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Executive Summary

Why We Assessed Community Readiness in NH in 2014 and 2016

• The FAST Forward System of Care is designed to serve the diverse needs of NH youth with severe emotional disturbance (SED) and their families
• FAST Forward's success hinges on the readiness of NH communities to provide accessible, well-coordinated, high-quality services and supports
• We compared NH readiness for a system of care in 2014 and 2016

How We Assessed NH Community Readiness, 2014 & 2016

10 NH Regions 7 Sectors 9 Readiness Levels 6 Dimensions

63/58 Key Informants Nominated 58/50 Key Informants Interviewed 94%/86% Response Rate

New Hampshire Remains in the Preplanning Stage

Efforts, resources, leadership, climate improved; knowledge declined
Average community readiness scores by dimension
2014 2016

Recommendations: Address the weakest dimensions and sectors of readiness first

• Prioritize Community Awareness and Climate
• Elevate and Empower Youth and Family Voice and Choice
• Promote and Support Communication and Coordination Across Care Systems, Especially Hospitals and Schools
• Plan System of Care Expansion to Address Persistent Barriers and Competing Issues
Why We Assessed Community Readiness in NH in 2014 and 2016

Improving care for NH children and youth with SED

The FAST Forward System of Care is a values-based system designed to serve NH children, youth, and families experiencing difficulties in day-to-day life due to a severe emotional disturbance (SED) and who are at risk for acute psychiatric hospitalization or placement in a residential treatment facility. Built on partnerships among service systems within the NH Department of Health and Human Services and community-based providers, FAST Forward offers access to individualized services, guided by a strengths-based, wraparound service planning process. These enhanced services and supports are designed to build resilience, coping, and strategies for families to better meet their child or youth’s behavioral health needs and to improve outcomes and functioning in home, school, and community. The success of FAST Forward hinges on the availability, utilization, and provision of well-coordinated, high-quality professional services, natural supports, and community resources in the home communities of youth with SED and their families.

Understanding, assessing, and improving community readiness

Community readiness is the degree to which a community is prepared to take action on an issue; a Community Readiness Assessment (CRA) offers a way to measure community readiness. For this assessment we sought to measure the readiness of NH communities to provide high quality, coordinated services and supports. We selected a tool developed by Tri-Ethnic Center for Prevention Research at Colorado State University, the utility of which has been demonstrated in many communities and on many issues (Plested, Edwards, & Jumper-Thurman, 2006).

The tool relies on the deep knowledge of key informants across six dimensions of readiness:

- **Existing Efforts**: Are there efforts, programs, and policies that address the issue?
- **Knowledge of the Efforts**: Do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?
- **Leadership**: Are leaders and influential community members supportive of the issue?
- **Climate**: What is the prevailing attitude—helplessness versus empowerment?
- **Knowledge About the Issue**: To what extent do community members know about the causes and consequences of the problem in your community?
- **Resources**: To what extent are people, time, money, and space available to support efforts?

The level of community readiness is assessed as falling within one of nine stages, ranging from “No Awareness” to “Community Ownership.” The tool captures not only the current status of readiness, but also recommends interventions and strategies most likely to bolster readiness and aid in program planning and improvement (Figure 1).

The CRA model recommends that programs target for improvement the lowest dimensions of readiness first, using an appropriate intervention. For instance, campaigns to convince people that the issue is a problem in their community are appropriate for low levels of awareness, whereas the same campaign strains the patience of audiences at higher stages of readiness, who are ready to take action and who want guidance about how to proceed (Figure 1).

Results from the 2014 CRA offered a window into the baseline level of readiness of NH communities as FAST Forward began serving youth with SED and their families. Results from the 2016 CRA help to determine what changes, if any, have occurred during the grant period and to target areas for improving NH community readiness as the NH System of Care continues to develop.
**Figure 1: Stages of Readiness, Community Readiness Model**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
<th>Intervention Goals</th>
<th>Appropriate Strategies</th>
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</thead>
<tbody>
<tr>
<td>1. No Awareness</td>
<td>Issue generally not recognized as a problem.</td>
<td>Raise awareness of the issue.</td>
<td>• Build support on an individual basis.</td>
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<td></td>
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<td>• Visit established groups.</td>
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<tr>
<td>2. Denial</td>
<td>Some concerned but few regard as a local problem or one that can be changed.</td>
<td>Raise awareness that the problem exists in the community.</td>
<td>• Use low intensity message and high visibility media to distribute information.</td>
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<tr>
<td>3. Vague Awareness</td>
<td>Recognition of the problem, but no motivation for action.</td>
<td>Raise awareness that the community can do something about the problem.</td>
<td>• Hold special events.</td>
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<td></td>
<td></td>
<td></td>
<td>• Use informal surveys to gauge public feeling.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Raise intensity of message in news/social media, websites, etc.</td>
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<tr>
<td>4. Preplanning</td>
<td>Recognition of the problem, agreement that something must be done, but few efforts underway.</td>
<td>Raise awareness with concrete ideas to address the problem.</td>
<td>• Conduct assessment of what is going on.</td>
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<td></td>
<td></td>
<td></td>
<td>• Hold focus groups to hear ideas.</td>
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<tr>
<td>5. Preparation</td>
<td>Active planning, modest community support.</td>
<td>Gather existing information to help plan strategies.</td>
<td>• Gather and present local data on issue.</td>
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<td></td>
<td></td>
<td></td>
<td>• Increase media exposure.</td>
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<tr>
<td>6. Initiation</td>
<td>Enough information to justify efforts; efforts are underway.</td>
<td>Provide community-specific info.</td>
<td>• Begin training providers and community members.</td>
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<td></td>
<td></td>
<td></td>
<td>• Conduct public forums and sponsor larger events.</td>
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<tr>
<td>7. Stabilization</td>
<td>One or two efforts supported; staff trained/experienced.</td>
<td>Stabilize efforts/program.</td>
<td>• Maintain business and other support.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Introduce new programs.</td>
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<td></td>
<td></td>
<td></td>
<td>• Increase media exposure.</td>
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<td></td>
<td></td>
<td></td>
<td>• Utilize evaluation for improvement.</td>
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<tr>
<td>8. Confirmation &amp; Expansion</td>
<td>Efforts in place and in use, data collected, recognize limitations of existing efforts and attempt to improve.</td>
<td>Expand and enhance efforts.</td>
<td>• Report data trends.</td>
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<td></td>
<td></td>
<td></td>
<td>• Solicit public opinion.</td>
</tr>
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<td></td>
<td></td>
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<td>• Provide evaluation feedback to community and professionals.</td>
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<tr>
<td>9. Community Ownership</td>
<td>Sophisticated understanding of the problem and efforts to address it in the community; strong training and effective evaluation.</td>
<td>Maintain momentum and continue growth.</td>
<td>• Diversify funding sources.</td>
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<td></td>
<td></td>
<td></td>
<td>• Maintain and expand business support.</td>
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<td></td>
<td></td>
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<td>• Track data for grant writing.</td>
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How We Assessed NH Community Readiness

The Center for Behavioral Health Innovation (BHI) at Antioch University New England conducted the 2014 and 2016 CRAs. BHI is a behavioral health evaluation and quality improvement hub in New Hampshire and beyond. BHI served as external evaluator for FAST Forward.

Defining the issue and identifying sectors and regions
The Community Readiness Model process involves identifying the issue for assessment, adapting the interview protocol, defining the communities, conducting interviews with key respondents, scoring the interviews to determine readiness scores, then developing strategies for action consistent with community readiness. For this assessment, the issue was defined as “the readiness and capacity of NH communities to provide high-quality, coordinated services and supports to children and youth with serious emotional needs and their families.” Based on input from FAST Forward partners, we identified seven sectors with a key perspective on the issue: youth with SED, family members, Community Mental Health Center (CMHC) children’s directors, public health officials, emergency medical service providers (EMS), substance abuse service providers, and special education directors. We identified 10 NH regions/communities for the purpose of the CRA, based on CMHC catchment areas (Figure 2).

Recruiting key informants in 2016
The CRA model suggests that interviewing four to six key informants per community will provide an accurate estimate of community-wide readiness. We planned to recruit seven key informants (one per sector) in each of the 10 geographic regions, for a total of 70 interviews. With the exception of the North Country, we sought to identify key informants for each sector who were centrally located within the major population hub in each region. Because there is no central hub in the North Country, we recruited informants who were dispersed through the region. Key informants were identified by FAST Forward stakeholders and recruited by the BHI evaluation team for all sectors and regions. A total of 58 potential key informants were identified, with at least one key informant identified per sector, per region, with the exception of youth with SED and family members, where only four youth and four family key informants were identified. A total of 50 key informants were interviewed, for an 86% response rate. With the notable exception of youth and families, the CRA process captured a broad array of perspectives and geographic representation.

Interviewing and scoring
We adapted the standard Community Readiness Model interview protocol; the final protocol contained 20 questions (Appendix). Telephone interviews took between 30 and 60 minutes. BHI evaluation team members were trained to score interviews using a set of anchored ratings for each dimension of readiness. Once they reached an 80% agreement rate for their scores, 2-3 raters independently scored each interview. Raters then came together as a team to reach consensus on discrepant scores. This process ultimately yielded a numeric score, ranging from 1-9, for each of six dimensions of readiness, as well as an overall readiness score.

Thematic analysis
We also conducted a thematic analysis of the ideas and sentiments expressed by the key informants, to augment the readiness scores. Interviewers identified text segments that captured the ideas and experiences expressed by the key informants. A team of coders assigned each text segment a word or phrase to capture the core meaning. Once the coders reached consensus on the initial core meanings, they searched for broader themes expressed by the key informants. These themes were subsequently clustered and labeled (e.g., “resources”). The final product of this process was a set of clustered themes, consisting of coded text segments.
Figure 2: Community Mental Health Regions of NH

New Hampshire Community Mental Health Regions

Region I
Northern Human Services
57 Washington St, Concord, N.H., 03301
Tel: (603) 447-3347 Fax: (603) 447-6893

Region II
West Central Behavioral Health
9 Hanover St, Suite 2, Lebanon, N.H., 03766
Tel: (603) 445-0126 Fax: (603) 445-0129

Region III
Genesis Behavioral Health
111 Church St, Laconia, N.H., 03246
Tel: (603) 524-1100 Fax: (603) 524-0760

Region IV
Riverbend Community Mental Health Center
70 Pembroke St, PO Box 2032
Concord, N.H., 03302-2032
Tel: (603) 224-1551 Fax: (603) 224-7508

Region V
Monadnock Community Services
84 Main St, Suite 301 Keene, N.H., 03431
Tel: (603) 357-4400 Fax: (603) 357-0929

Region VI
Community Council of Nashua
7 Prospect St, Nashua, N.H., 03064
Tel: (603) 884-1111 Fax: (603) 884-1514

Region VII
Mental Health Center of Greater Manchester
401 Cypress St, Manchester, N.H., 03103
Tel: (603) 624-1111 Fax: (603) 624-1114

Region VIII
Seacoast Mental Health Center
1142 Sagamore Ave, Portsmouth, N.H., 03071
Tel: (603) 431-8703 Fax: (603) 431-3733

Region IX
Community Partners
113 Crooked Rd, Dover, N.H., 03602
Tel: (603) 749-1119 Fax: (603) 749-1119

Region X
Center for Life Management
Salem Professional Park
44 Sites Rd, Salem, N.H., 03079
Tel: (603) 893-1546 Fax: (603) 893-1528
New Hampshire Remains in the Preplanning Stage

The total score (4.2) in both 2014 and 2016 indicates that, across dimensions, New Hampshire communities remain in Stage 4 (Preplanning) of readiness to provide high-quality, coordinated services and supports for children and youth with serious emotional disturbance and their families (Figure 3). From 2014 to 2016, New Hampshire’s readiness scores improved in Existing Community Efforts, Leadership, Community Climate, and Resources Related to the Issue, but declined in Community Knowledge of Efforts and Community Knowledge of the Issue. Preplanning means that there is clear recognition of the importance of the issue, but attempts to address it are nascent, not easily accessible, and/or ineffective.

2016 results show that the highest NH readiness dimension scores ranged from 5.8 (Preparation) for Existing Community Efforts, to 4.7 for Resources Related to Issue and 4.2 for Leadership (Preplanning). While efforts to address the problem are being actively prepared, NH communities may not be very informed about, supportive of, or able to access efforts.

The lowest 2016 NH readiness dimension scores ranged from 3.5 – 3.7, all within the Vague Awareness stage of readiness. While the community is aware of the issue, there is no motivation to do anything to elicit change.

Figure 3: NH Community Readiness by Dimension, 2014 and 2016
Family, Youth, EMS Perceive Lower Readiness than CMHC Children’s Directors, Public Health Officials and SA Service Providers

Figure 4 shows that the EMS Administrator sector perceived NH communities to be at a relatively low level of readiness (2.9, Denial/Resistance). At this stage, community members recognize the problem in the abstract, but not on the local level, or if there is a local problem, that nothing needs to/can be done about it. Characteristic attitudes are: “It’s not our problem” and “We can’t do anything about it.” The Youth (3.8) and Family (3.3) sectors perceived NH communities to be at a slightly higher level of readiness (Vague Awareness). They report that while local concern exists, immediate motivation to do anything about it is lacking. The highest levels of community readiness were perceived by the CMHC Children’s Health Directors (4.9), Public Health Officials (4.8), Substance Abuse Service Providers (4.7), and Special Education Directors (4.4), whose scores all fell in Stage 4 (Preplanning). Preplanning indicates that awareness exists, there may be groups addressing it, but efforts are not focused, accessible, well known, and/or effective.

*Figure 4: NH Readiness by Sector, 2016*
Readiness Profile Relatively Uniform Across NH Regions

The overall community readiness scores remain fairly uniform across NH. The Southeastern (4.6) and Greater Manchester (4.5), Strafford County (4.5), Lakes (4.3), Seacoast (4.2), Monadnock (4.2), and North County (4.0) regions scored in the low to middle range of the Preplanning stage: While awareness of the need exists, there may be groups addressing it, but efforts are not focused, accessible, well known, and/or effective. The remaining three regions scored on the high end of the Vague Awareness stage, indicating that while there is some level of local recognition of a problem, there is little immediate motivation to do anything about it (Figure 5).

**Figure 5: NH Readiness by Region, 2016**

Some regions stand out in particular dimensions of readiness. Community Efforts in the Southeastern Region (7.1) reach the Stabilization stage, and in the Lakes region (6.8) the Initiation stage (Figure 6). At Initiation, efforts are fully underway and no longer require justification; at Stabilization, trained/experienced staff leads community-specific efforts. Similarly, Resources in the Southeastern (5.8), Strafford (5.4) and Monadnock (5.4) regions has reached stage 5 (Preparation), where active planning is underway. Yet despite the relatively high level of community efforts underway in Southeastern and Lakes regions, the community knowledge of them remains comparable to other regions that haven’t reached that level of existing efforts. Whether services are more or less available in different regions, if community members are not aware of them, people may not be getting the help they need.

**Figure 6: Regions by Community Efforts, 2016**
**Key Informants Voice Perspectives on NH Readiness**

Thematic analysis of the CRA interview revealed six thematic clusters across all key informants (See Figure 7 for complete table of cluster and themes). This wide-ranging set of perspectives lends nuance to the CRA scores and spotlights key areas for community readiness improvement.

**Stigma Persists Among NH Public**

While some respondents noted an increase in community awareness of the issue, others continued to note a lack of awareness in the general public. Knowledge about mental illness as a whole is reportedly lacking. For those who know about mental illness and specifically mental health as it pertains to youth, information and data are not perceived as readily available or accessible. Although many stakeholders try to educate and raise awareness, they find it difficult to reach a large enough audience. Furthermore, NH’s individualistic, “pick yourself up by your bootstraps” culture, along with lack of understanding that mental health is part of overall health, seem to contribute to stigma. The need to better educate the public to reduce the stigma remains.

**Communicating and Collaborating Across NH Care Systems Remains Challenging**

While some service systems successfully collaborate and coordinate, others continue a siloed approach to providing services. Some service providers feel that it is too much effort to collaborate with other services. Other collaboration barriers include funds, staff, and lack of awareness that coordination can make a difference. Schools are reluctant hubs for the system. The reluctance is partially driven by under-funding and -staffing. Some schools also lack a consistent or coherent model to help them understand how to effectively manage resource barriers long-term. Hospitals and ERs are often the first point of entry into the system, but they do not seem well trained or coached in how best to support youth and families in crisis.

**Competing Issues and Persistent Barriers Hamper Expansion of System of Care**

Most key informants recognized an increase in services for youth and their families. In some areas, this was attributed to an increase in funding from federal grants but other areas continue to feel under-resourced. Other issues, such as the opioid crisis, have taken priority in other areas. Other barriers to an effective system of care include a lack of providers, insurance coverage, transportation, funding, timing, and staffing.

**Figure 7: Qualitative Clusters and Themes**

<table>
<thead>
<tr>
<th>Clusters</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services</td>
<td>In some areas, the hospitals and ERs tend to be the first line of defense for youth in crisis; however, departments are still somewhat uninformed and unprepared when it comes to behavioral health emergencies. Although pediatric training is an EMS requirement, there is a deficit in evidence-based training for psychiatric/behavioral health emergencies.</td>
</tr>
<tr>
<td>School Services</td>
<td>Behavioral health problems can be difficult to address in school due to the lack of consistency between home and school environments. Some schools are struggling to have a unified voice to understand behavioral health difficulties and how to most effectively manage them long-term. While some communities rely on schools as foundations for coordinating services, other communities find that it is difficult to involve schools due to systemic barriers that are unique to the school. Although schools play a very important role in behavioral health, they are greatly understaffed and underfunded to be able to meet children's needs. School leaderships’ attitudes are shifting: They are attending to mental health issues more seriously and are more open to asking for help.</td>
</tr>
</tbody>
</table>
| Facilitation and barriers to implementation | Grants are needed to fill gaps and create opportunities in services when insurance or managed healthcare services are unable to do so.  
Services are more accessible now than a few years ago, however there is still room to continue growing and building a coordinated continuum of care.  
The heroin epidemic has made it difficult to address necessary substance abuse and mental health issues in the community.  
Behavioral health services are lacking in areas such as availability, education, visibility, and prevention.  
Leadership is aware that mental health issues are important but lack the resources to elicit positive change.  
Coordination of mental health care is a priority, but funding and accomplishing it remains a barrier.  
Barriers to mental health services include a lack of providers, insurance coverage, transportation, funding, timing, and staffing. |
| Increased awareness and obstacles to awareness | Since the start of the grant, the number of individuals in the community who have become aware of the issue and provide support to this population has increased.  
One way to increase community awareness has been to promote the issue (i.e. through advertising or sharing story in public venue) to the general public; however, this has been difficult to do.  
One obstacle to increasing community awareness is the lack of general knowledge in general population about mental illness.  
In some regions, if a member of the community does not have personal experience with the issue they are less likely to be aware that it is occurring.  
Another obstacle to community awareness is the lack of data available to the public, which creates a lack of visibility of the issue. |
| Community Attitudes | Understanding of how mental health relates to overall health is lacking in the community, so people do not give as much attention to mental health issues.  
There's stigma against those suffering from mental health issues; People believe that those who suffer from mental health issues should take responsibility for their own problems.  
Sometimes parents of this population of children do not understand what is happening with their child and might expect others to solve take the lead to help.  
Continued need for education about mental illness needs in the general population in order to change the community's attitude about mental health issues; especially difficult to disseminate this information to low-income communities. |
| Strengths and barriers to collaboration | In some communities, parents find that there is already collaboration occurring while in others they are required to coordinate the services themselves.  
There has been an increase in coordination and collaboration between services in some communities.  
Some communities still struggle with coordinating efforts between various services; specifically some services feel that it is too much effort to coordinate/collaborate.  
Several challenges to coordinating efforts to help youth with mental illness, such as funding, staffing, and limited awareness that coordination can make a difference.  
Some communities are not seeing any coordination efforts occurring. |
Conclusions and Recommendations

These results indicate no significant change in community readiness from 2014 to 2016, despite significant gains in the implementation of a statewide high fidelity wraparound practice. The Community Readiness Model recommends addressing the lowest-scoring dimensions and regions first, lest they inhibit or constrain limit overall progress and curtail efforts to leverage strengths. These results point to the four community readiness improvement strategies below, which are consistent with NH System of Care goals and objectives and conform to Community Readiness Model recommendations.

1. Prioritize Community Awareness and Climate
2. Elevate and Empower Youth and Family Voice and Choice
3. Promote and Support Communication and Coordination Across Care Systems, Especially Schools and Hospitals
4. Plan System of Care Expansion to Address Persistent Barriers and Competing Issues

Prioritize Community Awareness and Climate
NH communities remain minimally aware of the local needs of youth with SED and their families, the community-wide impacts associated with those needs going unmet, and the existing efforts to address them. Educating the public about the importance of children’s behavioral health and systems of care, informing community members about the efforts already underway, and disseminating information and data about children’s mental health to the public should be high priorities. Low intensity information and media that align the needs and goals of youth with SED and their families, with those of their home communities, are the most effective approaches given these low levels of readiness. Other possible strategies include:
- Promote NHCBHC website and YouthMove Facebook page as information hubs
- Develop local, culturally and linguistically appropriate, flexible-use information about NH children/youth with SED and disseminate through conventional and social media
- Use YouthMove Facebook presence, and other social media (twitter, email blasts) to spread information and build a community of shared experience
- Introduce mental health awareness and stigma prevention and information on children/youth with SED at local community events and to unrelated community groups
- Present information on SED and its local implications at community events (e.g., organize local screenings of “Who Cares about Kelsey?”)
- Collect and disseminate local information and data about youth mental health

Elevate and Empower Youth and Family Voice and Choice
CRA sector results, together with the difficulty we experienced recruiting family and youth to take part in this CRA, suggest the need to 1) prepare and support youth and families to more successfully navigate the system; and 2) cultivate and infuse youth and family leadership and perspective throughout NH’s child-serving systems. Many youth and their families have a history of feeling let down by their local systems and communities; as such, those making efforts to engage them are likely to be initially met with well-founded skepticism and resistance. These efforts will need to start slowly, carefully working to build and repair trust and to cultivate a sense of community and connection before empowerment and transformation will take place. Possible strategies include:
- Provide one-on-one outreach to families of children/youth with SED.
- Create and disseminate region-specific roadmap/navigation information as a resource to families so they can benefit from the experience of others.
• Build a family network to share community- and culture-specific stories, experiences, and navigating/advocating “best practices.”
• Develop and sustain co-training, models, and tools that enable youth, families, community-based organizations, and systems to meaningfully collaborate, to infuse youth/family perspective into existing behavioral health governance and leadership structures.

Promote and Support Communication and Coordination Across Care Systems, Especially Hospitals and Schools
CRA sector results and qualitative themes highlight the important of promoting and supporting care communication and coordination to further NH community readiness. On a basic level, results indicate that different systems may need further education on the importance and impact of care coordination, training in youth mental health first aid, and information about system of care values. At a more complex level, developing a functioning “system of care” from multiple, complex systems demands a high degree of collaboration among diverse organizations. Possible strategies include:
  • Identify and build bridges to the NH 1115 Medicaid Waiver project to learn about care coordination gaps for youth with SED and ways to coordinate efforts
  • Use opportunity presented by FAST Forward 2 to develop ways to facilitate and support schools as effective and empowered community service hubs
  • Help CBHC to develop and support system of care collaboration function
  • Task CBHC with researching/developing care coordination training and support models

Plan System of Care Expansion to Address Persistent Barriers and Competing Issues
As the FAST Forward grant concludes and the NH System of Care efforts shift to encompass planning and preparation for Medicaid Expansion funding and FAST Forward 2 and Monadnock System of Care Implementation grants, use the opportunity of these broad planning efforts to address persistent barriers to SoC implementation and help to effectively frame the place of a NH System of Care within a dynamic healthcare environment. Possible strategies include:
  • Frame the Opioid Crisis efforts in a way that synergizes rather than competes with NH SoC values and priorities, for example, encouraging preventative efforts through addressing youth mental health
  • Address persistent barriers to an effective system of care: a lack of providers, insurance coverage, transportation, funding, timing, and staffing
References

Appendix: NHSoC Community Readiness Assessment Interview Guide

COMMUNITY EFFORTS (programs, activities, policies, etc.) AND COMMUNITY KNOWLEDGE OF EFFORTS (A and B)

1. Using a scale from 1-10, how important is making high quality, coordinated services and supports more available to children and youth with significant emotional and behavioral health needs and their families in your community (with 1 being “not at all” and 10 being “a very great concern”)? Please explain.

2. Please describe the efforts in your community to make high quality, coordinated services and supports more available to children and youth with significant emotional and behavioral health needs and their families. (A)

3. How long have these efforts been going on in your community? (A)

4. What does the community know about these efforts or activities? (B)

5. What are the strengths of these efforts? (B)

6. What are the weaknesses of these efforts? (B)

LEADERSHIP (C)

7. Using a scale from 1 to 10, how important is making high quality, coordinated services and supports more available to children and youth with significant emotional and behavioral health needs and their families to the leadership in your community (with 1 being “not at all” and 10 being “of great concern”)? Please explain.

8. How are these leaders involved in these efforts? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)

9. Would the leadership support additional efforts? Please explain.

COMMUNITY CLIMATE (D)

10. How does the community support efforts to make high quality, coordinated services and supports more available to children and youth with significant emotional and behavioral health needs and their families?

11. What are the primary obstacles to these efforts in your community?

KNOWLEDGE ABOUT THE ISSUE (E)

12. How knowledgeable are community members about the need to make high quality, coordinated services and supports more available to children and youth with significant emotional and behavioral health needs and their families? Please explain. (Prompt: For
example, dynamics, signs, symptoms, local statistics, effects on family and friends, etc.)

13. What type of information is available in your community about this issue?

14. What local data are available on this issue in your community?

15. How do people obtain this information in your community?

RESOURCES (time, money, people, space, etc.) (F)

16. To whom would children and youth with significant emotional and behavioral health needs and their families turn to first for help in your community? Why?

17. What is the community's and/or local business' attitude about supporting efforts to make high quality, coordinated services and supports more available to children and youth with significant emotional and behavioral health needs and their families, with people volunteering time, making financial donations, and/or providing space?

18. Are you aware of any proposals or action plans that have been submitted for funding that would address this issue in your community? If yes, please explain.

19. Do you know if there is any evaluation of these efforts? If yes, on a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being “not at all” and 10 being “very sophisticated?”)?

20. Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?