needs of children and families. **Eye Movement Desensitization and Reprocessing** (EMDR; Tiers 2–4) is a clinical intervention that relieves trauma-related feelings and symptoms by sequentially reprocessing traumatic memories while attending to a neutral stimulus. **Intercept** (Tier 3) is an intensive, evidence-based in-home therapy program offering parenting skills training, mental health services, care coordination, and case management to safely prevent, limit, and transition from out-of-home placement. **Multisystemic Therapy** (MST; Tier 3) is a clinical intervention that reduces family- and systems-level risk factors driving delinquent behavior among juvenile justice-involved youth. See the table below for more detail about each practice.

Practice descriptions

Practice	Tier	Type	Population	Description	Key Components	Length
CBT	2-5	Clinical treatment	Children & youth (3+) with behavioral health problems	CBT focuses on the interconnections between clients' thoughts, emotions, and behaviors. Therapists typically intervene at the behavioral and cognitive levels.	In CBT, the therapist helps clients learn how to replace negative with positive thoughts and behaviors in a short-term treatment focused on resolving present-day problems. The client and therapist collaborate to develop and track progress on individualized goals. Clients actively participate in treatment to self-monitor and practice learned skills.	12 weeks
ECW	3	Care coordination	Young children (0-5) at risk for serious emotional disturbance (SED) & their caregivers	ECW uses a team-based approach to provide individualized, coordinated services & supports to address the underlying needs of the child & family.	The four phases of ECW are: 1) Engagement & team preparation, 2) Initial plan development, 3) Implementation, & 4) Transition. Its key principles include: 1) family voice & choice, 2) team-based, 3) natural supports, 4) collaboration, 4) community-based, 5) culturally competent, 6) individualized, 7) strengths-based, 8) unconditional, & 9) outcomes-based.	6-18 months

Practice	Tier	Type	Population	Description	Key Components	Length
EMDR	2	Clinical treatment	Children & youth (2+) with trauma-related symptoms	EMDR helps children attend to and detoxify emotionally disturbing traumatic memories in brief sequential doses while focusing on a neutral stimulus (e.g., therapist-directed eye movements).	EMDR is predicated on the idea that symptoms arise from maladaptively stored memories of traumatic events. EMDR helps clients access memories, activate the brain's information system, and reprocess disturbing information to resolve it. A therapeutic relationship is established, the client is assessed & prepared, & memory is reprocessed with the aid of a neutral stimulus.	12 weeks
Intercept	3	Clinical treatment	Children & youth (birth-18) with SED at risk of out-of-home placement	Intercept is an intensive in-home program that combines parenting skills, mental health services, care coordination, and case management to safely prevent or limit out-of-home placement.	Intercept's case conceptualization model prioritizes safety and helps family intervention specialists identify and address youth referral issues. Specialists receive live guidance from an expert supervisor and access hundreds of best practice interventions through an online resource (GuideTree) for specific presenting issues. Intercept also supports care coordination, education and jobs, financial stability, and building natural supports.	Six months
MST	3	Clinical treatment	Youth (12-17) involved with the juvenile justice system	MST in an intensive in-home program that uses principles from family therapies to reduce antisocial and delinquent behavior and improve youth and family functioning by influencing the youth's important relationships in and among home, school, and community systems.	Critical features of MST include integrating empirically based interventions to address individual risk factors across various contexts; promoting behavior change in the youth's environment; and rigorous quality assurance to maintain fidelity and overcome barriers. MST therapists' small caseloads ensure timely crisis management and maximal scheduling flexibility for families.	Four months

Sites

These practices are implemented through NH's public mental health system, consisting of Community Mental Health Centers (CMHCs; Tier 2), Care Management Entities (CME's; Tier 3), Intensive In-home Support (IIHS) providers, and Residential Treatment Centers (RTCs). NH's 10 CMHCs provide comprehensive community-based behavioral health services. NH's two CMEs provide intensive care coordination for youth who are in or at high risk of out-of-home treatment placements. IIHS provides high intensity, home-based services to create a safe, stable, and positive home environment for children and their families who are referred by DCYF or the CMEs. RTCs are live-in health care facilities that provide multi-faceted treatment for substance use disorders, mental illness, or other behavioral problems.

Practices by site

See the table below for a break-down of sites that implemented and engaged in the SOC Assessment by submitting data and documentation and participating in a group interview for each practice.[1]

Practices by site

Type	Site	Practice				
		CBT	ECW	EMDR	Intercept	MST
CME	Connected Families New Hampshire (CFNH)		x			
	NFI North		x			
CMHC	Lakes Region Mental Health Center (LRMHC)			x		
	Monadnock Family Services (MFS)			x		
	Northern Human Services (NHS)			x		
	Seacoast Mental Health Center (SMHC)			x		
IIHS	Community Solutions Institute (CSI) – Manchester/Dover					x
	Community Solutions Institute (CSI) – Lebanon/Lincoln					x
	NFI North	x				
	Waypoint	x				
	Youth Villages (YV) - Manchester				x	
	Youth Villages (YV) - Plymouth				x	
RTC	Dover Children's Home	x				
	Home for Little Wanderers	x				
	Mount Prospect Academy	x		x		
	Nashua Children's Home	x				
	Orion House	x				

[1] Although we were only able to assess CBT at the sites listed, based on conversations with CMHC Children's Directors and administrators and staff from two sites, it is implemented similarly across all settings

System assessment tool and data sources

System of Care Assessment Tool (SOCAT)

BHII developed the System of Care Assessment Tool1 (SOCAT) with inspiration from Glasgow's RE-AIM model for measuring the impact of public health interventions,[2] BHII's related work in this area,[3] and support from CBHRC evaluation workgroup members. The SOCAT places behavioral health practice as delivered in naturalistic settings on a common metric, fostering comparability, transparency, and common language and understanding. The SOCAT trades depth and specificity for breadth and comparability. The resulting findings should be viewed as a rough approximation of reality, useful for identifying issues in the system that may require further investigation.

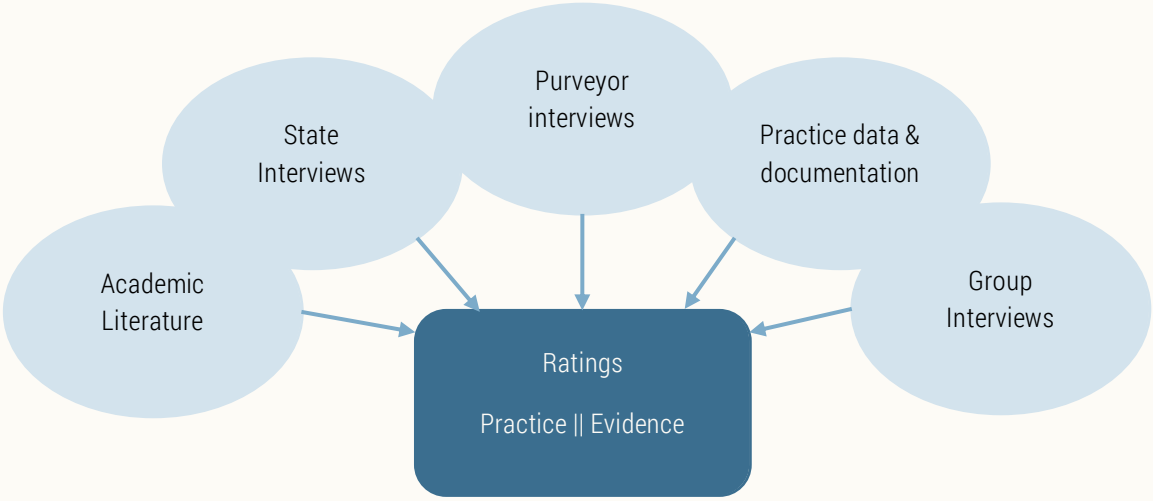
The SOCAT includes 21 items rated against a gold standard on a five-point scale ranging from 1 (not at all) to 5 (completely). The items are organized into five domains: SOC Values, Reach, Implementation, Potency, and Synergy. SOC Values assesses the degree to which community-based practices are implemented 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 focuses on professional development and other supports for practice fidelity – the degree to which a practice is delivered in a way that is consistent with the practice model and implementation science principles. Potency characterizes the extent and strength of evidence for the impact 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 how the five aforementioned practice models were implemented during calendar year 2023.

Data sources

The SOCAT leverages multiple data sources: academic literature, state interviews, purveyor interviews, practice documentation, and group interviews. The latter two require cooperation from the sites to submit readily available data and documentation and facilitate access to staff to participate in the group interviews for each practice-site combination.



Academic literature

A review of information posted to well-regarded evidence-based clearinghouses[4] and 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.

State interviews

We conducted interviews focused on state/systems level implementation supports and issues with the relevant DHHS program officer(s), as follows:

CBT – not applicable (no state program officer)

ECW – Hannah Maynard-Yung (Bureau for Children's Behavioral Health)

EMDR – Daryll Tenney (Bureau for Children's Behavioral Health)

Intercept – Ashley Janos, Christine Morrissey, Caroline Racine (DCYF)

MST – Christine Morrissey (DCYF)

Purveyor interviews

Purveyors are individuals or organizations with specialized expertise in dissemination and high-fidelity implementation of specific practice models. Purveyors support high-quality implementation of the model through activities such as training and certification, coaching and consultation, and monitoring and oversight. As such, purveyor interviews focused on professional development-related supports and systems, and were conducted with the following individuals:

CBT – not applicable (no dedicated purveyor)

ECW – NH Care Management Entities

EMDR – not applicable (no dedicated purveyor)

Intercept – Jennifer Mack, Carly Branconnier, Scott Manheimer (Youth Villages)

MST – Robert Butcher, Vonetta Lambert (Community Solutions Inc.)

Practice data and documentation

Practice documentation and data that were submitted by quality assurance/evaluation staff via a standardized form were reviewed for each site/practice combination. Practice manuals and other documentation related to practices and implementation were also consulted when provided. The practice documentation provided descriptive information about who, how, and to whom each site delivered each practice, and other supplementary information to inform SOCAT Reach, Implementation, Potency, and Synergy ratings. The comprehensiveness and quality of the information provided 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 20 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	State interviews	Purveyor interviews	Practice 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

Domains/Items		Data Sources				
Domain	Item	Literature review	State interviews	Purveyor interviews	Practice data	Group interviews
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	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	X
	6. Timeliness. Practice can be initiated for those who need it within one week of referral			X	X	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	X	X
	8. Equitable. Access, process, and outcomes are equitable across ethnic, racial, geographic, other relevant groups				X	
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	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		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	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	X	X

Domains/Items		Data Sources				
Domain	Item	Literature review	State interviews	Purveyor interviews	Practice data	Group interviews
	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	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			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		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	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			X

Raters

The SOC assessment was conducted by two doctoral-level psychologists: Mason Haber and Jim Fauth. Dr. Haber assessed ECW, EMDR, Intercept, & MST practice/site combinations (N=11); Dr. Fauth rated CBT practice/site combinations (N=7). 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 communicated regularly via email and Zoom to maintain integrity to the process, review and calibrate ratings, and develop the final report.

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 site was unable to provide the requested data.

The practice with the longest history in NH is CBT, followed by Intercept, and much more recently, ECW, EMDR, and MST. Most practices were delivered to a relatively small number of youths with a few notable exceptions: CBT at Mount Prospect Academy (107), Intercept across the two Youth Villages sites (136), and MST at Community Solutions Incorporated's Manchester/Dover site (103). Youth and families generally had to wait at least 30 days from referral to first service for practices delivered by CMHCs and CMEs; treatment was initiated more quickly by IIHS providers and RTCs. The number of staff delivering these practices ranged from 1 (CBT at Dover Children's) to 27 (Intercept across the two Youth Villages sites). The number of certified staff ranged from 0 (multiple site-practice combinations) to 27 (Intercept at Youth Villages). Sites were mixed in their assessment of the cost to revenue ratio for CBT, ECW, and EMDR; revenues were estimated to exceed costs for Intercept, whereas the reverse was the case for MST.

Descriptive data for each practice by site

Site	Type	Start	Served	Wait	Staff	Certified	Cost to revenue
CBT							
NFI North	IIHS	1/1/2009	ND	0-7 days	2	0	Costs = Revenue
Waypoint	IIHS	1/1/2001	31	8-14 days	5	0	Revenue > Costs
Dover Children's	RTC	11/1/2021	8	0-7 days	1	0	Costs > Revenue
Home for Little Wanderers	RTC	1/1/1990	40	0-7 days	9	0	Costs = Revenue
Mount Prospect Academy	RTC	1/1/2023	107	0-7 days	19	0	Revenue > Costs
Nashua Children's Home	RTC	1/1/2010	ND	15-21 days	5	0	Costs = Revenue
Orion House	RTC	8/27/1997	15	0-7 days	4	0	Costs = Revenue
ECW							
CFNH	CME	10/1/2020	12	29+ days	3	3	Revenue > Costs
NFI North	CME	3/1/2022	20	29+ days	4	4	Costs = Revenue
EMDR							
LRMHC	CMHC	5/31/2022	ND	29+ days	6	0	Costs > Revenue
MFS	CMHC	10/3/2021	30	22-28 days	2	2	Costs = Revenue
Northern Human Services	CMHC	10/9/2021	ND	29+ days	7	2	Costs > Revenue
SMHC	CMHC	ND	9	29+ days	3	0	ND
Mount Prospect Academy	RTC	5/12/2017	22	29+ days	5	0	Revenue > Costs

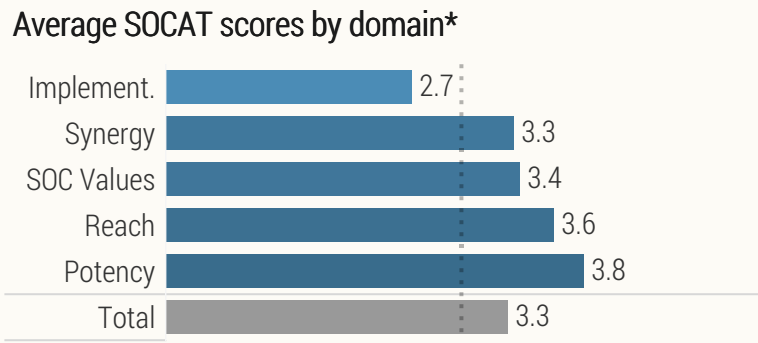
Site	Type	Start	Served	Wait	Staff	Certified	Cost to revenue
Intercept							
YV - Manchester	IIHS	12/31/2009	136	8-14 days	27	12	Revenue > Costs
YV-Plymouth	IIHS	12/31/2009		8-14 days			Revenue > Costs
MST							
CSI-Manchester/Dover	IIHS	12/1/2022	103	0-7 days	16	0	Costs > Revenue
CSI-Lebanon/Lincoln	IIHS	12/1/2022	18	0-7 days	2	0	Costs > Revenue

Note. CFNH = Connected Families New Hampshire; CSI = Community Solutions, Inc.; LRMH=Lakes Region Mental Health; MFS=Monadnock Family Services; SMHC=Seacoast Mental Health Center; YV = Youth Villages.

Domain- and item-level findings

Domain scores

The dashboard at right displays average SOCAT domain scores[2] across all practice-site combinations, providing a high-level perspective of the collective strengths and weaknesses of these practices. The vertical dotted line represents the midpoint ("somewhat in place") of the SOCAT scale. The domain scores ranged from a low of 2.7 (Implementation) to a high of 3.8 (Potency), with Synergy (3.3), SOC Values (3.4), and Reach (3.6) in between. Four of five domains exceeded the midpoint of the SOCAT scale. The total score across domains was 3.3.



Item scores

The domain-level scores mask substantial item-level variability, as evidenced by the dashboard on the following page. Five items scored below the midpoint of the SOCAT scale. Three of the lowest-scoring items came from the Implementation domain: Structural Support (1.9), Fidelity (2.6), and Professional Development (2.9). This finding is concerning because the advantage of these practices over treatment as usual hinges on high-fidelity implementation. The lowest-scoring item was Effect Size (2.0; Potency domain); research indicates that the advantage of these practices over treatment as usual is modest even when implemented with fidelity.

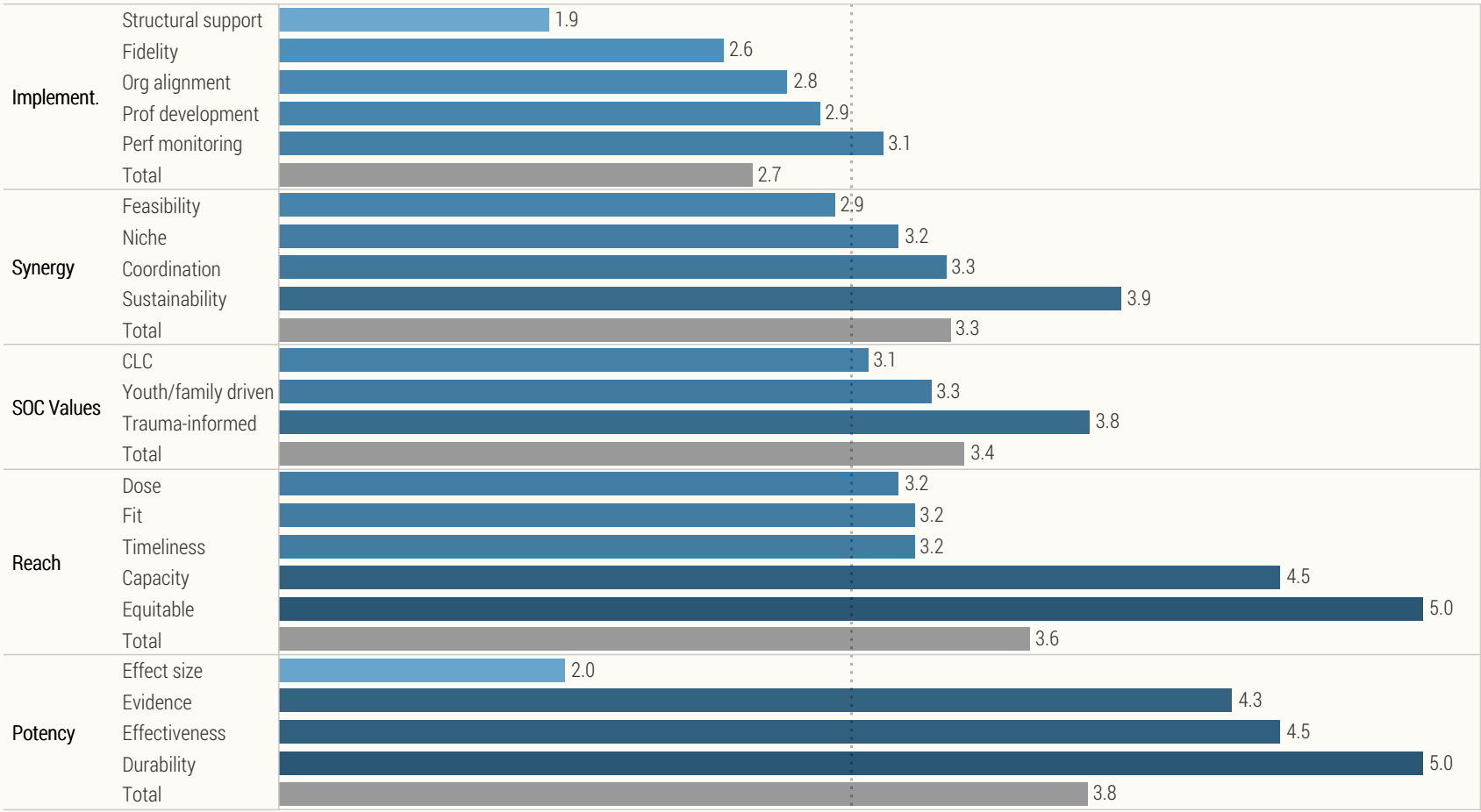
Seven items scored 3.9 or higher on the SOCAT scale. Three belong to the Potency domain: Level of Evidence (4.3), Local Effectiveness (4.5)[3], and Durability (5.0). Most of the practices are well-established with substantial evidence demonstrating their (small) advantage over treatment as usual with strong durability of gains post-treatment. The (limited) outcome data provided by sites looked encouragingly like those produced via rigorous research trials. Two of the highest-scoring items came from the Reach domain: Capacity (4.5) and Equitable (5.0).[4] Sites generally demonstrated sufficient capacity to provide these practices to all those referred to them, and utilization of the services was equitable from a racial and ethnic perspective. The final two highest-scoring items were Trauma-Informed (3.8) from the SOC Values domain and Sustainability (3.9) from the Synergy domain. All other items scored at or slightly above the midpoint of the SOCAT scale.

[2] This chart, like all the other charts in the report, treats the site-combination as the unit of analysis. Consequently, practices with more sites exert greater influence on average scores when we collapse across practices. In this chart, if we instead treated the practice as the unit of analysis (first took the average across sites for each practice, then averaged those together), the domain scores would be as follows: Implementation = 3.2; Synergy = 3.4, Values = 3.5, Reach = 3.6, Potency = 3.3.

[3] Outcome data were supplied only for the two MST sites

[4] Demographic data were supplied by only 5 site-practice combinations

Average SOCAT scores by domain and item

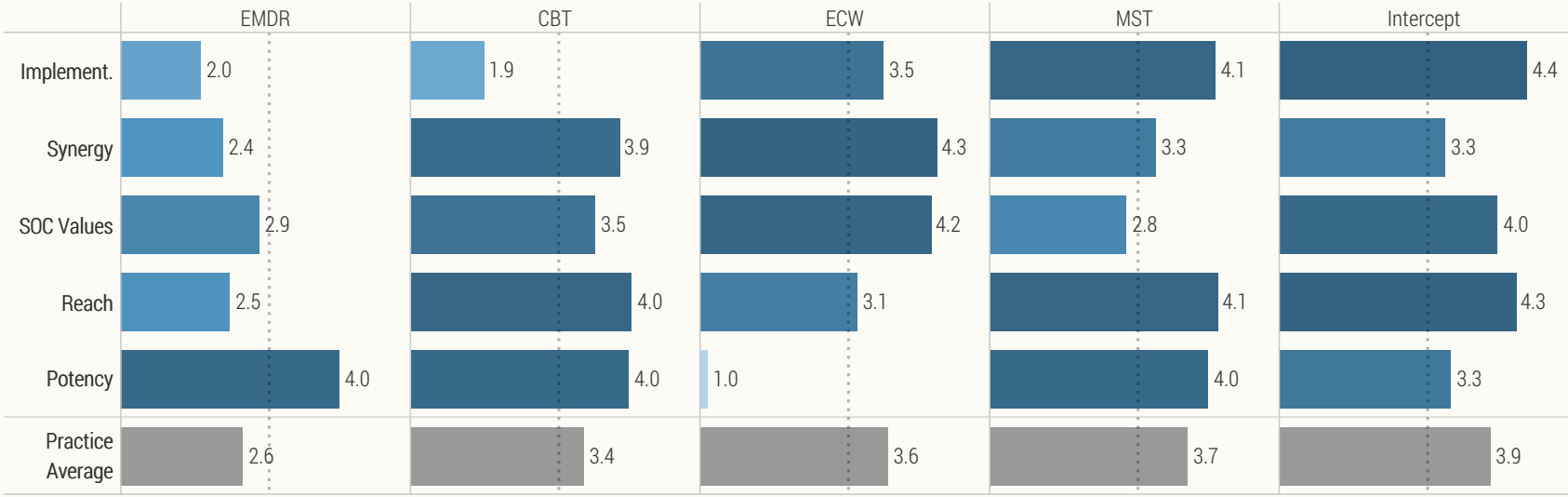


Domain scores by practice

Practice scores

The dashboard below presents domain (blue bars) and overall scores (brown bars) for each practice (columns). The dotted line denotes the midpoint of the five-point scale. EMDR exhibited the lowest scores (2.6), followed by CBT (3.4), ECW (3.6), MST (3.7), and Intercept (3.9). EMDR's strong Potency scores were offset by low Implementation, Synergy, and Reach scores. CBT's low Implementation scores negated its apparent strengths in other domains. ECW demonstrated proficiency in all domains except for Potency. MST exhibited robust Implementation, Reach, and Potency scores, with moderate Synergy and SOC Values scores. Intercept's Implementation, Reach, and SOC Values scores were very high, but its Synergy and Potency scores were moderate. Overall, MST and Intercept achieved the highest scores observed across three SOC assessments, encompassing a total of fifteen practices. For item-level scores by practice, please refer to Appendix B.

Average SOCAT scores by domain and practice



CBT profile

This section provides item- and site-level detail on CBT implementation. For the CBT item by site crosstab, see Appendix C.

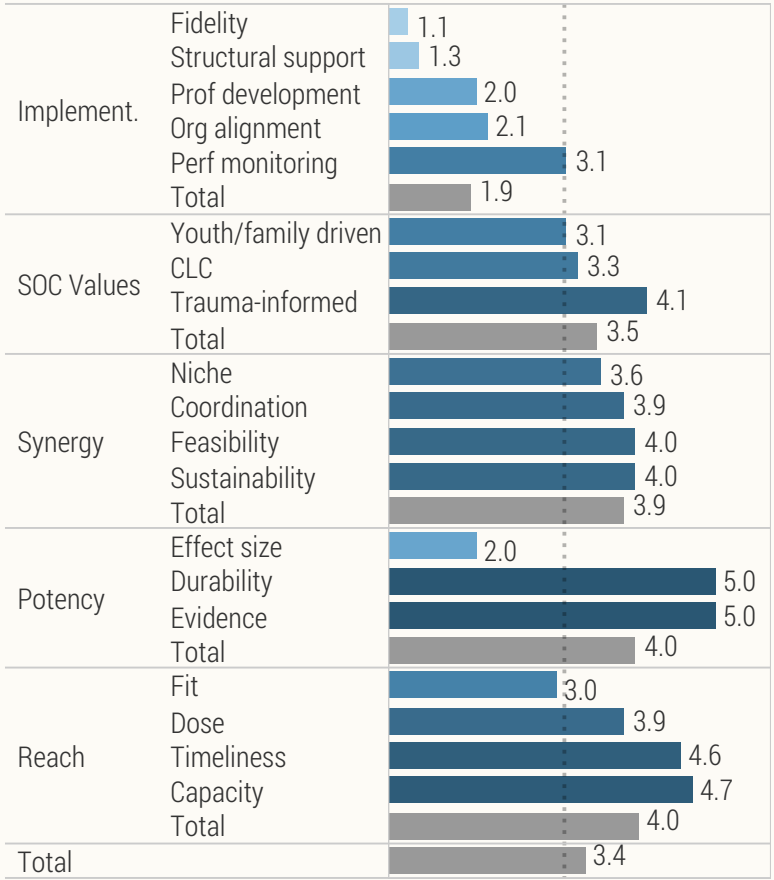
Item profile

The chart at right displays average CBT scores by item across sites.

Implementation was the lowest scoring (1.9) domain for CBT. CBT is a foundational but loosely defined practice within the NH SOC service array. The lack of a clearly defined practice model resulted in a low score (1.1) on the **Fidelity** item. Neither the state nor agencies/sites have invested in a generic CBT model,[5] leading to low **Structural Support** (1.3), **Professional Development** (2.0), and **Organizational Alignment** (2.1) scores. **Performance Monitoring**, although not specifically designed for CBT, achieved relatively high scores (3.1) due to the collection and use of observational data in RTCs, which comprised most of the CBT sites assessed.

SOC Values was the next highest scoring (3.5) domain for CBT. Limits on the degree to which practice can be truly **Youth/Family Driven** in IIHS and RTC contexts in which youth are often mandated to treatment inhibited the score (3.1) on this item, although it was clear that all sites strove to maximize youth/family engagement and input within those constraints. **Cultural and Linguistic Competence** achieved a similar score (3.3). While dedication to the ideals of CLC was evident, real-world application of them was less apparent. Adherence to **Trauma-Informed** (4.1) principles was strong, especially in RTCs, all of which integrated CBT within a trauma-informed milieu model (e.g., Attachment, Self-Regulation, and Competence; Trust-Based Relational Intervention).

CBT: Average SOCAT item scores



[5] The state has invested extensively in Modular Approach to Therapy for Children (MATCH) to serve as a foundational CBT practice within CMHCs, though they too use a diffuse version of CBT as a foundational practice due to barriers associated with high-fidelity implementation of that practice.

Synergy achieved a score of 3.9. Regarding **Niche,** CBT strategies were seen by sites as flexible and adaptable and especially complementary to the milieu approaches employed by residential sites, leading to a relatively high score of 3.6. Both internal (within site/agency) and external (with natural and professional supports) **Coordination** was structured and robust at most sites, resulting in a score of 3.9. An advantage of a loosely defined practice without significant structure or requirements is its relative ease of implementation and maintenance, leading to high **Feasibility** (4.0) and **Sustainability** (4.0) scores.

Potency achieved a score of 4.0. **Level of Evidence** and **Durability** each received the highest possible scores (5.0). Extensive, rigorous research supports the long-term efficacy of CBT practices for a wide range of youth and family populations and conditions, including anxiety,[5] obsessive compulsive disorder,[6] depression,[7] and internalizing conditions more generally.[8] CBT approaches that incorporate behavioral activation, cognitive restructuring (specifically, challenging dysfunctional cognitions), and caregiver involvement produce the most robust outcomes.[9] As such, As with most psychosocial interventions, effect sizes relative to treatment as usual for CBT are small, corresponding to a low score (2.0) on the **Effect Size** item. No outcome data were submitted by sites, so we were unable to rate the **Local Effectiveness** item.

Reach was the highest-scoring (4.0) domain for CBT. The **Fit** item received a score of 3.0 – inclusion/exclusion criteria were generally non-existent, although this is warranted to some extent since CBT has been successfully adapted to a wide range of conditions and populations. **Dose** received a relatively high score (3.9) due to the RTCs that participated in the CBT assessment; if more community-based, outpatient settings (IIHS, CMHCs) had participated, CBT would likely have scored lower on this item. Similarly, relative to CMHC and other outpatient settings, wait-times for services are lower at IIHS and RTC sites, leading to a robust **Timeliness** score of 4.6. Since CBT as practiced at these sites is highly flexibly and resource-light, the **Capacity** to provide it to all children/families referred to these sites was robust, leading to a very high score (4.7) on this item.

Site profile

CBT scores ranged from 2.8 to 3.7 across sites. **Implementation** scores were low across all site types (IIHS, RTC) and sites for the reasons articulated in the Item Profile section. Sites with more sophisticated performance monitoring systems, greater commitment to CBT as a foundational practice, and/or higher degrees of specification in their implementation of CBT scored slightly higher in this domain. **SOC Values** varied from 3.0 to 4.3; sites that integrated CBT within a strong youth/family driven and trauma-informed culture generally scored highest in this domain. NFI North's youth/family-driven culture and devotion to Trust-Based Relational Intervention were especially noteworthy in this regard. **Synergy** scores ranged from 3.0 to 4.5; sites that integrated CBT within a foundational trauma-informed model and/or emphasized internal and/or external coordination generally received higher scores. Dover Children's integration of CBT into their Trust-Based Relational Intervention milieu model fostered robust internal collaboration, which was further strengthened by significant efforts to collaborate with natural and professional supports. **Potency** is a property of the extant research evidence associated with each practice, so does not vary by site. **Reach** scores ranged from 3.0 to 4.6. Reach was most robust in RTCs, which have inherent advantages in Timeliness, Capacity, and (especially) Dose in comparison with their IIHS (outpatient) counterparts.

CBT: Average SOCAT domain scores by site type and site

	IIHS		RTC					
	Waypoint	NFI North	Nashua Children's	Home for Little Wanderers	MPA	Dover Children's	Orion House	Domain Average
Implement.	1.6	2.2	1.8	1.8	1.8	2.2	2.2	1.9
SOC Values	3.3	4.3	3.0	3.0	3.3	4.0	3.7	3.5
Synergy	3.0	4.5	3.8	3.3	3.8	4.5	4.3	3.9
Potency	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Reach	3.0	3.5	4.0	4.5	4.5	4.3	4.6	4.1
Site Average	2.8	3.6	3.2	3.2	3.4	3.7	3.7	3.4

ECW Profile

This section provides item- and site-level detail on ECW implementation. For the ECW item by site crosstab, see Appendix C.

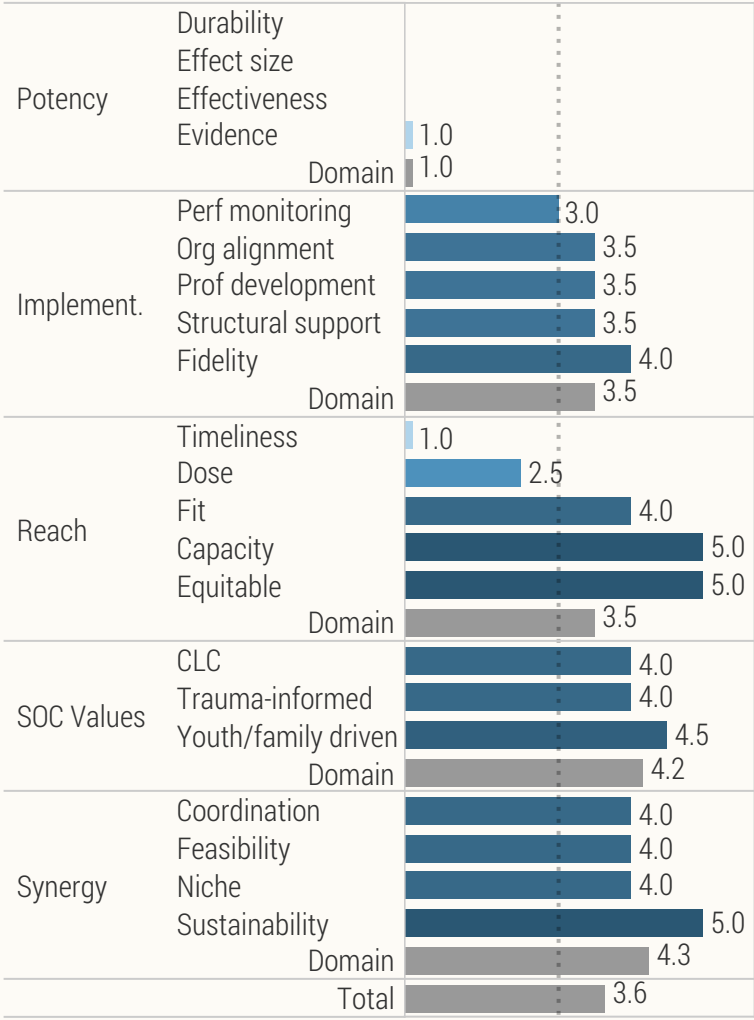
Item profile

The chart at right displays average ECW scores by item across sites.

Potency was the lowest-scoring (1.0) domain for ECW. A downside of a being a newly developed practice – even one modeled after a promising practice like Wraparound – is that no rigorous research has been conducted on ECW to date. The practice is not listed in any of the evidence-based/promising practice clearinghouses that we consulted (e.g., California Clearinghouse, Title IV-E Clearinghouse). Further, we could find no rigorous, systematic studies of delivery of ECW via a literature search. None of the published and grey literature studies provide outcome data on early childhood wraparound, per se, though some (uncontrolled) outcome research on implementation of systems of care in early childhood exists. As such, the **Durability** and **Effect Size** items could not be scored, and the **Level of Evidence** item received the lowest possible score (1.0) on the SOCAT scale. Finally, despite the ongoing collection of outcome data, there were too few ECW cases in 2023 to reliably estimate **Local Effectiveness**.

Implementation received a score of 3.5. Within this domain, the **Performance Monitoring** item received a score of 3.0. ECW programs collect an extensive set of assessments and other data on cases. On the other hand, use of this information to inform the care process and drive quality improvement were nascent, and group interviewees noted the need for an ECW-specific fidelity assessment. **Organizational Alignment** also received a rating of 3.5. Organizational support was generally viewed as adequate even

ECW: Average SOCAT item scores



though ECW is widely perceived as operating in the shadows of its older and larger sibling (FAST Forward). **Professional Development** received a rating of 3.5. ECW coordinators receive the standard FAST Forward training plus a day-and-a-half specialized ECW training, twice-monthly coaching, and a monthly practice consultation group. Reviews were mixed on the quality of ECW these professional development offerings. The **Structural Support** item also received a rating of 3.5. The Medicaid funding mechanism (daily rate) and longstanding productive partnership with BCBH are considered major assets. On the other hand, both CMEs called for greater early childhood system-building and outreach efforts to address fragmentation within the early childhood field, scale up the program through increased referrals, and enhance access to other community-based services that ECW families frequently need.[6] The **Fidelity** item received a score of 4.0. Scores from the ECW fidelity assessment were in the 50-57% range on average – a good start for a new practice – but a bit shy of the fidelity threshold (70%) on the instrument.

Reach was also received an average domain score of 3.5. **Timeliness** received the lowest rating (1.0) in this domain. Site documentation shows that it takes over 29 days on average from referral to initiation of ECW. Most of this time is spent completing the intake and eligibility process at BCBH, the initial point of entry for all CME referrals. Once the family is assigned to a CME, ECW can be initiated quickly. **Dose** also received relatively low scores (2.5). Site documentation showed many families drop out before the six-month mark or start of team meetings. **Fit** scores were high (4.0). Interviewees were particularly enthusiastic about reaching children and families at earlier ages and stages through ECW. However, the broad eligibility criteria lead to diversity in the acuity and complexity of cases, some of which could potentially benefit from lower-level care such as Family Resource Center services. **Capacity** received the highest-possible score (5.0). The capacity to serve all referred families is high, largely due to the very low volume of referrals at present. The **Equitable** item also received a score of 5.0. Demographic data provided by the CMEs indicates that access to ECW appears equitable across racial and ethnic groups.

SOC Values was the second-highest rated domain for ECW, with an average score of 4.2 – core SOC values are deeply embedded within the ECW model. The **Cultural and Linguistic Competence** item received a score of 4.0. The "timeline" tool used in ECW seems helpful in identifying cultural values and experiences of families and ultimately tailoring the approach accordingly and language services were reportedly readily accessible when necessary. The **Trauma-Informed** item also received a rating of 4.0. Group interviews suggested that the ECW process was collaborative and mutual and reflected the principles of empowerment, voice, and choice. The incorporation of peer supports was also viewed as critical to the trauma-informed ECW approach.[7] ECW was especially adherent to the **Youth/Family Driven** value, hence the high score (4.5) on this item. This value is infused throughout the practice, including unconditional, non-judgmental care and youth[8] and family voice and choice in all aspects of team development and plan of care creation, implementation, and monitoring. The perspective of the sites is supported by very high ratings on the Meeting Rating Scale, a caregiver-reported measure of the degree to which ECW meetings are youth and family driven.

[6] While this was primarily viewed by interviewees through the lens of limited early childhood system-building efforts and outreach efforts, the limited number of referrals has been a persistent issue with ECW programs in NH (including earlier, more localized grant-funded projects).

[7] It is notable, however, that trauma-informed care is not a major emphasis in the current ECW manual.

[8] Youth are engaged in a manner that is appropriate to their age and developmental level.

Synergy was the highest-scoring domain for ECW, with an average score of 4.3. **Coordination** received a rating of 4.0. ECW programs and staff are trained and experienced in coordination and profit from the foundation created in this regard by the larger FF program. Nonetheless, fragmentation of the early childhood system presents a barrier to coordination, as does limited access to early childhood mental health resources in some areas of the state. **Feasibility** also received a rating of 4.0. ECW is based on a well-established program model that can be implemented by bachelor's level staff with adequate training, coaching, and practice. While working within the fragmented early childhood system brings unique challenges, this is offset by the sense that families and supports are less burnt out and easier to work with than their FAST Forward counterparts. **Niche** also received a rating of 4.0. Care coordination for families with young children at risk of or already experiencing behavioral health problems clearly fills a gap within the SOC, and the need for ECW is viewed as widespread across several different sectors. Addressing risks for later problems in early development is seen as more effective than attempts to intervene later when families and service systems are "burnt out" by problems of the child and family. Indeed, the prevailing view is that the current size of the ECW programs falls short of addressing the estimated need. Finally, the **Sustainability** item received a rating of 5.0. The state and both CMEs are committed to sustaining the practice, and a viable long-term funding mechanism (Medicaid) is in place.

Site profile

The ECW practice was similarly strong at both CMEs. **Potency** is a property of the extant research evidence associated with a practice, so does not vary by site. **Reach** scores were identical across CMEs other than a slightly higher score for the dose item for NFI, due to a higher percentage of cases reaching the six-month/team meeting threshold. NFI was relatively advantaged in this regard as they inherited several cases (and staff) from a highly successful grant-funded ECW program. In terms of **Implementation**, NFI perceived the state system and their organization as slightly more supportive of ECW, and they benefitted from additional professional development opportunities afforded to them by virtue of being embedded within a mental health agency (CFNH's home agency is the County of Cheshire) and the presence of one of the chief pioneers of ECW in NH. On the other hand, the accessibility and use of data was rated as more fully developed at CFNH. Ultimately, fidelity between the two ECW programs was equivalent. **SOC Values** was likewise strong across programs, with youth/family-driven ethos viewed as particularly robust at CFNH. **Synergy** scores were high and identical across ECW programs.

ECW: Average SOCAT domain scores by site

	CFNH	NFI North	Domain Average
Potency	1.0	1.0	1.0
Reach	3.0	3.3	3.1
Implement.	3.4	3.6	3.5
SOC Values	4.3	4.0	4.2
Synergy	4.3	4.3	4.3
Site Average	3.5	3.6	3.6

EMDR profile

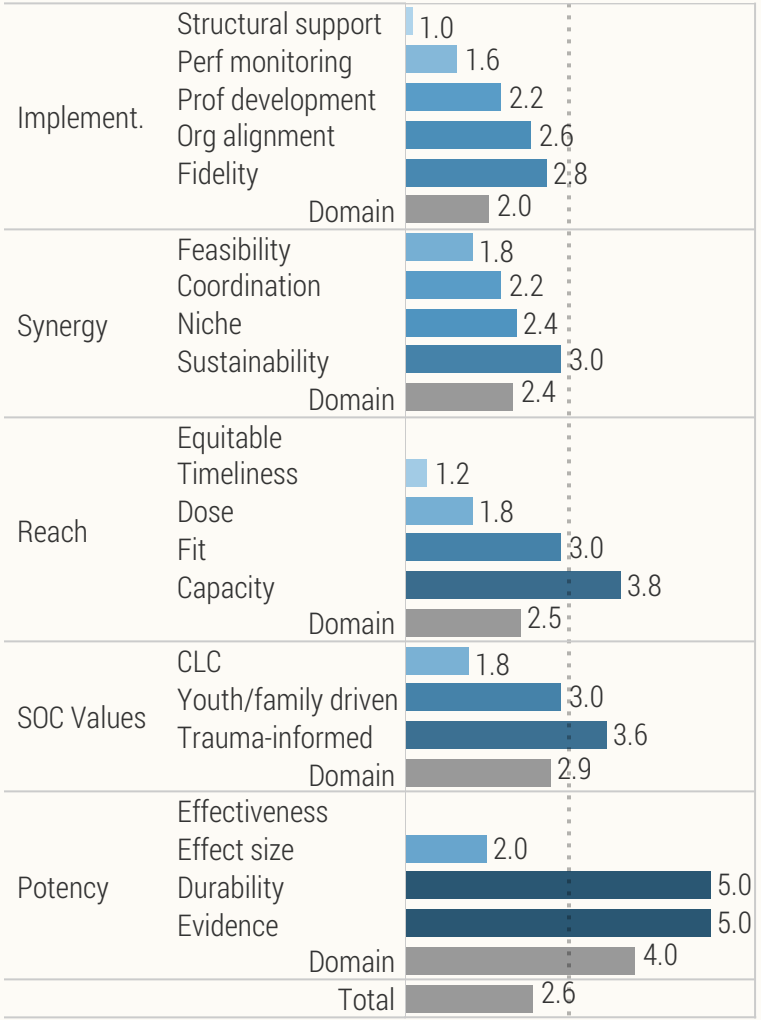
This section provides item- and site-level detail on EMDR implementation. For the EMDR item by site crosstab, see Appendix C.

Item profile

The chart at right displays average EMDR scores by item across sites.

Implementation was the lowest scoring domain (2.0) for EMDR. Within this domain, **Structural Support** was the lowest scoring item (1.0). Implementation of EMDR has arisen organically. The state has neither required nor supported the practice to date; that, along with longstanding issues with workforce shortages and reimbursement schemes insufficient for high-fidelity evidence-based practice, hampered implementation. **Performance Monitoring** received a score of 1.6. Performance monitoring was limited to state-mandated quarterly CANS and case progress reviews, supplemented by standard agency-level assessments at a minority of sites. In general, data from formal assessments are not easily accessible at the case level and are not systematically used at the practice level to drive quality improvement. The **Professional Development** item received a score of 2.2. Overall, access to professional development of sufficient frequency and quality to support high-quality implementation of EMDR was lacking at many sites. **Organizational Alignment** received a score of 2.6. Site-level support varied from minimal to strong buy-in backed by administrative and clinical champions and grant funding. The **Fidelity** item received a score of 2.8. None of the sites formally monitored fidelity. Based on the limited information available, the degree to which the model was fully and faithfully implemented (e.g., progressing through more phases of EMDR with a larger percentage of cases) tracked with the level of investment in the

EMDR: Average SOCAT item scores



model at the site level (e.g., the level and frequency of professional development provided to clinicians).

Synergy was the next lowest scoring domain for EMDR, with an average score of 2.4. Within this domain, the **Feasibility** item received a score of 1.8. EMDR was generally (but not universally) described as a challenging practice to learn, requiring sophisticated skills and "lengthy experience." The credentialing requirements of the leading purveyor, the EMDR International Association (EMDRIA) were also perceived as onerous. The **Coordination** item received a score of 2.2. Staff in group interviews described coordination with other professionals as challenging, due to limited knowledge of EMDR and its theoretical and empirical bases in the community, even among fellow clinicians. Consequently, clinicians and other professionals are often unaware of or uninterested in the multiple forms of coordination that may be involved in delivering the practice, such as recognizing opportunities for youth to receive EMDR treatment, helping youth continue EMDR treatment after a change in service status (e.g., following discharge from an inpatient setting), or supporting youth in applying EMDR skills outside of sessions. The **Niche** item received a score of 2.4. EMDR overlaps with other trauma treatments such as MATCH (the trauma module) and TFCBT, approaches may have some advantages relative to EMDR. These include a more extensive evidence base, more feasible training and implementation, and greater availability of resources to support implementation. Some clinicians interviewed for the assessment, however, argued that EMDR may provide a useful alternative to other approaches for addressing trauma and anxiety, particularly in outpatient settings in which youth can be seen for extended periods of time or for complex, severe, and/or difficult to treat cases. Several of our interviewees viewed EMDR as more in-depth and impactful than the MATCH trauma module and less taxing and verbally mediated than TF-CBT, potentially making it better fit for child/adolescent clients. This viewpoint has some support within the peer-reviewed literature.[10] The **Sustainability** item received a score of 3.0, with sites varying widely in terms of their impressions of the sustainability of the practice as well as the associated factor of expense to revenue ratio.

Reach scores (2.5) for EMDR were also below the midpoint of the SOCAT response scale. The **Timeliness** item received a rating of 1.2 due to the generally long wait times for an intake and the limited number of clinicians sufficiently trained to deliver EMDR. The **Dose** item received a rating of 1.8. According to practice documentation and group interviews, few youths advance beyond the initial phases of EMDR to reprocessing, a key mechanism of change in EMDR. **Fit** received a rating of 3.0. Sites generally did not have formal inclusion/exclusion criteria for EMDR and their views of the appropriate population for the practice varied greatly (with some narrow/restrictive, others very broad). Still, overall, staff in group interviews indicated that youth receiving EMDR are usually an appropriate fit for the practice. **Capacity** received the highest rating (3.8) in this domain. The majority of the EMDR sites could provide EMDR to all youth referred to them who might need it. Some sites, however, had more limited capacity.

SOC Values was the second-highest scoring domain (2.9) for EMDR, just shy of the midpoint on the response scale. **Cultural and Linguistic Competence** (1.8) was the lowest-scoring item in this domain; clinicians and supervisors generally struggled to identify ways of adapting EMDR to relevant dimensions of diversity in their work with clients. Linguistic responsiveness (access to/use of interpretation services, materials translated into relevant languages) was also generally lacking. The **Youth/Family Driven** item received a score of 3.0. EMDR programs were highly attuned to youth readiness, voice, and choice; however, caregiver/family involvement was less robust and at times discouraged, even though active parent involvement is generally recommended in the literature on EMDR with children.[11] The EMDR practice model, of course, is highly **Trauma-Informed**, as reflected in the generally high scores (3.6) on this item.

Potency was the highest-scoring domain (4.0) for EMDR. **Level of Evidence** (5.0) received the highest possible rating (5.0) in this domain. Three clearinghouse reviews and multiple meta-analyses of rigorous studies (including several RCTs) indicate that EMDR for children is at least on par with other well-established trauma treatments (e.g., TFCBT, other exposure-based therapies). The **Effect Size** item received a rating of 2.0. Like many EBPs, the outcome advantage of EMDR relative to treatment as usual is modest. On the other hand, rigorous research indicates that EMDR outcomes are generally well-maintained post-treatment, leading to a **Durability** item rating of 5.0.[12] No outcome data were submitted by sites, so we were unable to rate the **Local Effectiveness** item.

Site profile

The assessment revealed three "clusters" of EMDR programs: two newly developed EMDR programs in CMHCs scoring the lowest (2.1 and 2.2); a longstanding EMDR program in a RTC limited by the constraints of implementing an individual trauma therapy in a residential setting in the middle (2.8); and two robust, CMHC-based EMDR programs scoring just beyond the median of the scale (3.1 for both). In the lowest-scoring **Implementation** (2.0) domain, all programs were challenged by the lack of state support and performance monitoring was limited to nonexistent across programs. Higher scoring programs had greater organizational support and increased access to high-quality professional development and training. **Synergy** scores were consistently low (2.4); the most significant site variation in this domain was the perceived sustainability of EMDR, which ranged from a score of 2 at Northern Human Services to 4 at Mount Prospect Academy. In the **Reach** domain (2.5) scores were consistently low for Timeliness but Dose, Fit, and Capacity varied widely, with generally higher scores in the more robust programs. In the **SOC Values** domain (2.9), CLC received consistently low ratings across all sites. The EMDR programs at LRMHC and MFS were highly Youth/Family Driven, with ratings of 4.0 and 5.0, respectively, on that item. The MFS EMDR program strongly emphasized readiness, willingness, comprehension, and consent of youth clients not only during initiation but throughout the treatment process while thoughtfully tailoring family involvement based on the age (and privacy needs) of the youth. Trauma-Informed item ratings varied from 2 to 5. MPA's strong adherence to trauma-informed care principles in their EMDR program was amplified by their longstanding commitment to the Attachment, Regulation, and Competency (ARC) milieu model. **Potency** – the highest-scoring domain (4.0) – is a property of the research evidence associated with a practice, so does not vary by site.

EMDR: Average SOCAT domain scores by site

	NHS	SMHC	MPA	LRMHC	MFS	Domain Average
Implement.	1.6	1.4	2.0	2.8	2.4	2.0
Synergy	1.8	2.3	2.5	2.8	2.5	2.4
Reach	1.8	1.5	2.5	3.0	3.5	2.5
SOC Values	1.7	2.7	4.0	3.0	3.3	2.9
Potency	4.0	4.0	4.0	4.0	4.0	4.0
Site Average	2.1	2.2	2.8	3.1	3.1	2.6

Intercept profile

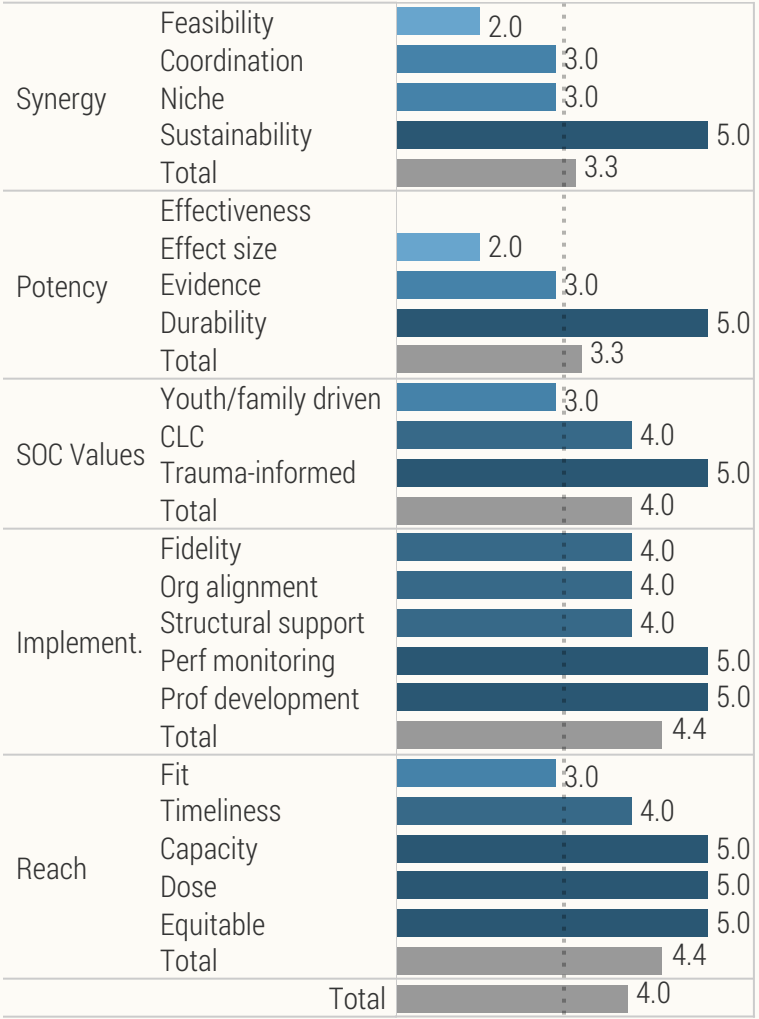
This section provides item- and site-level detail on Intercept implementation. For the Intercept item by site crosstab, see Appendix C.

Item profile

The chart at right displays average Intercept scores by item across sites. Intercept was the highest-scoring practice overall (4.0).

Synergy was the lowest-scoring domain (3.3) for Intercept, albeit one that was above the mid-point of the SOCAT scale. **Feasibility** (2.0) is the primary challenge in providing Intercept – it is a demanding practice for a complex and high-need population. The practice requires sophisticated infrastructure and a varied and highly skilled workforce to implement with fidelity. Youth Villages has created the internal conditions for Intercept to be successful in their agency, a "formula" that would be difficult to export to other settings. Intra-organizational **Coordination** (3.0) of Intercept is strong, as is their coordination with school-based and other key professionals in the child's life. At the same time, the program seems to prefer keeping the circles of support around the children they serve small, with less emphasis on coordinating with natural supports beyond the immediate family, which limited the score on this item. The need for a high-quality program that prevents avoidable out of home placement is clear, though Intercept's **Niche** (3.0) is a bit ambiguous. The state champions Intercept as a "first line" prevention technique, but it's unclear at what point in the care continuum such an intensive intervention is warranted over less resource-intensive approaches (Family Resource Center supports, wraparound) that may be appropriate in such circumstances. Likewise, Intercept is being used to support reunification and assist with transitions home following psychiatric/residential stays,

Intercept: Average SOCAT item scores



overlapping in this regard with the state's Transitional Enhanced Care Coordination (TrECC) model. Intercept received the highest-possible rating on the **Sustainability** (5.0) item – Youth Villages in a national organization with robust infrastructure and lengthy experience successfully operating the Intercept model, they have multiple sustainable funding sources in NH, the program is held in high regard throughout the state, and the agency is quite confident about the prospects for sustaining and expanding the program into the future.

Potency was the next highest scoring domain (3.3) for Intercept. The **Level of Evidence** item received a score of 3.0 ("promising research evidence"). The Title IV-E Prevention Services Clearinghouse cites two moderately rigorous studies with non-overlapping samples demonstrating reduced risk of out-of-home placement for youth treated with Intercept. The **Effect Size** item received a rating of 2.0 ("small") based on an overall treatment effect of .40. Out-of-home placement risk reduction was maintained 31 months post-treatment, as reflected in the highest possible **Durability** rating (5.0) for Intercept. No **Local Evidence** was provided, so that item was unable to be rated.

SOC Values was the next-highest rated domain (4.0) for Intercept, well beyond the mid-point of the scale. Of the items in this domain, **Youth/Family Driven** was the lowest rated (3.0). Care planning processes focus on youth and family goals that are regularly reviewed and adjusted, families are allowed to remain within the program indefinitely based on need, supervision pays careful attention to tailoring interventions to family needs and goals, and the "Collaborative Problem-Solving model is used to enhance youth voice. At the same time, the official goals in the treatment plan are driven by the expectations of the referring agent (typically, DCYC), which do not always align with the wishes of the family. Friction most often arises when caregivers are motivated primarily by a desire to obtain residential care. Requirements for safety planning within Intercept are also at times at odds with family priorities. As such, Intercept is probably more aptly characterized as "family centered" than "family driven." As a national organization, Youth Villages has clearly invested a great deal in **CLC**; hence the high score (4.0) on this item. At the same time, awareness/sensitivity to the forms of cultural/linguistic diversity most encountered in NH seemed limited, with some indication that the available national CLC resources may be inconsistently applied in practice. Intercept received the highest-possible rating (5.0) for adherence to **Trauma-informed** principles. Trauma-informed care is woven into the training and delivery of Intercept in a range of ways (e.g., CATS trauma screening, empowering families through self-advocacy, Guide-Tree protocols and interventions that are vetted to ensure adherence to trauma-informed principles, etc.), with all the principles of trauma-informed work clearly in evidence.

Implementation of Intercept was very highly rated, with a domain average of 4.4. **Structural Support**, **Organizational Alignment**, and **Fidelity** of all three receiving a rating of 4. At the state level, Youth Villages is a trusted provider, DCYF vigorously promotes Intercept, and the program benefits from two different federal funding streams. The only system-level soft spot may be at the field level, where the state's attempts to encourage DCYF field staff to use Intercept to prevent negative progressions toward out-of-home episodes may not have fully taken hold. Intercept is proprietary to Youth Villages, and the organization has strong implementation supports and structures (e.g., strict caseload limits, GuideTree) and a healthy culture rooted in norms and principles well-aligned with the program model. Intercept has dedicated "outward facing" marketing staff that promote and closely monitor emerging needs for the program. The only area of concern organizationally was staff turnover that can lead to case reassignments and inconsistencies in oversight and fidelity. With regard to fidelity, monitoring systems seem adequately operationalized and informative for practice. Based on the interview data, it seems likely that Intercept is implemented with fidelity on a reasonably consistent basis and that departures from fidelity, when they occur, can be detected and addressed. However, fidelity scores or even specific descriptions of performance on fidelity indicators were not submitted in practice

documentation, and questions about possible variation in fidelity based on the staff and leadership churn were raised in some interviews. **Professional Development** and **Performance Monitoring** both received the highest possible score (5.0). Intercept provides ample training, and its sophisticated supervisory framework includes 1) standard clinical supervisors and program experts, 2) six hours of supervision weekly per clinician, 3) general conceptual and implementation guidance as well as more typical case-oriented reviews, 4) regular field observations, 5) performance monitoring data, and 6) a regularly updated online clinical guidance tool system that provides detail on a wide range of potential interventions. Intercept's performance monitoring system, moreover, is comprehensive and sophisticated. Three different units collect and use of data at the national accreditation (JAYCO), program quality improvement, and case levels.

Reach was also highly rated (4.4). The flexibility of Intercept's inclusion/exclusion criteria may be a mixed blessing when it comes to **Fit** – the lowest-scoring item in this domain (3.0). The inclusion/exclusion criteria for the program are broad, and attempts are made to adapt the practice to as many cases as possible. This results in variability in how the target population is understood – some described Intercept as a prevention service to "interrupt" progressions toward out of home treatment "as early as possible," whereas others believed that post-hospital transition or reunification were the "bread and butter" of the program. Practice documentation indicates that the Intercept is typically initiated within 8-14 days of referral, earning it a high (4.0) rating on the **Timeliness** item. The **Capacity**, **Dose**, and **Equitable** items all earned the highest possible rating (5.0). Youth Villages can meet the needs of all families referred to Intercept, with the ability to hire more staff should referrals outstrip capacity. Based on Youth Villages data, about 85 percent of youth that initiate Intercept receive an adequate dose, a remarkably high retention rate for a psychosocial program. Finally, Youth Villages data indicate that access to the Intercept is equitable across racial and ethnic groups.

Site profile

The assessment revealed a high degree of consistency between the Youth Villages–Manchester and -Plymouth sites, as reflected in identical overall scores. This is partially a byproduct of operating a highly codified practice within a single parent agency that developed and continues to nurture it. It may also be partially due to the difficulty in fully separating the data, documentation, and experiences of the two sites. That said, some "place-based" nuance emerged between the sites. For instance, the Plymouth site seemed particularly adept in supporting youth/family voice in their interactions within the DCYF system. Staff in Plymouth did not raise the (mild) concern about staff turnover voiced by their colleagues in Manchester. On the other hand, Plymouth staff were less enthusiastic than their Manchester peers about using Intercept to stabilize youth prior to residential treatment and as a "step down" for youth exiting Hampstead Hospital. Most likely due to their rural setting, Plymouth staff were more likely to raise the specter of unmet basic needs – namely lack of transportation and stable housing – as barriers to successful treatment. Finally, although they are at least as enthusiastic about the quantity and quality of training, Plymouth staff must travel further to attend in-person trainings in Massachusetts than their Manchester peers.

Intercept: Average SOCAT domain scores by site

	Manchester	Plymouth	Domain Average
Synergy	3.3	3.3	3.3
Potency	3.3	3.3	3.3
SOC Values	4.0	4.0	4.0
Reach	4.3	4.3	4.3
Implement.	4.4	4.4	4.4
Site Average	3.9	3.9	3.9

MST profile

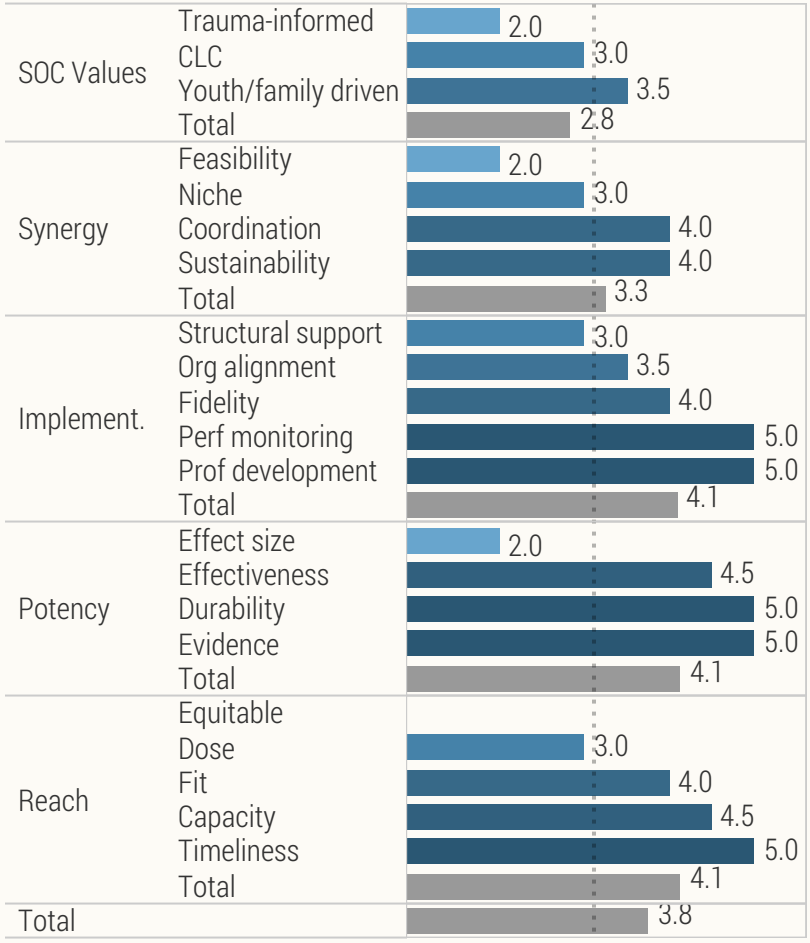
This section provides item- and site-level detail on MST implementation. For the MST item by site crosstab, see Appendix C.

Item profile

MST was highly rated, with an average score of 3.8 overall.

SOC Values was the lowest-rated domain (2.8) for MST, just below the mid-point of the scale. Of the items in this domain, **Trauma-informed** was the lowest-rated (2.0) in this domain. Although overlap between the principles of MST and trauma-informed practice is apparent, the MST Organizational Manual makes little mention of trauma-informed principles, and group interviews reflected a cursory understanding and application of these principles in practice (e.g., equating "safety planning" with the trauma-informed concept of safety). **CLC** was the next highest-rated item (3.0). NH's MST programs recognize the importance of cultural responsiveness, though articulation of how CLC principles are applied in practice varied. The capacity to work with linguistically diverse families was constrained by the limited availability and quality of translation services. **Youth/family-driven** was the highest rated (3.5) item in this domain. MST is family-focused, strengths-based, and seeks to empower parents through skills training. The family is intensively involved on an ongoing basis and care planning, interventions, and outcome monitoring are all driven by the youth and family's needs and goals. The fact that MST is often court-ordered represents a challenge to the youth/family driven ideal. MST staff address this challenge by emphasizing the voluntary nature of consent for treatment (although not signing may result in undesirable consequences). Treatment is intensively focused on caregivers, some of whom do not want and/or have the bandwidth to assume this level of responsibility.

MST: Average SOCAT item scores



Synergy was the next highest-scoring domain (3.3 **Feasibility** (2.0) is a central challenge in providing MST. The practice is resource intensive in terms of direct care and supervisory hours and requires a high level of engagement from families (as many as 3-5 meetings per week). Thus, achieving high fidelity practice can be challenging and demands major buy-in from sites and clinicians. Although MST programs can employ clinicians with varying skill levels and experience, recruiting and retaining these staff can be extremely challenging due to the 24/7 availability the role requires. Indeed, staffing and retaining clinicians in NH's programs has been challenging in ways that have adversely impacted implementation. **Niche** was the next highest-scoring item (3.0) in this domain. MST overlaps, in part, with Intercept; the models are similar, though Intercept is somewhat less resource intensive and focuses on a broader population. MST's unique strength is its level of specificity and demonstrated effectiveness in addressing ecological determinants of adolescent delinquent and antisocial behavior. As with other practices that initially struggle to establish a foothold in NH, the state seems inclined to relax MST inclusion/exclusion criteria to increase use of MST, which would increase the overlap with Intercept. MST **Coordination** was highly rated (4.0). MST focuses heavily on identifying resources and addressing barriers in the social networks, school, service connections, and other microsystems of youth and families; thus, efforts to understand, improve, and track progress in improving the supportiveness of these connections are emphases of the model. Facilitating communication between parents and schools is a priority and MST clinicians spend considerable time engaged in coordination activities. In addition, direct care providers, as well as supervisors and administrators, seek to strengthen their relationships with other professionals working with youth. The main challenge in NH is to improve MST's collaboration with Juvenile Justice offices and staff; efforts to bolster these relationships are ongoing. Any lack of coordination between MST and other services risks overburdening families with meetings and service providers; MST alone involves 3-5 meetings per week. MST **Sustainability** also received a rating of 4.0. Although MST is an expensive practice compared to some in child behavioral health, high quality implementation can be supported through a variety of financing strategies. In NH, the program is billed through a daily rate. MST, however, cannot bill to Medicaid, making the service more expensive for the state. While MST can be funded via Families First, this requires documentation that the referral was preventative. Nonetheless, the program leadership indicated that the program was "considerably sustainable" for the next two years under the terms of their current contract.

Implementation was one of the three highest-rated domains, with an average score of 4.1. The **Structural Support** item received a rating of 3.0. The consensus among those interviewed was that DCYF champions the practice and has been very responsive to issues brought to their attention. From a reimbursement perspective, the inability to bill the service to Medicaid makes the practice more costly to the state. Additionally, initial authorization requests for MST are sometimes provisionally capped at three months, which can be misunderstood in some cases as a hard limit. The most significant systemic issue, however, seems to be variable referral preferences among Juvenile Justice offices and Juvenile Probation and Parole Officers (JPPOs). Some are reportedly hesitant to alter longstanding referral tendencies, refer youth with milder infractions (e.g., truancy), or buy into MST's social ecological model. Others may refer *too* liberally to MST due to the lack of other intervention options in rural areas of the state. Finally, while some youth entering DCYF via Child Protection have the kinds of behaviors that would profit from MST, the default in that system seems to be Intercept. Although the state has been proactive and persistent in addressing these issues, their efforts have not yet been fully effective. The **Organizational Alignment** item received a rating of 3.5. MST is certified/accredited at the level of the program rather than the individual provider. This serves to promote fidelity and consistency of program level implementation. CSI's implementation of MST benefits from its lengthy history with and national infrastructure for the model. With limited exceptions, staff were

complementary of the level of support for the practice provided by the organization, especially peer support provided by the team approach, multiple levels of highly coordinated supervision, and opportunities for professional development. Opportunities for advancement are also available, as MST programs generally prefer to hire supervisors from their direct care staff. The biggest challenge for implementation has been difficulties with staff recruitment and turnover, which impacted both sites to varying degrees. The **Professional Development** item received a "perfect" rating of 5.0. MST has a well-developed, well-documented, fully integrated, and empirically supported model for training and supervision that contains all components specified in the SOCAT professional development indicator. Interviewees indicated that this sophisticated professional development system is firmly in place in NH. Three hours of supervision are provided on a weekly basis, including two with the team supervisor and one with a national program expert. Coaching and supervision by the supervisor and program expert are frequently assessed and feedback on any deviation from expected benchmarks is quickly provided. Field observation is used extensively, both of clinicians providing care and of supervisors and program experts and can be titrated to the needs of individual clinicians based on their level of experience and performance. Performance feedback based on extensive quality monitoring also directly informs yearly performance reviews and professional development planning. A feature of PD highlighted by staff as a particular strength is the initial training and onboarding process. Staff also commented on the amount of time given staff to begin seeing cases and acquire their full caseload. In some cases, staff shadow for weeks prior to being trained or seeing a client. Initial and advanced supervisor trainings are also delivered. All these trainings are delivered by national purveyors. **Performance Monitoring** also received a rating of 5.0. The MST model has one of the best developed performance monitoring frameworks of any intervention in child behavioral health, the utility of which has been established and refined through extensive research.[13] A suite of empirically validated tools and a tailored data system are used as one component of a larger QI framework. Data on fidelity, outcomes, services, and experience of care are collected and used at case, practitioner, and program levels. Supervision, consultation, and clinician performance review are grounded in the use of data from regularly and frequently administered MST standardized assessments. The MST data system provides capacity for program directors to easily generate reports of fidelity, outcome, and experience of care data, which are used in a structured fashion on an ongoing basis for practitioner and program level performance monitoring and quality improvement. **Fidelity** received a rating of 4.0 based on data from the MST Data System, which indicates that between 61 to 74 percent of cases across the sites studied met the MST fidelity threshold.

A second highly rated domain was ***Potency***, with an average score of 4.1. The **Level of Evidence** item received a rating of 5.0 based on rigorous, peer reviewed RCTs by multiple research teams including independent samples from several state systems in the U.S. and in Europe. The evidence base on MST indicates that it is most efficacious for delinquency, family, and parenting variables and less so for mental health symptoms, substance abuse, peer relations, and school outcomes. Ongoing oversight from a purveyor organization (including MST Services, Inc., which accredits CSI), program fidelity, and treatment adherence are crucial for achieving positive youth outcomes. Meta-analytic findings from the Washington State Institute for Public Policy (WSIPP) and Title IV-E Prevention Services Clearinghouse indicate effect sizes from .2-.3 for delinquency, crime, problem behavior, and behavioral and emotional functioning, corresponding to a "small" effect relative to treatment as usual, and an **Effect Size** item rating of 2.0.[14] MST also received the highest possible rating (5.0) on **Durability**. Many studies of MST have documented strong maintenance of gains post-treatment over periods stretching up to multiple years.[15] The **Local Effectiveness** item received a rating of 4.5 based on outcome data supplied by CSI. Most of the youth enrolled in NH MST programs remain at home, attend school or go to work, and avoid further arrests.

Reach also received average score of 4.1. Ensuring an adequate dose is a focus of the CSI/MST quality improvement protocol. Practice documentation indicates that the case completion rate currently falls in the 40–59% range, which translates to a score of 3.0 on the **Dose** item. The **Fit** item received a rating of 4.0. Assessing fit of youth and families to MST is a major emphasis of the program model and its implementation at CSI. Staff described appropriate checks in their procedures to help ensure that youth and families admitted to the program are appropriate (e.g., consultation with a national program expert in cases for which appropriateness may be unclear). A potential future threat to fit has to do with encouraging use of MST as a "prevention" service for less severe cases – some research suggests its effects are weaker among youth with less severe or pervasive problem behavior. The **Capacity** item received a rating of 4.5; generally speaking, the current MST offices and teams can meet needs for referrals without resorting to waiting lists, though at one of the two sites, fluctuating needs have resulted in some instances in which staff have full caseloads and referrers send youth and families to other programs. **Timeliness** received a rating of 5.0 based on CSI documentation that they can initiate MST for families within seven days of referral. No demographic data were supplied for MST programs in NH so the **Equitable** item could not be rated.

Site profile

Scores across NH MST sites were similar, including identical scores in the **Synergy** domain. In the **SOC Values** domain, the Manchester/Dover team seemed especially attuned to Youth/family Driven and CLC principles. The slight difference between sites on **Implementation** was attributable to the Manchester/Dover team's greater enthusiasm for aspects of Organizational Alignment, especially documentation, data collection, and performance monitoring requirements. In the **Potency** domain, local evidence provided by CSI indicated slightly more positive outcomes for cases at the Lebanon/Lincoln site. The other slight variation was slightly greater capacity relative the need in the Manchester/Dover office; at times, the Lebanon/Lincoln site must resort to (very short) waiting lists.

MST: Average SOCAT domain scores by site

	Lebanon/Lincoln	Manchester/Dover	Domain Average
SOC Values	2.3	3.3	2.8
Synergy	3.3	3.3	3.3
Implement.	4.0	4.2	4.1
Potency	4.3	4.0	4.1
Reach	4.0	4.3	4.1
Site Average	3.7	3.9	3.8

Lessons learned and next steps

System-wide themes

Echoes from previous assessments

Several themes from the first two SOC Assessments apply equally well this year. First, **geography and context matters** – it is inherently more difficult to implement evidence-based and promising practices with fidelity in smaller agencies, rural areas serving highly dispersed populations, and/or in thinly resourced regions of the state. Second, **you get what you pay for** – when resources are readily available to attract and retain a sufficient workforce and support the "unbillable" aspects of EBPs, reach and implementation are improved. Third, you can **never take your foot off the gas** – up-front investment in the installation of new practices is insufficient for sustaining 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, with few exceptions, the system continues to operate in a **data-poor environment**, which hampers client care, transparency and accountability, and our ability to learn and grow as a system.

Emergent themes from this year's assessment

Two additional cross-cutting themes emerged from this year's assessment. The first is that **specialization has its benefits,** as evidenced by the successful implementation of Intercept and MST in agencies that have made significant long-term investments in infrastructure specific to these practices. For example, Intercept is a proprietary practice of Youth Villages, which they are clearly motivated to continue to maintain and scale-up as part of an overall growth strategy for the agency. This phenomenon was present to a lesser extent in previous assessments as well, including in NH's CMEs that concentrate on a small set of interrelated care coordination practices, and even in generalist settings such as CMHCs in the form of specialized teams that are highly dedicated to particular practices focusing on specific populations and types of outcomes (e.g., NAVIGATE, CPP).

Relatedly, the **more deeply embedded the support structures, the better the implementation**. Youth Villages' structures for high-fidelity implementation of Intercept exemplify this theme. The agency has made substantial, long-term investments in both the development of the practice itself and specialized infrastructure to support it, including specific staffing procedures (hiring, onboarding, and human resource support); professional development practices (expert training, coaching, and supervision); and performance monitoring tools (data systems, clinical decision tools, and comprehensive quality improvement protocols). CSI's MST implementation support structures serve as another illustration from this year's assessments. Approximations of this kind of long-term investment in other successful NH practices, include 1) the longstanding group of NH-based technical assistance organizations that have scaffolded the FAST Forward and other CME practices and 2) the Center for Trauma-Responsive Practice Change's longstanding CPP learning community. We recommend efforts to develop and deeply embed such practice and implementation expertise either within or in close proximity to the practice setting(s).

Practice-specific themes

CBT as treatment as usual

Until rate structures can sustainably support the high-fidelity implementation of more clearly defined and operationalized evidence-based practices throughout the system, the version of CBT depicted in this assessment is likely to remain the default option ("treatment as usual"). Most practitioners have foundational

exposure to CBT prior to entering the workforce, supervisors feel comfortable mentoring practitioners in this approach, and it is often the most feasible available option (especially in "billable hour," fee-for-service environments).

Any modifications or further specification of CBT must be "light touch" to maintain its feasibility advantage. One option is to identify an existing, more formalized model of CBT that would be appropriate for most cases. Indeed, the system has invested significantly in Modular Approach to Therapy for Children (MATCH) – an evidence-based CBT practice with impressive research backing – to fulfill this function. However, this strategy has only been partially effective thus far. First, MATCH implementation has been restricted to CMHCs, limiting spread to other settings (e.g., IIHS and RTCs). Second, although MATCH is relatively straightforward to deliver, systematic implementation of its algorithms, modules, and data system have nonetheless proven challenging to achieve at scale due to factors such as time pressure, workforce turnover, reliance on a national purveyor for training and certification, practitioner preferences for alternative models and/or more organic approaches, and more.

Another option would be to enlist the expertise of NH mental health providers in defining and articulating the core principles and strategies of CBT, either as it is currently practiced in NH or in a more aspirational manner to scaffold sites in optimizing their CBT practice. This approach could ultimately result in a resource as elaborate as Intercept's "GuideTree" system or a simpler product such as a core set of readings, materials, and resources from the extant literature as well as recommended resources and tools to better define and support CBT practice. Working with NH technical assistance centers to develop a logic model or practice profile could also be beneficial.

A further alternative for improving treatment as usual would be a statewide clinical feedback system. Known as routine outcome monitoring, these systems provide practitioners with automated feedback on client progress (and sometimes, corresponding decision support tools) based on scores from a frequently administered, brief, and standardized assessment tool. Research suggests that these systems can increase client retention and enhance the effectiveness and efficiency of treatment as usual, even in the absence of other systematic efforts to otherwise add to or further specify existing practices. The effect sizes associated with routine outcome monitoring are comparable to those for evidence-based practices,[16] with the additional benefit of systematically capturing valuable outcome data for program, agency, and systemwide decision-making and quality improvement. Several such systems already exist that utilize different assessment tools and feedback algorithms to identify "off-track" cases.[17]

Surrounding ECW with a more cohesive EC system

The primary challenge facing Early Childhood Wraparound (ECW) is the relatively fragmented nature of the New Hampshire (NH) early childhood education and care system and their isolation from the overall SOC. This impedes ECW's ability to generate referrals to the practice and facilitate referrals to additional community supports that families often require, particularly in rural and resource-constrained areas of the state. This underscores the need to integrate early childhood services and supports and enhance cross-sector coordination at the systems level for young children and their families—a proven and cost-effective strategy for enhancing care for children at risk in early childhood.[18]

An illustrative example comes from a recent grant-funded ECW program in Manchester, NH, operated by Waypoint. Referrals to the practice languished initially but increased substantially when the ECW program established a crucial connection with the local Adverse Childhood Experiences Team (ACERT) operated by Amoskeag Health. ACERT involves collaboration between police officers and case managers to facilitate timely referrals for children recently exposed to adverse childhood experiences. As such, ACERT encounters many young children who may be suitable for ECW services. Further interconnections with Family Resource

Centers, early childhood education programs, and other providers of early supports and services for infants, toddlers, and young children would also be beneficial. An opportune moment to engage in this early childhood systems work is the forthcoming "Tier 1" workgroup under the Children's Behavioral Health Advisory Committee.

EMDR's place within the overall service array

EMDR has emerged recently and organically based on agency and clinician interest. Proponents argue (with some research support) that EMDR is potentially less demanding and more effective for some clients than MATCH's trauma module or even Trauma-Focused Cognitive Behavioral Therapy (TFCBT). And clearly, there is value in allowing practitioner interest and passion to influence the composition of the service array.

Nonetheless, the overlap between EMDR and these more widely recognized models is evident. High-fidelity implementation of EMDR would represent a sizable investment, and there is additive value in remaining within the CBT family of interventions rather than incorporating a more novel approach.

Earlier in this section, we advocated for doing a small number of practices well – three trauma treatments for the same age group in CMHC settings would seemingly violate this principle and divert attention from other priorities. Therefore, we advocate for the state to work with its technical assistance and practice partners to make an explicit decision about which trauma practice(s) it will endorse and support. Because MATCH's other modules make it useful as a generalist, foundational model, the choice of which additional model to endorse – if any – seemingly comes down to EMDR or TFCBT.[9]

[9] TFCBT has also not been state-supported; the practice was historically supported via a series of grants awarded to the Dartmouth Trauma Interventions Research Center (DTIRC), with adoption waning over time.

When and with whom to use Intercept

Currently, Intercept's niche within the overall service array is unclear. Some of the key questions to be clarified include: 1) if Intercept is to be used as a first-line prevention strategy, when should youth and families be referred to Intercept versus alternatives such as FAST Forward, a CMHC, or even a Family Resource Center? 2) In cases of more intensive need, should Intercept be the preferred model in all cases, or are there instances in which referral to other options may be preferred (e.g. MST in cases with severe histories of delinquency, regardless of whether the entry point was Child Protection or Juvenile Justice) and 3) when should Intercept be used for children exiting the psychiatric hospital or residential settings versus other step-down options such as Transitional Enhanced Care Coordination?

Once these decisions are made, they could be supported by developing an electronic referral decision support tool for DCYF workers and other potential referral partners. Such a tool should go beyond assessing fit with Intercept's inclusion/exclusion criteria and include the capacity to recommend alternative treatments such as TrECC or MST. Ideally, the tool would use algorithmic decision-rules to identify the least intensive practice that meets the needs of each child and family, based on the best available evidence and the state's carrying capacity for each intervention.

Bolstering MST's referral and support network

The most pressing challenge facing MST appears to be uneven knowledge and acceptance of the practice, leading to irregular referral patterns from field offices. To some extent, this issue may be exacerbated by tendencies to characterize MST as a prevention service. We recommend adhering to traditional inclusion/exclusion criteria for MST, as the practice is only cost-effective for the

populations and outcomes it was originally designed to serve. The aforementioned referral decision support tool could include MST as an option. Written guidance about the circumstances under which an MST-appropriate case (one that meets the standard inclusion/exclusion criteria) would be eligible for Families First funding and associated documentation standards could be helpful for field offices and staff.

Overall, the state appears to be supportive of MST and has demonstrated an interest in continuing education and outreach efforts to further disseminate use of the practice in the Juvenile Justice system. We recommend continuing and expanding these through use of tools to engage the target audience such as case stories, videos, and word-of-mouth anecdotes. Involving various champions would also enhance outreach efforts (e.g. CSI leaders, MST practitioners, or JPPO MST champions from NH and other states).

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	

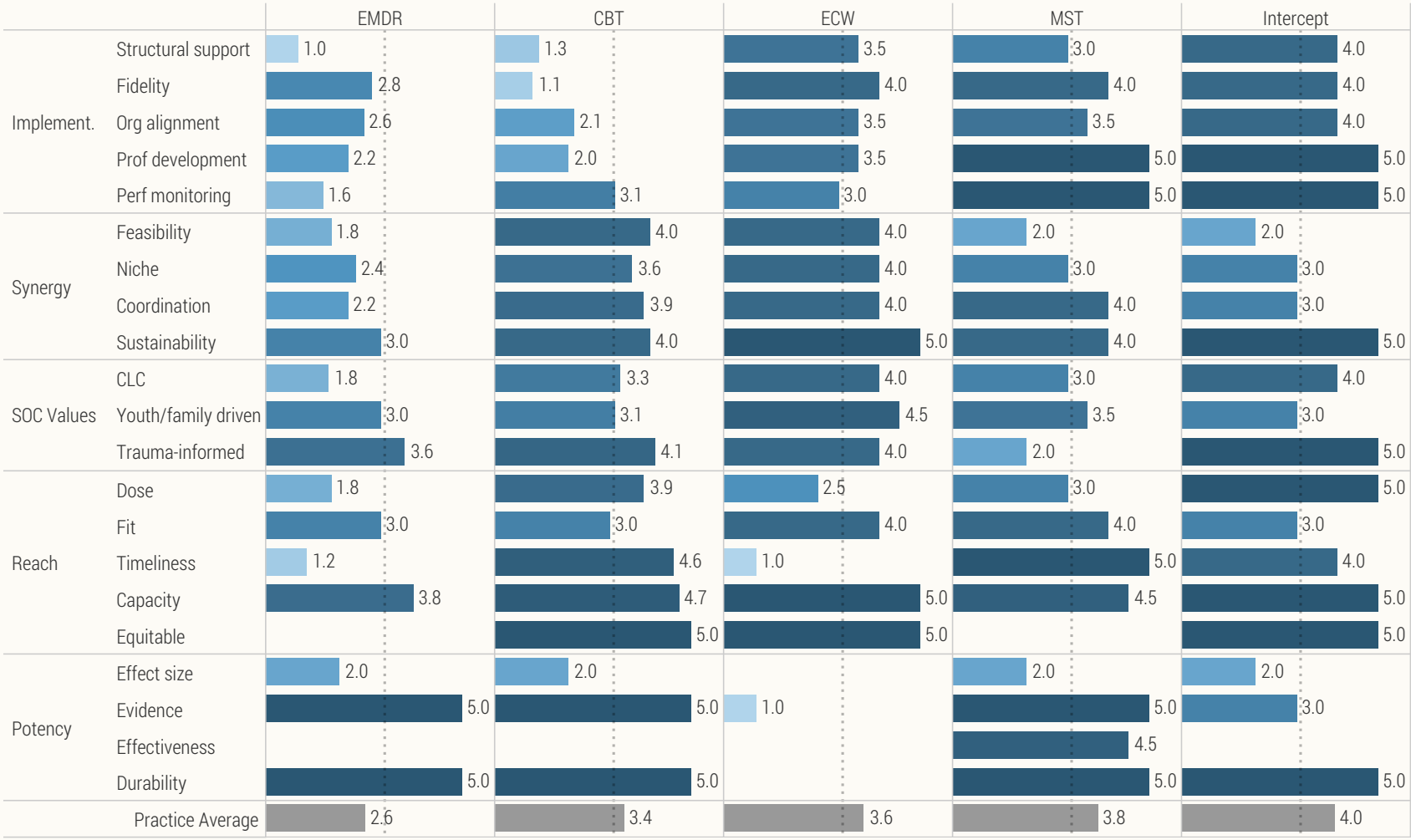
Domains/Items		Practice Rating					
Domain	Item	○	◔	◑	◕	●	Not rate-able
	12. Performance monitoring Ongoing, frequent, rigorous, and comprehensive monitoring of demographics, service delivery, alliance/experience of care, fidelity, and outcomes; regular, structured use of data for data-based decision-making 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

CBT: SOCAT item scores by domain and site

		Waypoint	Nashua Children's	Home for Little Wanderers	MPA	NFI North	Dover Children's	Orion House	Item Average
Implement.	Fidelity	1	1	1	1	1	1	2	1.1
	Structural support	1	1	1	1	2	1	2	1.3
	Prof development	2	2	2	2	2	2	2	2.0
	Org alignment	2	2	2	2	2	3	2	2.1
	Perf monitoring	2	3	3	3	4	4	3	3.1
SOC Values	Youth/family driven	3	2	3	3	4	4	3	3.1
	CLC	3	3	3	3	4	3	4	3.3
	Trauma-informed	4	4	3	4	5	5	4	4.1
Synergy	Niche	2	4	3	4	4	4	4	3.6
	Coordination	4	4	3	3	5	4	4	3.9
	Feasibility	3	4	4	4	4	5	4	4.0
	Sustainability	3	3	3	4	5	5	5	4.0
Potency	Effectiveness								
	Effect size	2	2	2	2	2	2	2	2.0
	Durability	5	5	5	5	5	5	5	5.0
	Evidence	5	5	5	5	5	5	5	5.0
Reach	Fit	3	3	3	3	3	3	3	3.0
	Dose	1	5	5	5	2	4	5	3.9
	Timeliness	4	3	5	5	5	5	5	4.6
	Capacity	4	5	5	5	4	5	5	4.7
	Equitable							5	5.0
	Site Average	2.8	3.2	3.2	3.4	3.6	3.7	3.7	3.4

ECW: SOCAT item scores by domain and site

		CFNH	NFI North	Item Average
Potency	Durability			
	Effect size			
	Effectiveness			
	Evidence	1	1	1.0
Implement.	Perf monitoring	4	2	3.0
	Org alignment	3	4	3.5
	Prof development	3	4	3.5
	Structural support	3	4	3.5
	Fidelity	4	4	4.0
Reach	Timeliness	1	1	1.0
	Dose	2	3	2.5
	Fit	4	4	4.0
	Capacity	5	5	5.0
	Equitable	5	5	5.0
SOC Values	CLC	4	4	4.0
	Trauma-informed	4	4	4.0
	Youth/family driven	5	4	4.5
Synergy	Coordination	4	4	4.0
	Feasibility	4	4	4.0
	Niche	4	4	4.0
	Sustainability	5	5	5.0
	Site Average	3.6	3.7	3.6

EMDR: SOCAT item scores by domain and site

		NHS	SMHC	MPA	LRMHC	MFS	Item Average
Implement.	Structural support	1	1	1	1	1	1.0
	Perf monitoring	2	1	2	1	2	1.6
	Prof development	1	1	2	4	3	2.2
	Org alignment	2	2	3	4	2	2.6
	Fidelity	2	2	2	4	4	2.8
Synergy	Feasibility	1	2	2	2	2	1.8
	Coordination	2	2	2	3	2	2.2
	Niche	2	2	2	3	3	2.4
	Sustainability	2	3	4	3	3	3.0
Reach	Equitable						
	Timeliness	1	1	1	1	2	1.2
	Dose	1	1	2	2	3	1.8
	Fit	3	2	2	4	4	3.0
	Capacity	2	2	5	5	5	3.8
SOC Values	CLC	1	2		2	2	1.8
	Youth/family driven	2	3	3	3	4	3.0
	Trauma-informed	2	3	5	4	4	3.6
Potency	Effectiveness						
	Effect size	2	2	2	2	2	2.0
	Durability	5	5	5	5	5	5.0
	Evidence	5	5	5	5	5	5.0
	Site Average	2.1	2.2	2.8	3.1	3.1	2.6

Intercept: SOCAT item scores by domain and site

		Youth Villages -- Manchester	Youth Villages -- Plymouth	Item Average
Synergy	Feasibility	2	2	2.0
	Coordination	3	3	3.0
	Niche	3	3	3.0
	Sustainability	5	5	5.0
Potency	Effectiveness			
	Effect size	2	2	2.0
	Evidence	3	3	3.0
	Durability	5	5	5.0
SOC Values	Youth/family driven	3	3	3.0
	CLC	4	4	4.0
	Trauma-informed	5	5	5.0
Implement.	Fidelity	4	4	4.0
	Org alignment	4	4	4.0
	Structural support	4	4	4.0
	Perf monitoring	5	5	5.0
	Prof development	5	5	5.0
Reach	Fit	3	3	3.0
	Timeliness	4	4	4.0
	Capacity	5	5	5.0
	Dose	5	5	5.0
	Equitable	5	5	5.0
	Site Average	4.0	4.0	4.0

MST: SOCAT item scores by domain and site

		CSI: Lebanon/Lincoln	CSI: Manchester/Dover	Item Average
SOC Values	Trauma-informed	2	2	2.0
	CLC	2	4	3.0
	Youth/family driven	3	4	3.5
Synergy	Feasibility	2	2	2.0
	Niche	3	3	3.0
	Coordination	4	4	4.0
	Sustainability	4	4	4.0
Implement.	Structural support	3	3	3.0
	Org alignment	3	4	3.5
	Fidelity	4	4	4.0
	Perf monitoring	5	5	5.0
	Prof development	5	5	5.0
Potency	Effect size	2	2	2.0
	Effectiveness	5	4	4.5
	Durability	5	5	5.0
	Evidence	5	5	5.0
Reach	Equitable			
	Dose	3	3	3.0
	Fit	4	4	4.0
	Capacity	4	5	4.5
	Timeliness	5	5	5.0
	Site Average	3.7	3.9	3.8

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