Children’s Behavioral Health Collaborative Network Assessment

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Executive Summary

We assessed the Children’s Behavioral Health Collaborative (CBHC)

The purpose of the study was to study CBHC relationships, contributions and outcomes. We collected data in February 2015 and June 2016 using PARTNER, an integrated online survey and network analysis tool. 53 (63%) of the key respondents from CBHC member organizations completed the survey in 2015 and 55 (57%) in 2016.

Results

CBHC network remains diffuse and trusting
CBHC contact has increased and become more coherent and centralized over time
Philanthropy, Advocacy and Gov’t sectors are most central; Social Service and Healthcare sectors are most peripheral
CBHC remains Concord-Centric; North Country and Upper Valley regions emerge; South East loses ground
Perception of CBHC “success” grows, increasingly attributed to convening diverse stakeholders to share knowledge and to plan
Access, coordination, and integration of supports and services are most valued; technical assistance least valued

Recommendations

Leverage increasing consensus that access and delivery of services and supports are the most important CBHC outcomes to drive agenda
Cultivate emergent regional networks
Nurture increased engagement of key peripheral sectors
Further develop CBHC governance, process, and accountability structures and tools
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Why We Assessed the Children’s Behavioral Health Collaborative (CBHC)

**FAST Forward Aims to Improve Care for NH Youth with SED**
FAST Forward is a youth-guided, family-driven system of care, designed to serve NH with serious emotional disturbance. Built on partnerships within the NH Department of Health and Human Services and community-based providers, FAST Forward offers access to individualized services, aligned with the potential and needs of each child and family, and guided by a strengths-based, wraparound service planning process. These enhanced services and supports build resilience, coping, and strategies for families to better meet their child’s behavioral health needs and to improve outcomes and functioning in home, school, and community. A major component of FAST Forward involves developing the connections and capacity to support a NH system of care. The success of NH’s system of care rests, in part, on the degree to which diverse stakeholders are able to *collaborate effectively* to reach shared goals.

**Collaborating across NH Organizations and Regions**
Collaboration around children’s behavioral health in NH connects FF directly to the developing network of organizations comprising the NH’s CBHC, which formed at the initiative of the Endowment for Health and the New Hampshire Charitable Foundation in 2010. At that time, the CBHC began a 3-year strategic planning process to develop a system of care for NH’s children and youth with significant emotional and behavioral health needs. Drawing on input from diverse stakeholders, the CBHC developed the Children’s Behavioral Health Plan, released in March 2013. Since its inception, the CBHC has secured substantial investments toward sustainable best practices, workforce development, service delivery, advocacy and policy. Notably, in 2012, SAMHSA awarded the NH Department of Health and Human Services (NHDHHS) a System of Care Implementation Grant to develop FF. Nurturing collaboration among FF stakeholders and the broader CBHC network across NH regions is an essential component of implementing a system of care.

**Center for Behavioral Health Innovation Assessed CBHC Network Functioning**
To measure the strengths and weaknesses of partnerships among the CBHC network, evaluators from Antioch University New England’s (AUNE) Center for Behavioral Health Innovations (BHI) conducted a baseline network assessment in early 2015 and then again about 18 months later in late spring 2016. Network assessments benefit collaboratives by gauging levels and types of partner engagement and offering strategizes to build capacity. Network analysis is also useful in assessing changes in collaboration, to help measure how a network is progressing over time.
How We Assessed the CBHC Network

CBHC Networks Assessed Using Social Network Analysis
Collaborative networks face the challenges of how to understand the nature of their network, to measure their effectiveness, and strategize ways to enhance their functioning. Social Network Analysis (SNA) offers a methodology for understanding the nature of these kinds of networks. SNA involves the measuring, mapping, analyzing, and interpreting of social network structures. BHI evaluators chose the PARTNER tool, a publically available, integrated online survey and SNA tool, to assess these networks. PARTNER assesses the amount and nature of relationships, capacities and contributions, and outcomes within networks over time. The tool includes a customizable online survey to collect data and an integrated Excel-based social network data analysis program. While the overall focus was on the overall CBHC network, the tool allowed us to derive some insights into subnetworks.

PARTNER Survey Modified
We modified the PARTNER survey based on multiple rounds of input from stakeholders and the PARTNER tool developer (Danielle Varda, University of Colorado Denver). The final version of the survey contained 22 items designed to assess 1) basic demographic information (e.g., length of service, involvement in CBHC working groups, grants and partner projects), 2) NH network relationships (i.e., perceived trust, value, and amount of collaboration between members), 3) CBHC Contributions (i.e., the amount and types of contributions by various members to the functioning of the CBHC), and 4) CBHC outcomes. See Appendix A for the survey.

PARTNER survey measured network development over time
We assessed the entire CBHC network. To be considered a CBHC member, an organization had to meet one of two criteria: 1) active participation in a CBHC work group, steering committee, and/or grant-funded project and/or 2) natural mission alignment with the CBHC (i.e., Community Mental Health Centers and Regional Public Health Networks.) For both administrations, a CBHC official provided advanced notice and encouraged participation through an email sent to the key respondents of all member organizations. All other communication about the survey was generated and sent via the PARTNER tool. Appendix B includes a list of CBHC organizations.

The first administration took place in February 2015. Eighty-four member organizations met criteria, and a key respondent was selected from each to respond to the survey. Potential respondents received an initial invitation to participate and up to three follow-up email prompts. At the end of the response period, 53 CBHC key respondents had completed at least 50% of the survey, for a response rate of 63%. The second administration took place in June 2016. Ninety-seven organizations met the criteria for CBHC member organization. At the end of the response period, 55 key respondents had completed at least 50% of the survey, for a response rate of 57%.
Network Scores Explained

The PARTNER tool describes key attributes of whole networks by calculating scores for density and degree centralization, dimensions that describe the overall structure of the network, as well as overall network trust. The network trust score is an index derived from scores of all network organizations about other network organizations in the areas of “reliability,” “support of mission,” and “openness to discussion.” Network integration, or relationships among subgroups, is another attribute of networks we’ll consider.

Density scores reflect the percentage of the total possible ties that exist among organizations in the network. In a very dense network, every organization is connected to every other organization, whereas a diffuse network has few connections (Figure 1). Each network must consider its ideal density in light of its goals and structure; there is no inherently good or bad density score.

**Figure 1: Network Density**

![Network Density Diagram]

Degree centrality scores describe the extent to which the network organizations are alike in terms of their number of connections to each other. In a very decentralized network, organizations have similar numbers of connections to each other, while in a very centralized network, one or two organizations might have many more connections within the network than other organizations. Often, as networks mature, centralization and structure increase.

**Figure 2: Degree Centrality**

![Degree Centrality Diagram]
Interconnectivity between different types of entities within a network, or *network integration*, is another way to think about networks: to what degree are subgroups in the network (e.g., sectors, regions) integrated? (Figure 3) Each network must consider its ideal level of integration in light of its goals and structure.

*Figure 3: Network Integration*
CBHC Network Remains Diffuse and Trusting; Becomes More Centralized Across Administrations

Figure 4: CBHC Network Scores, 2015 & 2016

CBHC Becomes More Centralized
Higher centralization scores indicate that activity is centralized around a few members who hold highly central positions; in these cases, positions of brokerage and information sharing are held by small number of members. Lower centralization scores indicate a less centralized collaborative in which connections (and thus influence and control) are more evenly distributed. The CBHC network became more centralized, moving from 59% to 65%, suggesting a moderately centralized network, where information, power and control are shared across a set of key players in active grant-focused subnetworks.

CBHC Network Remains Diffuse
Network density is an indicator of the overall cohesiveness of a network. CBHC density scores remained fairly low (12.9% in 2015 and 13.7% in 2016), reflecting the relatively low number of active connections among the total number possible within the CBHC. The CBHC contains a number of peripheral members with “weak ties” to the network. Members with weak ties are most useful to a network when they provide a point of intersection with other important/related networks.

CBHC Network Reports “Fair” Levels of Trust
Trust – a resource that increases rather than decreases through use, and becomes depleted if not used – is a key characteristic of properly functioning networks. To achieve a 100% trust score, each member of the network would have to fully trust every other member with whom they interact. At 76.4% in 2015 and 74.9% in 2016, the CBHC network has maintained “fair” levels of trust, reflecting members’ stable commitment to a joint, focused, and important mission. These levels of trust represent a network resource as well as an opportunity for growth. In 2016, of the three items that make up the trust score for the CBHC, “open to discussion” was highest (3.4 of 4), followed by “in support of mission” (3.2) and “reliability” (3.1). No substantial changes were observed in these item scores between 2015 and 2016 administrations.
CBHC Contact Intensifies; Peripheral Organizations Engage

Figures 5 and 6 display networks maps of the entire CBHC network in 2015 and 2016 with lines between organizations representing weekly contact. The positions of the organizations on the map represent their relative centrality in the CBHC network. The maps display a distinct change in the magnitude of weekly contact throughout the CBHC. Peripheral organizations in the 2015 map show more connections and greater centrality in 2016. Certainly, the network has become a bit denser at the weekly level over time.

Figure 5: Weekly Contact in CBHC Network, 2015

Figure 6: Weekly Contact in the CBHC Network, 2016
Social Service and Health Care Sectors Peripheral; Philanthropy, Advocacy and Gov’t Sectors Central

Figure 7 displays weekly contact in the CBHC network with circles representing organizations and colors coded to indicate sectors; lines show weekly contact. This network map shows a mix of sectors at the center, primarily Government, CMHC, and Other (i.e., a combination of Philanthropy, Advocacy, Professional Orgs and Coalitions sectors). A few Education (K-12 and Higher Education sectors) organizations and PHNs occupy central positions but others are dispersed throughout it. Health and Social Services (Health Care and Social Services sectors) organizations occupy more peripheral positions in the network. The CBHC shows a highly varied degree of network integration, with some sectors in the CBHC network displaying significant levels of integration, while other sectors are not integrated.

*Figure 7: Weekly Contact in CBHC Network, Reduced Sectors, 2016*
Figure 8 offers another way of looking at the information displayed in Figure 7 by showing which sectors are most central and connected, and receiving the most benefit from membership in the network. Degree centrality is the number of connections a network member has to other members of the network. Typically, a member with a high number of connections holds a central position by being highly embedded in the network. Most sectors have made small gains in average degree centrality across administrations (the map shows this same effect when all organizations move toward the center). Notably, the Philanthropy sector has gained in centrality, reaching about twice the average centrality of the next closest sectors, Advocacy and Government.

Relative connectivity is an indication of how much each member is benefiting from being a part of the network; a member gets a high relative connectivity score when they have a lot of connections with valuable partners who trust them. The Philanthropy sector is the most central/benefitting from the collaborative; Health Care, Professional Orgs, PHNs and Social Service Agency sectors are the least central/benefitting the least. Most sectors maintained stable relative connectivity over time. In contrast, the relative connectivity of PHNs leaped forward from time 1 to 2. The philanthropy sector also gained relative connectivity in 2016, reaching about twice the relative connectivity of the next closest sectors, Advocacy and Gov't.

*Figure 8: Average Centrality and Connectivity by Sector, 2015 & 2016*
Health Care and CMHC Sectors Lose Network Trust and Value; PHNs and Professional Orgs Gain

Figure 9 compares value and trust scores across sectors and administrations. The network trust score is an index derived from scores of all network organizations about other network organizations in the areas of “reliability,” “support of mission,” and “openness to discussion.” Most sectors experienced between “a fair amount” and “a great deal” of trust at both time 1 and 2. Trust scores for the PHNs, Professional Orgs, and K-12 Education sectors have increased; scores for the Health Care and CMHC sectors have decreased, with both dropping into the range between “a small amount” and “a fair amount” of trust in 2016.

Value is another index derived from respondents’ perceptions of organizations’ “power and influence,” “level of involvement,” and “resource contribution.” Members do not supply value in the same way; some use their power and influence, some donate time through their level of involvement, and some are able to contribute specific resources that the collaborative needs to function. The sectors display more variability in the area of value, with the Philanthropy sector at one extreme scoring between “a fair amount” and “a great deal” and most other sectors hovering around “a fair amount” in 2016. In 2016, Health Care’s value score dropped into the “small amount” range; CMHC’s also lost some perceived value over time. The PHN, Coalition, and Professional Org sectors gained value in the network across administrations.

**Figure 9: Average Trust and Value by Sector, 2015 & 2016**
CBHC Remains Concord-Centric; North Country and Upper Valley Regions Emerge; South East Loses Ground

Figure 10 is a network map displaying weekly contact among the same group of CBHC organizations, with color reflecting NH regions. The Concord-centric nature of the CBHC connections stands out on this map. The map reveals small regional sub-networks with varying degrees of cohesion and centrality. The Monadnock Region stands out on the map as relatively central (i.e., connected to Concord) and coherent. Manchester displays some centrality, yet little coherence. In contrast, Upper Valley and Lakes/Central display some coherence, yet little centrality.

Figure 10: Network Map of CBHC Weekly Contact by Region, 2016
Most Regions—Notably North Country and Upper Valley—Make Gains in Centrality and Connectivity or Remain Stable; South East Decreases in Both

Figure 11 offers another way of looking at the information displayed in Figure 10 by displaying which regions are most central and connected, and receiving the most benefit from membership in the network. The range of average centrality and relative connectivity scores is more constricted for regions than it was for sectors. Most regions gained in centrality, especially the North Country and Upper Valley. The only region with less centrality over time was the South East. The relative connectivity scores show a similar pattern, with most regions gaining connectivity, with greatest gains in the North Country and Upper Valley regions. South East and Monadnock both lost relative connectivity from time 1 to 2.

*Figure 11: Average Centrality and Connectivity by Region, 2015 & 2016*
North Country and Central/Lakes Regions Gain in Network Value and Trust; South East Loses Some Ground

Most regions scored at about or just over “a fair amount” of network trust across administrations (Figure 12). One standout was the North Country where trust scores increased considerably. The value scores for all regions fell between “a small amount” and “a fair amount” across administrations. North Country and Central/Lakes Regions gain some network value over time. The South East region shows a consistent pattern of declining degree centrality, relative connectivity, trust and value.

Figure 12: Average Trust and Value by Region, 2015 & 2016
Perception of CBHC “Success” Grows, Increasingly Attributed to Convening Diverse Stakeholders to Share Knowledge and to Plan

Figure 13 depicts key respondents’ perceptions of CBHC’s success in achieving system change in 2015 and 2016. In 2016 more key respondents perceive CBHC as “successful” and fewer respondents perceive CBHC as “somewhat successful” than in 2015.

**Figure 13: CBHC Success at Achieving System Change, 2015 & 2016**

Respondents believe that bringing together diverse stakeholders, exchanging information/knowledge, and strategic planning around a shared mission/goals are the primary drivers of CBHC success to date. (Figure 14) Each of these factors was endorsed by about half of the respondents in each administration of the survey.

**Figure 14: What Contributes to CBHC Success**

CBHC most successful at bringing together diverse stakeholders; biggest increase in publicizing events
Access, Coordination, and Integration of Supports and Services most Valued; Technical Assistance, Collaboration least Valued

When asked to select the most important CBHC outcome to achieve and sustain, 2016 endorsements coalesced around improving access to and delivery of supports and services. (Figure 15) Access to supports and services, coordination/integration of supports and services, and more well trained, competent behavior health workers together received about half of all endorsements in 2016. These outcomes are more proximal to the ultimate goals of the CBHC, whereas items such as technical assistance, collaboration, and evaluation might be considered means to an end (and thus, less important).

Figure 15: Most Important CBHC Outcome, 2015 & 2016

Services & supports, workforce, funding emergent CBHC priorities

- Better access to high quality tools and expert help
- Improved collaboration among key stakeholders
- Enhanced data collection, monitoring, and evaluation
- A more youth/family guided, culturally and linguistically competent system
- Better informed and more supportive communities and environments
- Better early detection and prevention
- Increased funding/more efficient use of resources
- More well-trained, competent behavioral health workers
- Better coordinated and integrated services and supports
- More access to high quality, community-based supports and services
Summary and Recommendations

Leverage increasing consensus that access and delivery of services and supports are the most important CBHC outcomes to drive agenda

At the same time that consensus about prioritizing outcomes around service and support access and delivery grows in the CBHC, the centrality and connectivity of Health Care and Social Service sectors decline or remain peripheral. Network trust and value has declined for the Health Care sector. Bringing about change in service and support access and delivery will be impossible without engaging Health Care and Social Service sectors in the work of the CBHC. Increasing CBHC relevance and responsiveness to Social Service and Health Care organizations is of primary importance. Efforts around enhancing access, improving and supporting training of behavioral health workers, and coordination/integration of service and support delivery may offer ways to build bridges to these sectors and demonstrate the value of network collaboration in effecting systemic change. Engaging these peripheral sectors in genuine collaboration over issues around which they have abiding interest and bring expertise is paramount.

Cultivate emergent regional networks

The CBHC has demonstrated the ability to construct and promulgate a coherent message, effectively address state policy, and develop a strong Concord-centric state hub. A next step in developing an effective system of care might be developing stronger community and regional networks in which youth and families – and their natural and professional supports – are embedded, and through which systems of care are delivered. The Monadnock region’s connectivity and centrality, nurtured through a SAMHSA System of Care planning (and now implementation) grant, offers one model for nurturing regional capacity without eroding statewide coherence. Perhaps this strategy can be replicated throughout the state by leveraging System of Care funding, regional “Integrated Delivery Networks” via the Medicaid 1115 Waiver, and other resources and efforts.

Nurture increased engagement of key peripheral sectors

Several sectors that would seemingly be critical to CBHC success are among the most peripheral members of the network. Perhaps most critical among these peripheral sectors are Health Care, Social Services, and the Public Health Networks. All three of these sectors might be most effectively engaged through the aforementioned Integrated Delivery Networks. Recruiting one or more children’s behavioral health champions from each of these sectors might also elevate the CBHC cause.

Develop collaborative effectiveness through enhanced CBHC governance structure, process and accountability

As networks mature – and become more effective – their governance and communication processes tend to become more intentional, structured, and efficient. Furthermore, member engagement typically increases as collaboratives develop clear structures and processes.
Appendix A: CBHC PARTNER Survey Questions

1) Please select your organization/entity from the list: (See Appendix B for list of CBHC member organizations.)

2) What is your role in this organization/entity?

3) How long have you been in this role? (Estimate to nearest year.)

4) The mission of the CHBC is to improve the behavioral health of NH's children, youth, and families. Please indicate what your organization/entity contributes to the CBHC. (Choose as many as apply.)
   a) Advocacy for system of care values and other CBHC priorities with funders and policymakers
   b) Public awareness, communication, education, and marketing
   c) Leadership and strategic planning
   d) Planning and facilitating events and meetings
   e) Paid staff
   f) In kind resources (donated and volunteer effort, meeting space, etc.)
   g) Social capital and connections
   h) Mobilization of funding and fiscal management
   i) Shared measurement and data resources (data collection, analysis, reporting)
   j) Behavioral health expertise and tools
   k) Public/population health, systems change expertise and tools
   l) Local, community-based expertise (e.g., norms, customs, values within specific areas of NH)
   m) Implementation of new/better policies, programs, services, and/or supports

5) What is your organization/entity's most important contribution to the CBHC? (Choose one.)
   a) Advocacy for system of care values and other CBHC priorities with funders and policymakers
   b) Public awareness, communication, education, and marketing
   c) Leadership and strategic planning
   d) Planning and facilitating events and meetings
   e) Paid staff
   f) In kind resources (donated and volunteer effort, meeting space, etc.)
   g) Social capital and connections
   h) Mobilization of funding and fiscal management
   i) Shared measurement and data resources (data collection, analysis, reporting)
   j) Behavioral health expertise and tools
   k) Public/population health, systems change expertise and tools
   l) Local, community-based expertise (e.g., norms, customs, values within specific areas of NH)
   m) Implementation of new/better policies, programs, services, and/or supports
6) Which of the following outcomes should the CBHC try to achieve and sustain? (Choose all that apply.)
   a) Improved collaboration among key stakeholders
   b) Increased funding/more efficient use of resources
   c) More well-trained, competent behavioral health workers
   d) Better access to high quality tools and expert help
   e) Enhanced data collection, monitoring, and evaluation
   f) Better early detection and prevention
   g) More access to high quality, community-based supports and services
   h) A more youth/family guided, culturally and linguistically competent system
   i) Better coordinated and integrated services and supports
   j) Better informed and more supportive communities and environments

7) Which outcome is most important to try to achieve and sustain? (Choose one.)
   a) Improved collaboration among key stakeholders
   b) Increased funding/more efficient use of resources
   c) More well-trained, competent behavioral health workers
   d) Better access to high quality tools and expert help
   e) Enhanced data collection, monitoring, and evaluation
   f) Better early detection and prevention
   g) More access to high quality, community-based supports and services
   h) A more youth/family guided, culturally and linguistically competent system
   i) Better coordinated and integrated services and supports
   j) Better informed and more supportive communities and environments

8) How successful has the CBHC been at achieving system change?
   a) Not Successful
   b) Somewhat Successful
   c) Successful
   d) Very Successful
   e) Completely Successful

9) Which of the following contributes most to the CBHC's success to date? (Choose all that apply.)
   a) Bringing together diverse stakeholders
   b) Meeting regularly
   c) Exchanging info/knowledge
   d) Publicizing events
   e) Sharing resources
   f) Strategic planning
   g) Informal relationships created
   h) Making collective decisions
   i) Having a shared mission/goals
   j) Identifying and applying to funding opportunities
   k) Not applicable --- CBHC has not achieved any success
10) Next, please select from the list each organization/entity you are actively working with to advance the CBHC mission. You will then answer a series of questions about each of these organizations/entities. We want to make this as useful for the CBHC and as easy for you as possible. So, report only on relationships with other organizations/entities that a) have been inspired or otherwise facilitated by the CBHC and b) involve intentional efforts to improve the behavioral health of children/youth within the next year. (See Appendix B.)

11) How frequently do you or others in your organization work with this organization/entity to improve the behavioral health of NH’s children?
   a) Never/We only interact on non-CBHC issues.
   b) Once a year or less
   c) About once a quarter
   d) About once a month
   e) Every Week
   f) Every Day

12) What types of CBHC-inspired efforts to improve the behavioral health of NH’s children/youth are you currently planning or implementing with this organization/entity? (Choose all that apply.)
   a) Awareness, education, and/or anti-stigma campaigns
   b) Data gathering, research, and/or evaluation activities
   c) Healthier environments/environmental interventions
   d) Natural support systems
   e) Policy development and/or advocacy
   f) Professional service and support systems

13) How valuable is this organization/entity's power and influence to achieving the overall mission of the CBHC?
   *Power/Influence: The organization/entity holds a prominent position in the community or field by being powerful, having influence, success as a change agent, and showing leadership.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

14) How valuable is this organization/entity’s level of involvement to achieving the overall mission of the CBHC?
   *Level of Involvement: The organization/entity is strongly committed and active in the partnership and gets things done.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal
15) How valuable is this organization/entity's resource contribution to achieving the overall mission of the CBHC?
   *Contributing Resources: The organization/entity brings resources to the partnership like funding, information, or other resources.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

16) How reliable is this organization/entity?
   *Reliable: this organization/entity is reliable in terms of following through on commitments to the CBHC.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

17) To what extent does this organization/entity share a mission with the CBHC's mission and goals?
   *Mission Congruence: this organization/entity shares the vision of the CBHC.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

18) How open to discussion is the organization/entity? *Open to Discussion: this organization/entity is willing to engage in frank, open and civil discussion (especially when disagreement exists). The organization/entity is willing to consider a variety of viewpoints and talk together (rather than at each other). You are able to communicate with this organization/entity in an open, trusting manner.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

19) This partnership has contributed or led to: (Choose all that apply.)
   a) Expanded and improved infrastructure (e.g. networking, collaboration, data collection and evaluation, training, resources, tools.)
   b) Enhanced services and supports (e.g. early detection/prevention, higher quality, integrated, community-based services and supports, a more youth/family guided, linguistically and culturally competent system.)
   c) Better-informed and more supportive communities/environments.
   d) Has not yet contributed or resulted in systems change.

20) Please indicate to which of the following CBHC structures/workgroups your organization/entity contributes. (Check all that apply.)
   a) CBHC Steering Committee
b) Behavior Health Equity

c) Communications and Social Marketing

d) Evaluation

e) Policy

f) School Behavioral Health

g) Workforce Network

21) Please indicate on which of the following funded projects your organization/entity has a formal/contracted role. (Check all that apply.)

   a) FAST Forward
   b) Project LAUNCH
   c) Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW)
   d) Safe Schools, Healthy Students
   e) Spark NH Early Childhood Advisory Council
   f) NAMI-NEXUS Statewide Suicide Prevention
   g) Partners for Change at Dartmouth
   h) Cheshire County System of Care
   i) Project AWARE

22) Do you have any additional comments or feedback about the CBHC?
Appendix B: CBHC Member Organizations

Antal Consulting, LLC
Antioch University New England
Berlin Schools District; Project Aware
Carroll County Coalition for Public Health
Carroll County Prevention Network
Center for Life Management
Center for Program Design and Evaluation, Dartmouth
Child and Family Services
Child Health Services
Children's Behavioral Health Collaborative
Children's Hospital at Dartmouth-Hitchcock, Concord
Children's Hospital at Dartmouth-Hitchcock, Pediatric Residency
Communities for Alcohol and Drug-Free Youth
Communities United Regional Network of Sullivan County
Community Bridges
Community Partners
Concord School District; Safe Schools/Healthy Students
Conval School District
County of Cheshire
Dartmouth Trauma Interventions Research Center
DHHS: Mental Health Services
DHHS: Bureau of Children's Behavioral Health
DHHS: Bureau of Drug & Alcohol Services
DHHS: Division for Children, Youth, and Families
DHHS: Division of Behavioral Health
DHHS: Office of Minority Health and Refugee Affairs
Disability Rights Center - NH
Dover Coalition for Youth
Early Learning NH
Elliot Health Systems: Neonatology Services
Endowment for Health
Families in Transition - Family Willows
FASTER (Families Advocating Substance Treatment, Education and Recovery) Support Group
Foundation for Healthy Communities
Genesis Behavioral Health
Goodwin Community Health
Granite State Federation of Families for Children's Mental Health/YouthMove
Granite United Way
Greater Derry Public Health Network
Cheshire Medical Center/Greater Monadnock Regional Public Health Network
Greater Nashua Mental Health Center
Hampton School District
Headrest, Inc.
Indian Stream Health Center
International Institute of NH
Ken Jue, Independent Consultant
Laconia School District; Safe Schools/Healthy Students
Lakes Region Partnership for Public Health
Makin It Happen Coalition for Resilient Youth
Manchester Community Health Center
Manchester Health Department
MAPS Counseling
Mary Hitchcock Memorial Hospital/Upper Valley Public Health Network
Mental Health Center of Greater Manchester
Mid-State Health Center
MJC Health Solutions, LLC
Monadnock Family Services
Monadnock United Way
Monadnock Voices for Prevention
NAMI NH
Nashua Division of Public Health and Community Services
New Futures, Inc.
New Hampshire Center for Effective Behavioral Interventions and Supports
New Hampshire Center for Excellence
New Hampshire Charitable Foundation
New Hampshire Hospital, Child & Adolescent Psychiatry
New Hampshire Hospital, Social Work Department
New Hampshire Kids Count
New Hampshire Pediatric Society
NH Department of Education
NH Medical Society
North American Family Institute
North Country Health Consortium
Northern Human Services
Office of Youth Services-Manchester
Parent Information Center of NH
Partners in Prevention Coalition
Plymouth State University; School Psychology
Raymond Coalition for Youth
Riverbend Community Mental Health
Rochester School District; Safe Schools/Healthy Students
SAU 18; Project Aware
SAU 7; Project Aware
Seacoast Mental Health Center
Seacoast Public Health Network
Seacoast Youth Services
Southwest Region Planning Committee
Southern New Hampshire University; Community Mental Health and Mental Health Counseling
Spark NH Early Childhood Advisory Council
Strafford Learning Center
Sullivan County Regional Public Health Network
Traci Fowler Consulting
University of New Hampshire; Institute on Disability
Upper Valley Substance Misuse Prevention Partnership
Wediko Children's Services
West Central Behavioral Health
Youth Council-Nashua