NH Children's Behavioral Health Field

2017-2024 Assessment of Field Progress

Behavioral Health Improvement Institute
September, 2024

This report was funded by
the New Hampshire Endowment for Health
Concord, NH

Behavioral
Health
Improvement
Institute

Keene
STATE COLLEGE

Contents

Acknowledgement

To the twenty-six key informants who contributed their time and wisdom to this report, we offer our thanks for your generosity and our admiration for your efforts on behalf of NH's children and families.

Executive Summary

Assessing the Children's Behavioral Health field using the Field Assessment Tool (FASST)

The Behavioral Health Improvement Institute (then the Center for Behavioral Health Innovation at Antioch University) was asked by the Endowment for Health (EH) to develop an assessment process that could inform strategic allocation of resources in EH's priority areas. The resulting Field Assessment Tool (FASST; Fauth, Phillips, and Nordstrom, 2016) estimates field development across 7 domains and 32 items based on key informant interviews. The FASST was first used to assess the conditions of NH's Children's Behavioral Health (CBH) field in 2017 (Nordstrom & Fauth, 2017). The assessment was repeated in 2020 and 2024; the latter constitutes the focus of this report.

The Children's Behavioral Health field has matured well into the Action stage of development

In 2017, New Hampshire's CBH field was within the Action stage of development, with deeply shared goals and values, yet facing substantial challenges in recruiting the public awareness and support needed to improve program quality and access. The 2020 CBH FASST demonstrated substantial advances in policy and funding, with gains also in shared purpose and quality of programs. State government has stepped forward to fulfill more leadership functions, powerfully advancing the policy agenda while also leaving some stakeholders uncertain how to sustain some of the voices and purposes that had been enabled by the Children's Behavioral Health Collaborative, now in hiatus.

Since 2020 the Covid pandemic has tested, stimulated, and then depleted the adaptive capacities of NH's CBH field, trailing unmoored youth and exhausted service systems in its wake. Pandemic disruptions spread awareness of children's suffering broadly, legitimizing distress and reducing stigma. At the same time, hostility and intolerance in public discourse are threatening to overwhelm shared concern and prosocial action.

Recommendations for CBH field development

Re-commit to the perennially low scoring Health Equity domain. Collect data about health services and outcomes that can be disaggregated by demographic characteristics, and use that data for strategic planning and storytelling about the needs of affected populations. Recruit local community advisory groups to assist in evaluating needs and planning/monitoring interventions.

Deepen the field's sophistication about implementation of evidence-based practices. Expand investments in demonstrated drivers of high-fidelity implementation, including targeted skills training, expert coaching, ongoing monitoring and feedback, and communities of practice – all of which NH has successfully implemented in pockets.

Re-vitalize NH's commitment to prevention and wellness promotion, as envisioned in NH's 10-year Mental Health Plan. Among the emphases in that Plan where progress has been made are early childhood supports with the Pyramid Model and Family Resource Centers, scaling up MTSS-B, early interventions for acute distress and suicide prevention, and expansion of peer supports. Yet access to community-based outpatient care remains severely constrained by workforce shortages and related resource limitations.

.

NH's Children's Behavioral Health Field

Endowment for Health's field building activities

The Endowment for Health (EH) is a statewide, private, nonprofit foundation dedicated to improving the health of New Hampshire's people, especially the vulnerable and underserved. EH engages in "field building" by providing resources to develop systems-change capacity within its priority areas ("fields"). Howard and Wu (2009) define a field as "a community of actors who engage in a common set of core practices with a common goal for their work" (p. 10). EH's field building involves creating strong coalitions and networks, enhancing the NH knowledge base, growing leadership and advocacy capacity, developing shared measures and data-based decision making, and supporting other systems change capacities. EH currently supports six fields: children's behavioral health, early childhood, health equity, healthy aging, health policy, and health care workforce ("Forward Fund").

New Hampshire's Children's Behavioral Health field: 2005-2024

In 2005, the EH recognized the need for investment in CBH, to improve prevention and services while reframing the system to be youth and family centered. EH committed to 5 years of responsive grantmaking (it had not yet adopted the field building approach) reviewing and funding the best CBH-related applications it received. Many worthwhile projects were implemented with EH support during this time, though sustainability beyond the period of grant funding often proved challenging.

EH's commitment to Children's Behavioral Health accelerated with their support for a series of reports from 2007-2009 by the NH Center for Public Policy Studies (2007a; 2007b; 2009), the NH Association for Infant Mental Health (2009), and the New England Network for Child, Youth & Family Services (2009), which collectively painted a picture of burgeoning need for children's mental health services in the state, coupled with workforce shortages, lack of systematic coordination, and barriers to access. In 2010, the EH supported the creation of the Children's Behavioral Health Collaborative (CBHC), creating the infrastructure to develop a shared vision and goals for the state. Over 50 organizations committed to creating a statewide, comprehensive strategic plan that leveraged the strengths while addressing the challenges and shortcomings of the CBH field. The CBHC became a major driver of statewide policy reform over the ensuing decade.

In 2012, with support from the CBHC and EH, NH DHHS received a 1-year Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant to reduce barriers to services, ensure child and family-centered care and improve cultural and linguistic competence among service providers for children with serious emotional disturbance and their families. The planning grant led to an additional 4-year grant (FAST Forward) that successfully developed, implemented, and sustained high fidelity wraparound and a more robust array of services for children with complex needs and their families. FAST Forward established a model for a growing array of subsequent statewide and regional System of Care initiatives.

In 2013, the CBHC released a comprehensive state plan to improve behavioral health of children, youth and families (NH CBHC, 2013). The plan subsequently helped to leverage a stream of federally funded initiatives, including:

Early childhood interventions (Project Launch in Manchester)

Development of a multi-tiered system of support in schools (Project AWARE and Safe Schools Healthy Students)

Improving outcomes for children, youth and families with the most complex needs through expanded services: high fidelity wraparound, better coordination of family/youth-driven care, family and youth peer support (NH System of Care grants)

Expanding access to screening, assessment, treatment and recovery for adolescent substance use disorders (State Youth Treatment Planning)

Regional SOC approaches (Monadnock System of Care; Manchester System of Care)

Expanding System of Care Approach to Education (NH Department of Education System of care grant)

From 2015 through 2019, the CBH field achieved numerous legislative and state government successes. These include passage of SB 534-FN, which ensures the collaboration of DOE and DHHS in building a coordinated, statewide System of Care for youth with mental health challenges, by addressing structural barriers and using System of Care practices. The creation of the Office of Social Emotional Wellness (OSEW) with the NH Department of Education (DOE), and the Bureau for Children's Behavioral Health (BCBH) with the NH Department of Health and Human Services (DHHS) added considerable visibility and capacity within NH's state government. SB 14 in 2019 expanded on SB 534-FN with a host of revisions to the Care Management Entity requirements that redesigned the array of intensive services and supports available to youth and families, and doubled the staff of the BCBH to support these system expansions.

In 2019, NH DHHS issued the first 10-Year Mental Health Plan that explicitly addressed the needs of children and their families. Just months after its release, the State's FY20-21 operating budget committed substantial resources to implementing the Plan's recommendations for youth services, including:

funding an infant and early childhood mental health plan;

expanding and relocating inpatient capacity for youth away from the state hospital;

implementing Mobile Crisis Response Teams for children and youth;

enhanced investments in suicide prevention training;

expanding the scope of services eligible for reimbursement by Medicaid;

instituting incremental increases in Medicaid reimbursement rates;

creating new DHHS staff positions with expertise in early childhood mental health

The figure on the next page depicts some of the milestone events in the recent history of NH's CBH field.

Children's Behavioral Health Field Milestone Events

2008	EH establishes Children's Mental Health as a priority focus
2010	Launch of the Children's Behavioral Health Collaborative (CBHC)
2013	CBHC promulgates NH's first Children's Behavioral Health Plan
2016	SB 534 / RSA 135-F establishes System of Care for Children's Mental Health
2019	NH's 10-Yr Mental Health Plan explicitly addresses children/families
2019	SB 14 amplifies SB 534 with Care Management Entities, community-based services, evidence-based practices

Field Assessment Tool Domains and Items

In 2015, EH commissioned what is now the Behavioral Health Improvement Institute (BHII) at Keene State College to develop a field assessment tool that could guide strategic decision making. The resulting Field Assessment Tool (FASST; Fauth, Phillips, & Nordstrom, 2016) assesses seven domains, depicted in the table below with their component items.

Experience with the tool has taught us that most informants feel prepared to comment on four of these domains, whereas the remaining three domains tend to be more selectively accessible to respondents with relevant focal interests or experience. The table below is thus split into Core versus Special Interest Domains, followed by a description of a tiered approach to the interview.

Core Domains	Item	Definition
Shared Purpose	Outcome/Goal Consensus	Agreement on a set of clearly articulated shared goals, with a process for collaborative, ongoing revision
	Shared Values	Common values that guide the public face and private actions of field actors
	Strategy Alignment	A portfolio of coordinated, complementary, and purposive strategies to achieve shared goals
	Network Connectivity	A network of highly engaged interactive actors who seek to leverage collective resources and capacities
	Trust	The extent to which actors feel that others in the field with whom they interact are reliable, support field goals/actions, and are open to discussion
	Governance Structure & Process	The level of intentional hierarchy and centralization of leadership, and formality of process, within the network that helps to facilitate and sustain communication, cooperation, and decision-making
Leadership & Community Support	Knowledgeable, Ready, Supportive Leaders	Identifiable leaders/exemplary organizations that are knowledgeable, actively supportive, and ready for collective action
	Diverse, Representative, Knowledgeable Actors	A representative, knowledgeable, and culturally competent set of field actors
	Empowered Beneficiaries	The group(s) whose needs the field is intended to address are engaged and empowered to self-advocate at all levels of the field
	Aware, Supportive & Engaged Communities	A receptive community atmosphere/context that supports effective field action; communities that are aware of field issues/needs and supportive of field efforts
Adaptive Capacity	Monitoring	Ability to monitor and assess external environments in order to identify needed shifts relevant to field strategies, tactics, and needs
	Adaptation	Ability to alter strategies and tactics in response to new information in a timely manner
	Flexibility of Resources	Degree to which resources are reallocated, shared, leveraged among higher- and lower-resourced actors to successfully cope with changing conditions
Health Equity	Equity Lens	An equity perspective, including recognizing root causes of disparities, is infused throughout the field's vision, values, goals, and strategies
	Equity Related Data and Shared Measures	Equity-related data, including disaggregated data about vulnerable populations in the field, and shared measures are available and used by field actors to understand ingrained and emergent issues facing communities of color and to guide strategy and action
	Informed Policy Makers	Leaders and decision-makers understand the importance of cultural competence, social determinants of health, and health equity to the field
	Inclusive Participation	A growing quantity and variety of partnerships with representatives from vulnerable populations, in particular communities of color, are fostered / valued in the field
	Cultural and Linguistically Competent Programs	Culturally and linguistically appropriate programs are accessible to vulnerable populations in the field

Special Interest Domains	Item	Definition
Shared Knowledge	Applied Knowledge	The extent to which scholarly theory and research, and/or local, credible information is leveraged to support efforts in the field
	Knowledge Sharing & Dissemination	Effective sharing of relevant knowledge among field actors and to external audiences
	Professional Standards	Presence and use of standards of practice in the field, such as practice guidelines, credentialing processes, and reporting standards and platforms
Quality Programs & Services	Reach	The percentage of the relevant population of the field's potential beneficiaries who are reached by evidence-based and promising practices
	Implementation	The extent to which drivers of high-fidelity, high-quality implementation of program and services are in place in the field, such as training, coaching, and evaluation/performance monitoring
	Comprehensiveness	The extent to which the array of programs and services in the field is sufficient to meet the needs of potential beneficiaries
	Linkages	Presence of linking mechanisms that allow beneficiaries to successfully transition from one related program to another
Adequate funding & Support for Policy	Shared Measurement	Existence and utilization by field actors of shared measures and a common data sharing platform, to monitor progress and inform decision making
	Funding	The availability and security of the resources and funding to support effective collective action in the field
	Technology	Existence and utilization of needed technologies to support effective action in the field
	Policy Environment	Presence of an enabling policy environment to support effective action in the field
	Policy Knowledge	Field actors have the knowledge necessary to inform and shape an enabling policy environment
	Policy Advocacy	Presence of a sustainable advocacy infrastructure to support effective action in the field

FASST Method

Key Informant Interviews

FASST ratings and qualitative themes are developed based on key informant interviews. Working with EH staff, we seek the most knowledgeable and involved informants, with the broadest perspectives on the field. EH staff identified key informants from the following sectors in the CBH field: advocacy, service providers, technical assistance providers, and government. Twenty-six informants took part in an hour-long, semi-structured telephone interview with one of three BHII evaluators in January-February of 2024.

Tiered Interview Strategy

Core Domain items are asked of all interviewees, with an invitation to pass over any items for which they do not feel sufficiently informed to respond. We specifically seek informants whose interests and experience we estimate to be distributed across the Special Interest Domains, and we aim to delve into just one of these domains with each informant. Our individualized interview invitation includes a description of the Special Interest Domains and our proposal for which one might be a suitable focus for the candidate. Candidates are invited to select a different Special Interest Domain if they would prefer.

Quantitative Scoring

FASST includes a set of quantitative, anchored rating scales for scoring each (audio-recorded) key informant interview. Each interview session was scored by the primary interviewer for that session, and the first six interviews were also scored by one of the other two interviewer/raters, using the audio recording. The interviewer and second rater came together to review and achieve consensus on the ratings. Confident by that point in our inter-rater reliability, the primary interviewer for each session scored the remaining 20 interview recordings alone.

Qualitative Themes

In parallel with quantitative scoring, each rater culled qualitative themes from the key informant interviews for each FASST item, using thematic analysis. The qualitative themes supplement and elaborate the quantitative ratings and resulting recommendations.

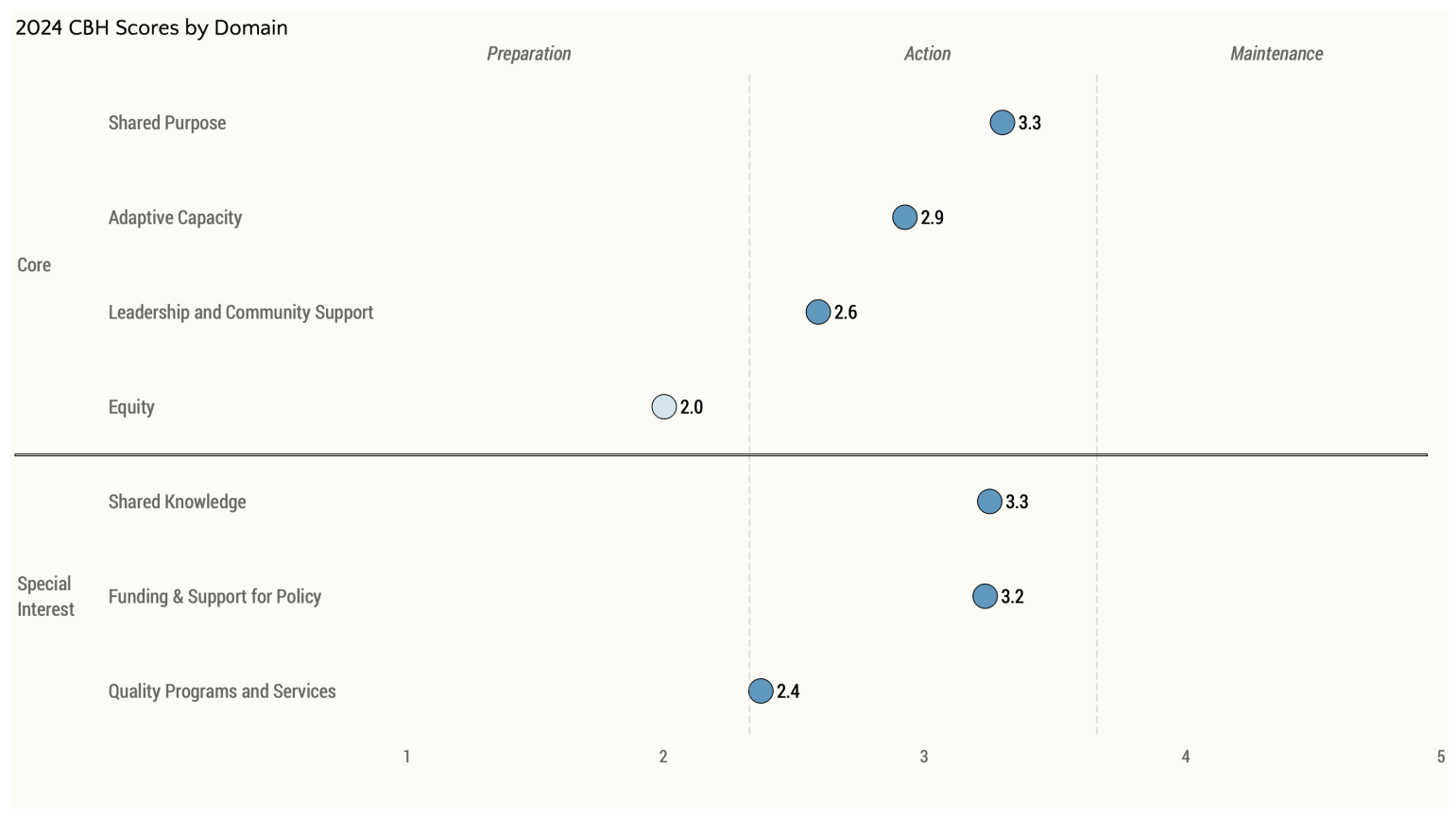
Understanding the Findings

FASST scores are summarized at the item level by averaging scores across key informants. Likewise, domain scores are computed by averaging scores across items. Finally, we classify the domain- and item-level scores onto one of three phases of field development – Preparation, Action, or Maintenance – used by the EH. The Preparation stage is characterized by absent, conflicted, fragmented, or undefined field properties. Field properties in the Action stage are underway and emergent, but not yet comprehensive or stable. The Maintenance stage is characterized by mature, sustainable field properties with collective, wide-reaching impacts. Scores in the lowest, middle, and highest portion of the five-point scale map onto the Preparation, Action, and Maintenance stages, respectively. The FASST charts display the average score for each item/domain along the five-point continuum through the placement of a colored circle, with darker shading indicating higher scores. For this year's FASST, three dots depict the trajectory over time from the baseline (2017) score, through the 2020 assessment, to this year's 2024 follow-up. Preparation, Action, or Maintenance stages of development are bounded by dashed horizontal lines. Qualitative themes contextualize the ratings and provide the basis for a narrative explanation of the findings.

The sample sizes noted in each domain-level chart approach the full sample for Core domains, and only the subset of respondents matched to each Special Interest domain.

Overview of all Domain Scores in 2024

The chart below displays the average domain scores across items for the CBH field from the 2024 assessment. Overall, the CBH field has matured well into the Action stage of development. As we've seen with other fields, Shared Purpose and Shared Knowledge lead the way. Advancements in Funding and Policy have *not* typically followed so closely in our field assessments – this is clearly a signal achievement for the CBH field. Adaptive Capacity attained unprecedented levels during the pandemic, which are now vulnerable as resource infusions dwindle. Key informants expressed some concerns about the readiness of local Leadership and Community Support to translate policy and funding victories into implementation. Quality of Programs and Services typically lags behind the capacities needed to elevate it, as is the case this year. Health Equity is gaining ground as a shared aspiration, but less as an attainment. In the pages that follow, we'll explore progress over time in each of these domains in greater depth, in the order depicted in the chart below.



Shared Purpose

Shared Purpose is the degree to which the field is galvanized around a shared vision and works systematically, collaboratively, and effectively. This domain includes governance, strategy alignment, goal consensus, trust, network, and shared values. Shared Purpose has been among the highest rated CBH FASST domains across all three assessment occasions, straddling Action and Maintenance phases of development. Progress has been driven by strong alignment around **Shared Values** that informants often summarized as "System of Care Values": services driven by youth and family needs and voice, trauma-informed, culturally and linguistically competent.

Trust among field actors has made impressive gains since our previous assessment in 2020, now bordering on the Maintenance phase. Respondents credit longstanding relationships and expertise that facilitate collaboration to address targeted challenges such as, for example, care for substance exposed infants, or the expansion of MTSS-B and the Pyramid Model to support social emotional development and success more generally. Correspondingly, trust erodes around systemic crises such as ED boarding and workforce shortages, which frustrate all involved with their intractability and repetitive confrontation with insufficient resources. Observers note that state contracts and other funding mechanisms can exert perhaps underappreciated leverage favoring or discouraging collaboration; recent emphasis on regional strategies, for example, while intended to elevate local priorities, can promote territorial attitudes and undermine collaboration that transcends regions.

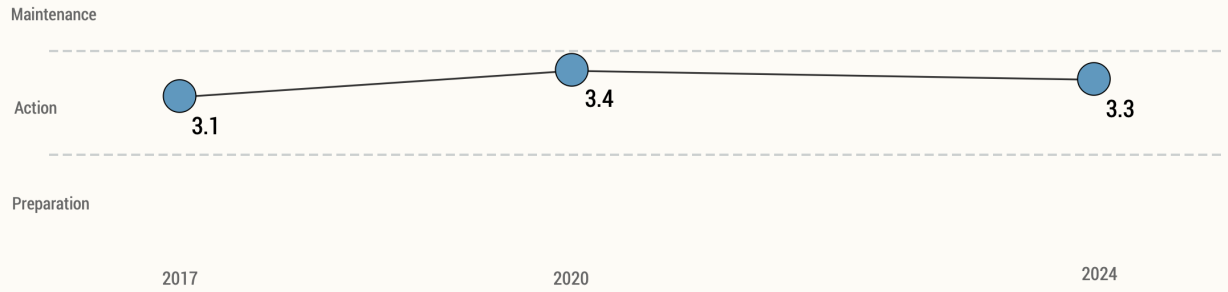
The **Goal** of NH's CBH field is to offer an accessible and evidence-based continuum of care, located as close as possible to the family's home community and in the least restrictive environment. The prevention zone of the care continuum is said to struggle for priority in the face of acute care crises.

Network Connectivity, reflecting the engagement of multiple actors in resource sharing for a common purpose, has experienced a slight downward trend since RSA 135f envisioned a blueprint for the SOC in 2016. Multiple respondents related contrasting impressions of recent DHHS and DOE engagement in the SOC, with the former perceived as a reliable advocate, while the latter seems more reluctant to embrace opportunities for integration of mental health and SEL initiatives into schools. More broadly, respondents cite fractures between the practice community, DCYF, the legislature, the courts, and State offices.

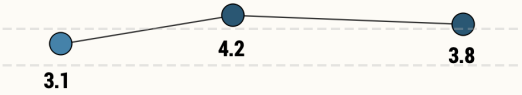
A decline in **Strategy Alignment** was frequently ascribed to the current hostile political climate, hindering otherwise positive developments such as integration of care under Care Management Entities, growth of MTSS-B and other tiered prevention frameworks, in-home therapeutic supports, peer support, workforce development, community education and engagement, advisory councils, and the leveraging of lived experience. Alignment of these strategies is said to attain its highest levels when directed toward acute crises, whereas preventive efforts are more diffuse as mentioned earlier.

Governance was the least developed element of Shared Purpose, dispersed as it is across multiple evolving entities. The most cited locus of State governance is the bi-monthly Children's SOC Advisory mtg, which, however, was critiqued for offering few actual opportunities for advisement. The advent of the Bureau of Children's Beh Health is widely seen as a promising yet relatively untested outgrowth of 135f. The Oversight Commission on Children's Services and the Taskforce on Child Abuse & Neglect were also named as holding some governance functions. NAMI, the UNH Institute on Disability (IOD), and New Futures contribute advocacy, training and technical assistance to NH's CBH field. Many noted a persistent vacancy left by the cessation of the CBHC (Children's BH Collaborative), whose empowerment of grassroots voices seems not to have been effectively replaced.

Shared Purpose (Core Domain; n=26)



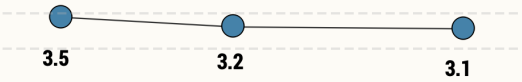
Shared Values



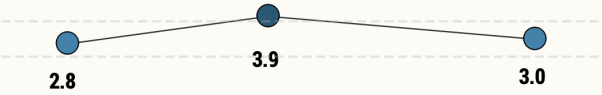
Trust

Outcome/Goal Consensus

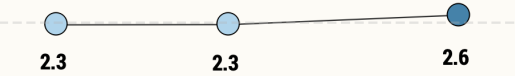
Network Connectivity



Strategy Alignment



Governance Structure & Process

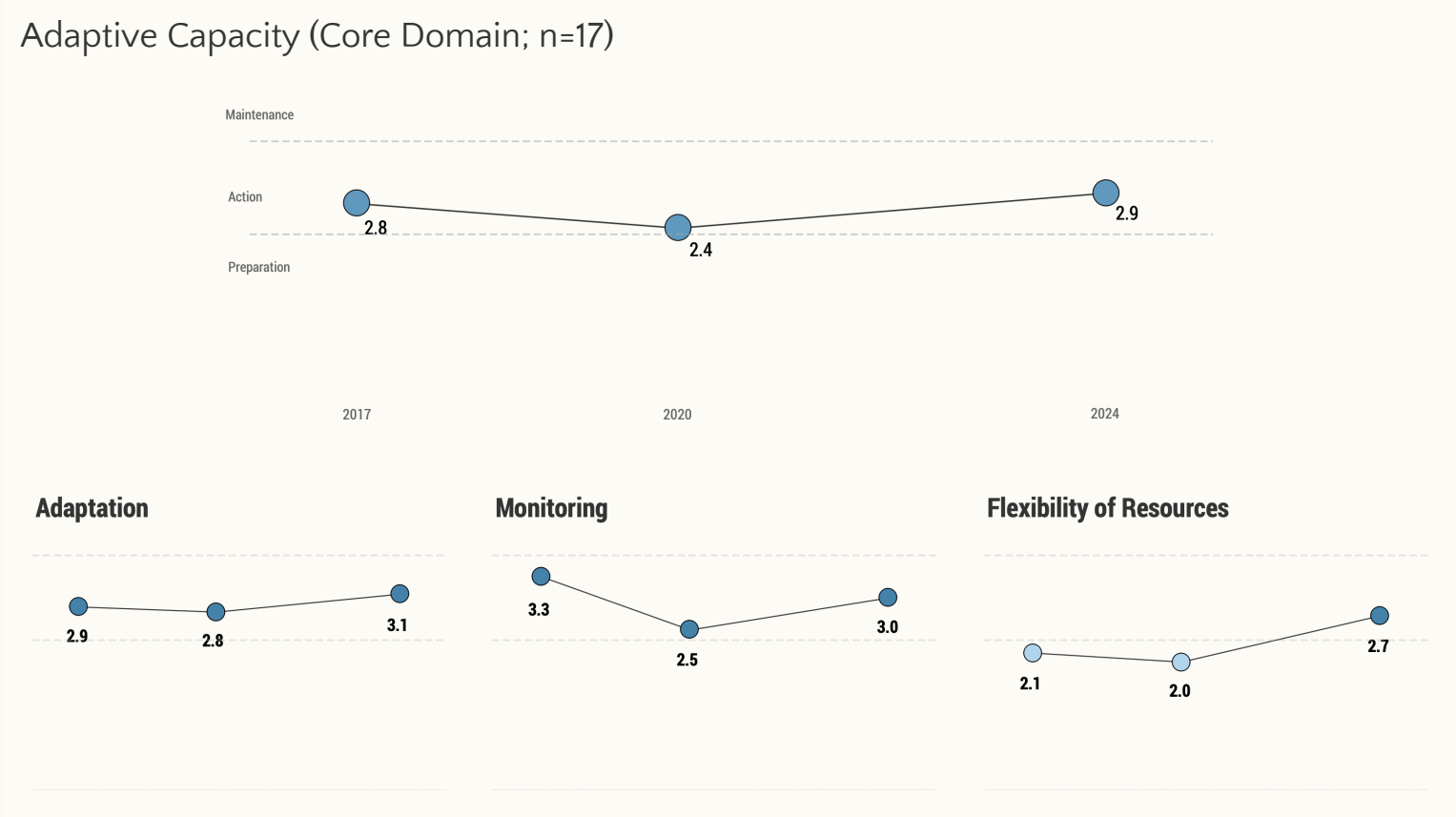


Adaptive Capacity

Adaptive Capacity is the degree to which the field monitors and adapts to barriers and takes advantage of emergent opportunities in an ever-shifting environment.

The COVID pandemic accelerated **Adaptive Capacity** for the CBH field, as policy makers and service providers devised creative solutions to longstanding challenges. Enacting these solutions called for perspective, insight, and coordination exerted by leaders who were granted broad latitude and resources to address urgent needs.

As the most overt pandemic threats recede, some of those permissive conditions for innovation are fading along with them. Meanwhile evidence accumulates for enduring injury to children's academic and social well-being, coinciding with depleted capacities of the systems that serve them. Efforts under way in NH to enrich the workforce across child and family services and broaden access to a robust care continuum are seen as critical to meeting these needs.



Leadership and Community Support

Leadership and Community Support reflects the degree to which formal and informal leaders actively support the field and include representation from grassroots and racially and ethnically diverse actors. This domain includes items addressing empowered beneficiaries, diverse actors, knowledgeable leaders, and engaged communities. This domain has shown a relatively flat trajectory across three FASST administrations, hovering around the boundary between Preparation and Action stages of change.

We heard widespread respect for the **Knowledge, Readiness, and Commitment** of leadership across DHHS toward collective impact, often shaped by career trajectories that have included provision of direct services to troubled youth and families. Reflecting on perceptions of DOE leaders as less oriented toward collective impact on CBH, some observers suggested that the professional preparation and priorities of educators may offer less natural alignment and efficacy for the SOC vision.

Respondents also identified a tension between the philosophy of collective impact and NH's famously proud commitment to locally determined identity, priorities and strategies. Ready access to invocation of "local control" can present a challenge for advocates of collective impact.

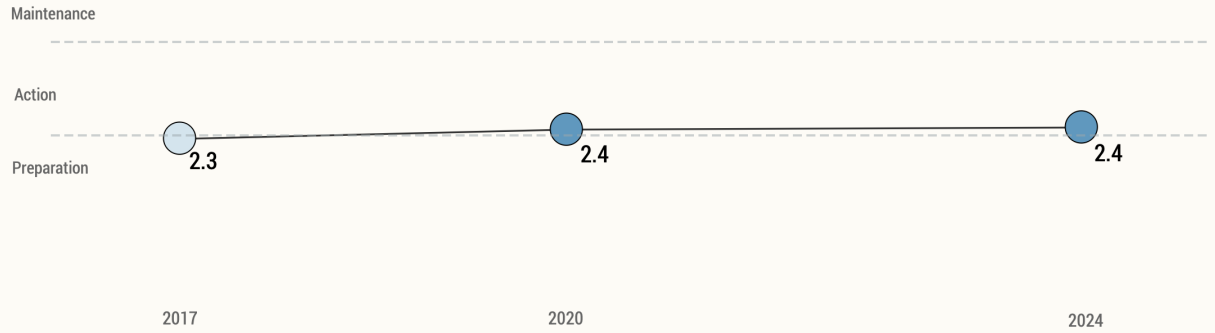
Finally, observers perceived many knowledgeable leaders around the state whom they thought could be better leveraged to complement the work of government agencies. Related to agency capacity, recent turnover has elevated the urgency of succession planning for state leadership roles.

Awareness and Support at the local Community level is seen as improving, as communities become increasingly aware of local unmet need. Some respondents experience bi-partisan support, others striking cynicism around leaders' hostility to concepts related to SEL, DEI, and elevation of parental rights over children's welfare.

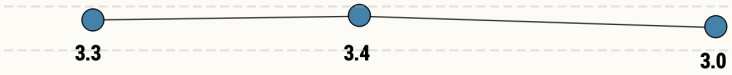
Empowerment of Beneficiaries improved between 2017 and 2020 as elements of the CSOC emerged, but has since receded. NH's Care Management Entities (CMEs) were designed to elevate family perspectives, as are many of the services supported by the SOC (Wraparound, TRECC, Peer support). NAMI has been advocating for youth in more active leadership roles, in a climate in which their voices are too easily overridden by concern for parental rights. Family stories of lived experience do exert leverage in the State legislature, though they are less in evidence in the CSOC Advisory Council. The experience of crisis tends to magnify a sense of personal vulnerability, and consequently to suppress the voices of the most distressed segments of the population.

Informants recognized some expansion of **Diverse, Representative Actors** in the direct care workforce, with several community-based service agencies cited for recruiting staff with lived experience and other historically marginalized identities. There is a broadening menu of professional development offerings designed to enhance Cultural and Linguistic Competence of the workforce yet reaching those goals hinges on centering diversity and belonging as well as stemming the turnover that is eroding all forms of competence in the CBH workforce (Carson et al., 2022). Among recent creative approaches to diversifying the workforce is making crisis responder certification accessible to students, so they can enter the workforce while still pursuing their studies.

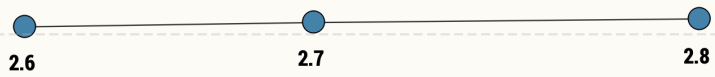
Leadership & Community Support (Core Domain; n=26)



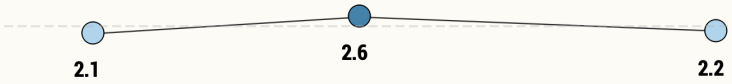
Knowledgeable, Ready, Supportive Leaders



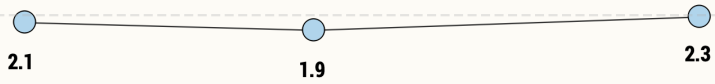
Aware, Supportive, Engaged Community



Empowered Beneficiaries



Diverse, Representative Actors



Health Equity

Health Equity is the degree to which everyone has a fair opportunity to achieve their full health potential. EH emphasizes health equity throughout its field-building work. This domain consists of items designed to tap the equity dimension of each of the other domains: equity lens (Shared Purpose), equity-related data (Shared Knowledge), informed policy makers (Funding and Policy), inclusive participation (Leadership and Community Support), and culturally and linguistically competent programs (Quality of Programs and Services).

Health Equity has remained the lowest rated domain in New Hampshire's Children's Behavioral Health field since it was incorporated into the FASST protocol in 2017. The nearly horizontal line at the domain level conceals variability in the constituent components.

Equity Data addresses both *collection and use* of data about the needs of communities of color and those with language differences. Few informants felt qualified to respond to this topic, but those who did suggested that there are pockets where this data is increasingly available but not well utilized to estimate population-specific needs. These pockets include local data from the YRBS and office disciplinary referrals (ODRs) from schools.

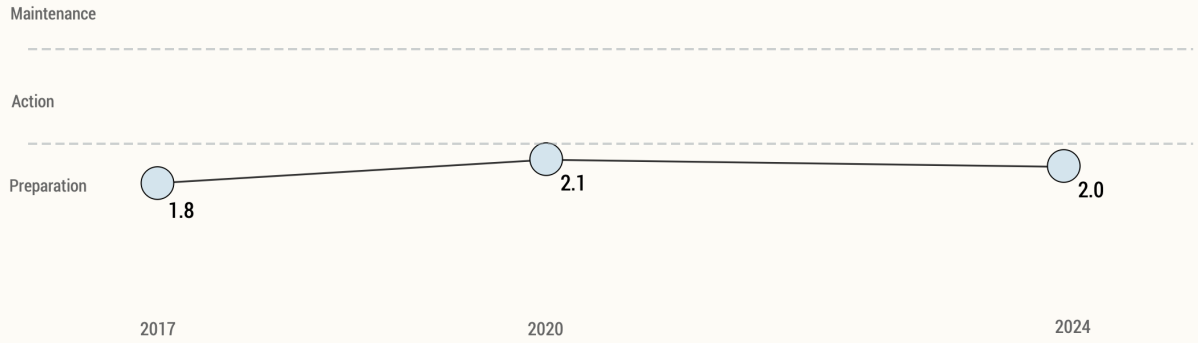
The **Cultural and Linguistic Competence (CLC) of Children's Behavioral Health programs** has benefitted from growing availability of simultaneous language translation (aided by technology), yet this service is seen as a superficial substitute for a more diverse workforce.

Equity lens reflects the extent to which respondents perceive the goals, values, and strategies of NH's Children's Behavioral Health field as promoting the highest levels of well-being for all residents. Respondents report progress in supporting LGBTQ youth, less for people of color and immigrants, and an overall plunge in compassion demonstrated by legislators and policy makers (see below). Increasing federal requirements for data stratification by population are seen as an asset to this work. Persistent underestimation of racial diversity in NH is a barrier, as is resistance to building cultural and linguistic competence into service models perceived as already flexible.

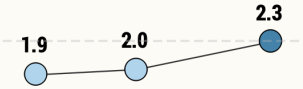
Inclusive Participation refers to the representation of communities of color in decision making in the Children's Behavioral Health field. Respondents reported some improvements in opportunities for people with lived experience to participate in decision making, although diversity remains underrepresented. The Health Equity Workgroup of the CSOC and the DHHS Office of Health Equity were named as leaders in these efforts.

Informed Policy Makers, meant to indicate the embrace of an equity perspective among leaders and decision makers, saw the greatest *decrement* across FASST administrations of any item in the entire interview protocol, with respondents lamenting the most hostile legislative climate in recent memory for equity matters. Nevertheless, there has been some improvement in representation of diverse perspectives in the legislature.

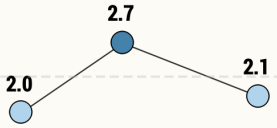
Health Equity (Core Domain; n=24)



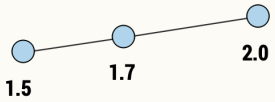
Equity Data/Measures & Equity Data/Shared Measures



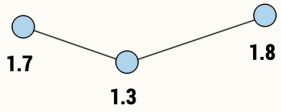
Equity Lens



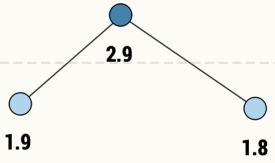
Culturally And Linguistically Competent Programs



Inclusive Participation



Informed Policy Makers



Shared Knowledge

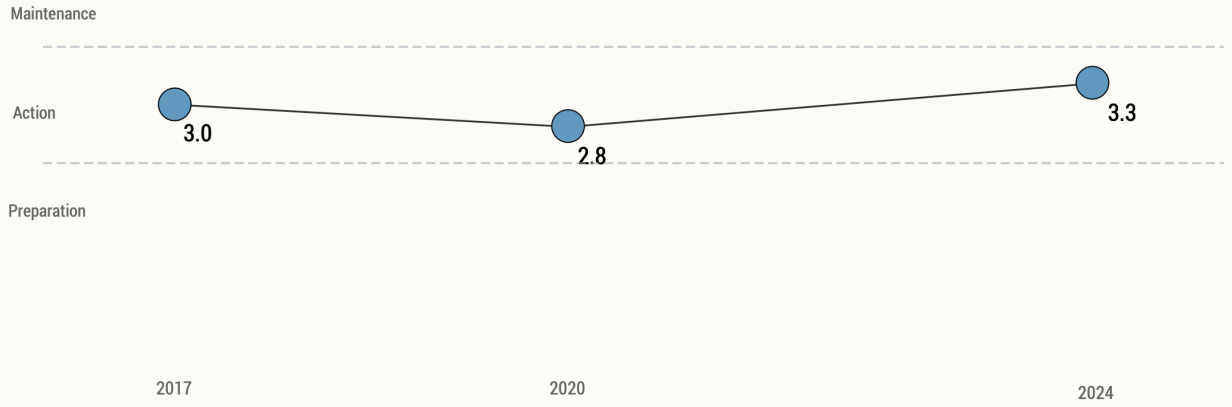
Shared Knowledge is the degree to which applied knowledge exists, is used to guide action, and is translated into professional standards that advance children's behavioral health. The domain includes knowledge sharing, applied knowledge, and professional standards. Shared Knowledge was one of the highest-rated CBH domains in the 2017 FASST and has slightly gained since.

Applied knowledge is the extent to which scholarly theory and research and/or local, credible information is leveraged to support efforts in the CBH field. NH has seen a dramatic increase in prioritization of evidence-based practices (EBPs) in planning, policy, state contracts, and grant applications. As we will discuss in greater detail in relation to Quality Programs and Services, commitment to EBPs has not reliably extended to the infrastructure needed to support fidelity (adherence) in practice: coaching, monitoring implementation for purposes of continuous quality improvement, communities of practice (currently convened for CPP and the Pyramid Model).

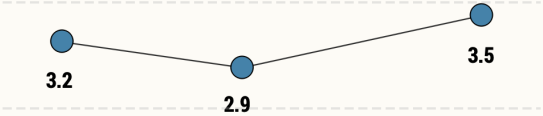
Professional Standards support the penetration of evidence into practice with development opportunities and credentialing standards for the field's workforce. Respondents report an abundance of professional development opportunities in Children's Behavioral Health, along with well-defined credentialing requirements for licensed providers such as psychologists, social workers, and psychiatrists. Credentialing requirements are more variable for school personnel and sometimes non-existent for less mainstream approaches such as person-centered care coordination.

Knowledge Sharing refers to how local data about practices and outcomes is shared within and beyond the field. The leading example cited by FASST informants is use of NH's MTSS-B outcome data to shape technical assistance provided to schools and to advocate for effective school policies. Beyond the school context, respondents report little collection and sharing of local outcomes, or discussion of how scholarly evidence should be translated for application to the local context.

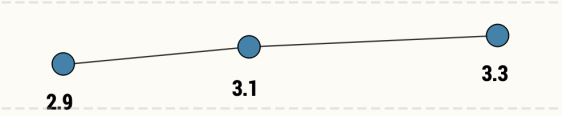
Shared Knowledge (Special Interest; n=6)



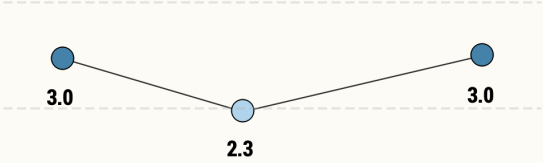
Applied Knowledge



Professional Standards



Knowledge Sharing/Dissemination



Adequate Funding and Support for Policy

The Funding and Policy Support domain reflects the degree to which the resource and policy environment supports the field. This domain scored just into the Action stage in 2017 and has trended upward since. At the item level, **Policy Advocacy** and **Policy Knowledge** both made large gains between 2017 and 2020 and have since edged into the Maintenance phase of change. NAMI, New Futures, and other professional advocates are widely seen as sophisticated and effective, and other actors such as CASA and Easter Seals reliably join advocacy efforts. Importantly, these advocacy collaborators are well respected in the State legislature. Lack of representation of people of color is identified as a weakness.

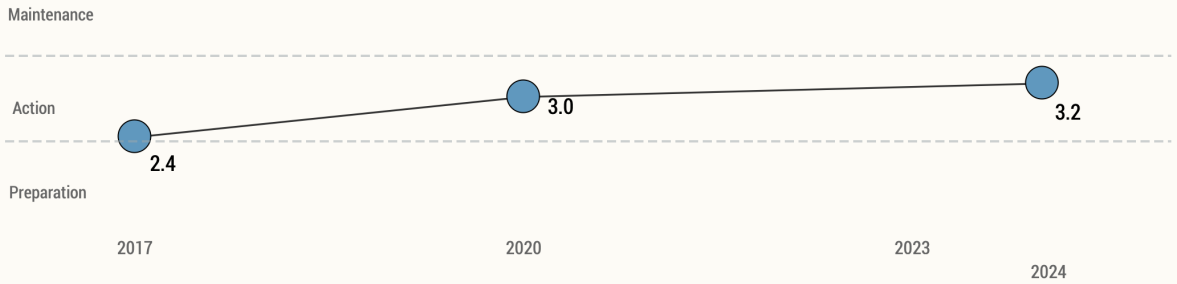
Technology saw pandemic stimulated acceleration in access to telehealth and other remote services. Additional promising developments include the State's implementation of event notification technology that alerts heath care providers when a youth in their care is hospitalized, as well as efforts under way to establish a statewide closed-loop referral system.

NH's **Policy Environment** for CBH has suffered volatility across the history of these FASST assessments, experiencing a major boost in the wake of RSA 135f and accompanying budget commitments, only to plummet during the divisive political climate of recent years. Despite general bipartisan interest in children's behavioral health, maneuvering among legislators and other public figures has made it harder for families to pursue care and for CMHCs to deliver services in schools, while also diverting advocacy resources toward fending off what is perceived as cynical legislation.

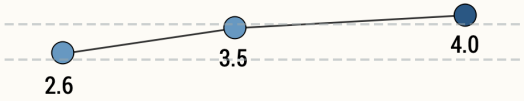
The dominant feature of the **Funding** landscape for CBH is unreliability: widespread evidence of urgency prompts short-term injection of resources yet fails to recruit longer-term commitments. A crisis orientation neglects the more proactive regions of the care continuum (community-based services, prevention, peer support), while also undermining the willingness of service providers across the continuum to develop infrastructure that may be destined for collapse once temporary (often grant) funding expires. Informants credit leadership from DHHS and sustained philanthropic support for progress toward the vision for NH's Children's SOC, while lamenting the reluctance of NH's DOE to embrace that vision.

Shared Measurement remains barely into the Action stage of change in 2024. Respondents readily foresee benefits that could accrue from committing to a common set of high-quality measures. At present, though, few such measures are routinely disseminated, although some are reportedly available to legislators and other policy makers if they know whom to ask. Only recently have state contracts begun to escalate expectations for performance measurement from service providers and other contractors, which promotes identification of measures and builds capacity to collect, analyze, and share data.

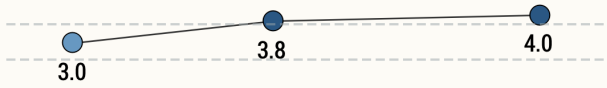
Funding & Support for Policy (Special Interest; n=7)



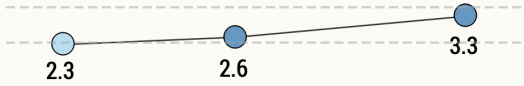
Policy Advocacy



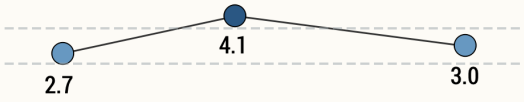
Policy Knowledge



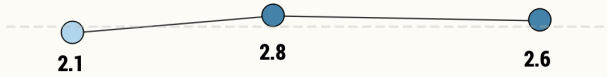
Technology



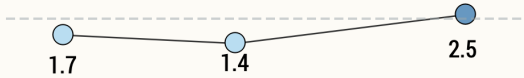
Policy Environment



Funding



Shared Measurement



Quality Programs and Services

Quality Programs and Services indicates the availability of effective, comprehensive, and coordinated CBH services and supports. This domain involves the reach, quality of implementation, linkages among, and comprehensiveness of the CBH support and service array. These elements reside near the furthest reaches of the field development theory of action (they are what all the other field development domains are meant to support) and are consequently often among the last domains to demonstrate improvement. Nevertheless, Quality of Programs and Services has improved across FASST administrations, now hovering around the boundary between Preparation and Action stages of change.

Infrastructure to monitor and support **Quality of Implementation** is said to be weaker for children's behavioral health than for adult services. State contracts and other funding sources increasingly require commitment to evidence-based practices and even regular reporting of performance measures to provide accountability. Evidence-based practice exerts its greatest leverage when it includes routine monitoring of practice fidelity and outcomes – *local* evidence - for continuous quality improvement. Challenges to enacting this gold standard version of EBP include insufficiently defined criteria for adherence to the intervention, regional variation in intervention features, and the infrastructure required for routine monitoring and CQI. The result is fragmented uptake of EBP components in all but the most structured and well-resourced CSOC interventions (MATCH, Wraparound, MTSS-B, CPP).

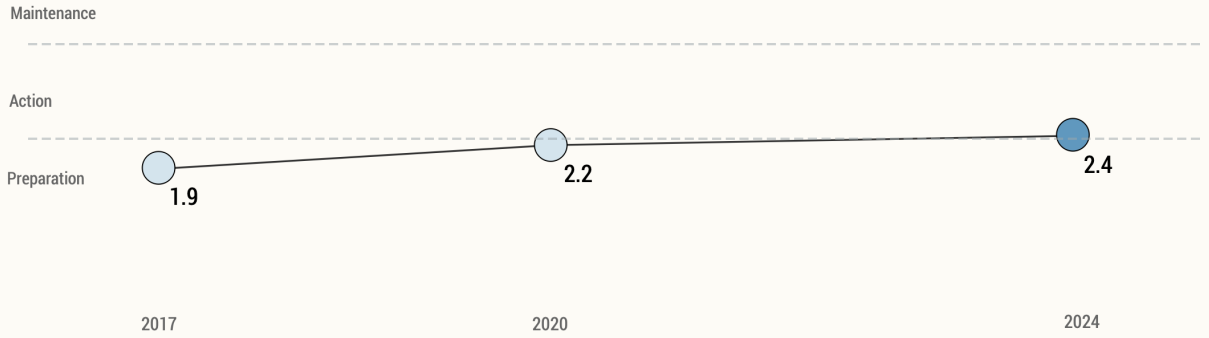
Linkages are intended to assist families in navigating the service array, and there is broad consensus that enhanced (assisted) referrals with "closed-loop" feedback to reinforce follow-through are a prime mechanism for promoting that goal. These referral enhancements are time and expertise intensive, particularly where services are in short supply. Linkages are strongest at the acute end of the CSOC continuum, such as for residential treatment and other intensive services arranged through the CMEs.

The **Comprehensiveness** of the service array is substantially undermined by workforce flight, widely attributed to weak compensation. Acute needs make the headlines (and are very real), but preventive and community-based services are even more neglected: some assert that an insufficient supply of inpatient beds is an indirect measure of inadequate lower intensity supports.

Efforts to expand the **Reach** of services for distressed youth and families are widely acknowledged. Examples include outreach offered through less traditional service environments such as schools, and greater access to high intensity services that once required a court order through juvenile justice or DCYF. Notwithstanding these efforts, informants perceive escalating need and persistent workforce limitations fueling a seemingly intractable deficit in acute care. As previously noted, relative neglect and consequent erosion of preventive supports may be exacerbating demand at the acute end of the care continuum.

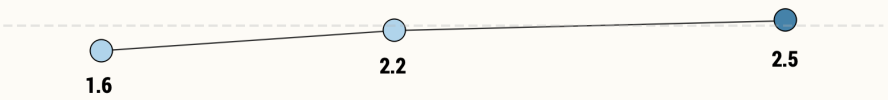
.

Quality Programs & Services (Special Interest; n=10)

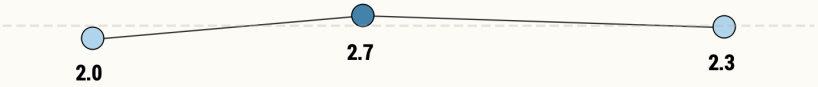


Implementation

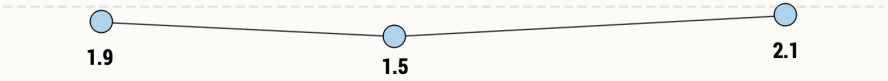
Linkages



Comprehensiveness



Reach



“Most Important Developments in recent years . . .?”

In follow-up administrations of the FASST, we add a final question asking respondents to reflect on changes in the field since the previous assessment (2020). Responses this year converged on the following developments:

Recognition of the need for CBH services by both the general public and legislators: naming, normalizing, destigmatizing;

Increased commitment to innovation: scaling up MTSS-B and the Pyramid Model, telehealth, mobile crisis, Child-Parent Psychotherapy (CPP), Medicaid reimbursement for Wraparound;

Reduced reliance on court intervention, growing emphasis on voluntary, community-based services.

Conclusions and Recommendations

This follow-up assessment of New Hampshire's Children's Behavioral Health field offers a snapshot of field development in 2024, along with key challenges and opportunities. The COVID pandemic tested, stimulated, and depleted the adaptive capacities of NH's CBH field, trailing unmoored youth and exhausted service systems in its wake. Pandemic disruptions spread awareness of children's suffering broadly, legitimizing distress and undermining stigma. At the same time, hostility and intolerance in public discourse are threatening to overwhelm shared concern and prosocial action. Innovations have nevertheless set the stage for continued progress in Children's Behavioral Health. Below, we offer several recommendations for the CBH field.

Re-commit to the perennially low scoring Health Equity domain

Confront reluctance to collecting and reporting data disaggregated by demographic characteristics; this practice is not discriminatory but instead demonstrates commitment to acknowledging and addressing health disparities. Use the resulting data for strategic planning and storytelling about needs and outcomes for affected populations.

Accelerate novel approaches to diversifying workforce composition and decision-making processes. Recruit local community advisory groups to assist in evaluating needs and planning/monitoring suitable interventions.

Revive a forum where voices of lived experience are centered (widely lamented as lost with the expiration of the CBHC).

Deepen the field's sophistication about implementation of evidence-based practices

Expand investment in the demonstrated drivers of high-fidelity implementation:

Targeted skills training for practitioners

Expert coaching at points of practice

Ongoing monitoring with routine feedback to support practice improvement

Consider convening Communities of Practice as venues for ongoing practice improvement.

NH has experience with all of these implementation supports. MTSS-B and Wraparound, for example, provide exemplars of coaching and fidelity monitoring, while Child Parent Psychotherapy and the Pyramid Model have sustained effective Communities of Practice.

Revitalize NH's commitment to the prevention and wellness promotion portion of the care continuum

NH's 10-year Mental Health Plan (NHDHHS, 2019) included several recommendations to bolster community education, prevention and early intervention services. The state has made meaningful progress with suicide prevention and early intervention for acute distress, as well as expansion of peer supports. Nevertheless, erosion of preventive supports may still be magnifying demand at the acute end of the care continuum.

Redouble efforts to address NH's persistent workforce crisis

As of 2022, approximately 20% of clinician positions across NH's community mental health system were vacant (Carson et al., 2022), constraining access to acute care. NH's health care workforce shortage has been well studied, and we must continue to elevate the urgency of addressing it (c.f., NH Endowment for Health, 2022).

References

Carson, J., Boege, S., Schreiber, E. (2022). The Early Childhood Behavioral & Mental Health Workforce at New Hampshire's Community Mental Health Centers: Staff Vacancies. Research brief retrieved 9-5-24 from the Carsey School of Public Policy website: https://carsey.unh.edu/sites/default/files/media/2023/03/nh_pdg_ess_workforce_staffvacancies_final.pdf

Fauth, J., Phillips, M, & Nordstrom, A. (June, 2016). Field Assessment Tool (FASST) Manual. Unpublished report, commissioned by New Hampshire Endowment for Health.

Health Resources in Action (2020). Working Towards a System that Supports Early Childhood, Infant, and Family Mental Health: An Assessment of New Hampshire's Early Childhood and Family Mental Health Workforce. Retrieved 9-24-20 from the NH Endowment for Health website: https://endowment-assets.nyc3.digitaloceanspaces.com/resources/Early-Childhood/Full20Report1.pdf

Howard, D. & Wu, P. (2009). *Assessing California's multiple pathway field: Preparing youth for success in college and career*. Retrieved from The James Irvine Foundation website: http://files.eric.ed.gov/fulltext/ED506581.pdf

New England Network for Child, Youth & Family Services (2009). Supporting the Direct-Service Workforce in Behavioral Health Programs for Children and Youth in New Hampshire. Retrieved 7-15-20 from the NH Endowment for Health website: https://www.endowmentforhealth.org/uploads/resources/id44/1836%2003-09-09%20Behavioral_Health_Workforce_Report.pdf

NH Association for Infant Mental Health (2009). Mental Health Services for New Hampshire's Young Children and Their Families: Planning to Improve Access and Outcomes. Retrieved 7-15-20 from the NH Endowment for Health website: https://www.endowmentforhealth.org/uploads/resources/id40/NHAIMH_ECMH_REPORT_2009.pdf

NH Center for Public Policy Studies (September, 2007a). Few and Far Between?: Children's Mental Health Providers in NH. Retrieved 7-15-20 from the NH Endowment for Health website: https://www.endowmentforhealth.org/uploads/resources/id54/cmh_workforce_september_2007.pdf

NH Center for Public Policy Studies (September, 2007b). Mental Health Services for NH's Children. Retrieved 7-15-20 from the NH Endowment for Health website: https://www.endowmentforhealth.org/uploads/resources/id118/cmh_service_use_and_cost_september_2007.pdf

NH Center for Public Policy Studies (April, 2009). Mental Health Services in New Hampshire's Schools. Retrieved 7-15-20 from the NH Endowment for Health website: https://www.endowmentforhealth.org/uploads/resources/id39/mental_health_in_nhs_schools_2009.pdf

NH Children's Behavioral Health Collaborative (2013). Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children. Retrieved 7-15-20 from the NH Endowment for Health website: https://www.endowmentforhealth.org/uploads/resources/id9/CBH_Plan_Executive_Summary.pdf

NH Department of Health and Human Services (January, 2019). New Hampshire 10-Year Mental Health Plan. Retrieved 7-15-20 from NH DHHS website: https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf

NH Endowment for Health (2022). Giving Care: A strategic plan to expand and support New Hampshire's health care workforce. Retrieved 9-20-24 from the NH Endowment for Health website: https://endowment-

assets.nyc3.digitaloceanspaces.com/images/Executive-Summary-Giving-Care-March-2022.pdf

Nordstrom, A., Fauth, J. (July 2017). Children's Behavioral Health in NH: A Field Assessment. Unpublished Report, commissioned by New Hampshire Endowment for Health.