



February 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***

Report funded by The Endowment for Health and New Hampshire Children's Health Foundation
Report produced by Health Resources in Action



Health Resources in Action
Advancing Public Health and Medical Research

Contents

Executive Summary..... ii

Introduction 1

 Assessment Methods..... 2

 Qualitative Data Collection 2

 Provider Survey 3

 Review of Secondary Data 4

 Environmental Scan 4

 Assessment Limitations 5

Key Findings 6

 Description of the System..... 6

 Evidence-Based Models for Child and Family Therapy..... 6

 Evidence-Based Models for Parent Education..... 8

 Evidence-Based Models for Home Visiting and Early Childhood Education..... 10

 Barriers to Implementing Evidence-Based Models..... 11

 System Strengths 12

 System Challenges and Gaps 13

 Members of the Early Childhood and Family Mental Health Workforce 15

 Early Childhood and Family Mental Health Credential..... 16

 Facilitators and Barriers to Providing and Accessing Services 17

 Barriers to Accessing Services..... 20

Key Themes and Recommendations..... 24

 Key Themes..... 24

 Recommendations 25

 Develop a Statewide Early Childhood Mental Health System 25

 Workforce Development Strategies 26

 Availability and Accessibility of Services..... 28

 Reduction of Structural Barriers 30

Appendix A. Survey Respondents Demographics 31

Appendix B. Environmental Scan 32

Executive Summary

While mental health services have historically been targeted towards adolescents and adults, there is growing recognition of the need for increasing the availability and capacity of services and programs to promote healthy social, emotional development for young children and their families. The Endowment for Health and the New Hampshire Children’s Health Foundation commissioned an assessment of the capacity of the workforce serving this population in the New Hampshire. The objectives of the assessment were:

- To identify **who** is providing early childhood and family mental health services, **where, how**, and with **what** training and credentials.
- To identify **barriers**, beyond those of financing, **to providing and accessing** early childhood mental health services.

“Early childhood mental health services” refers to both clinical mental health services *and* child and family strengthening programs (e.g., home visiting, family resource centers). The inclusion of family strengthening programs is consistent with the New Hampshire 10-year Mental Health Plan. The assessment used a mixed-methods approach, including key informant interviews, focus groups, a survey of providers, and collection of secondary data (e.g., Census and administrative data).

Key Findings

There is no one singular system of care designated to deliver early childhood and family mental health services in New Hampshire. Overall, early childhood and family mental health services were described as disjointed, siloed, and, in some cases, non-existent. Assessment participants detailed the difficulty that families experience accessing and navigating care, perceived as arising in part from a lack of communication and coordination between the different services and providers that fall under the umbrella of early childhood mental health.

There is a widespread shortage of qualified mental health providers across the state. Limited workforce capacity in the fields of mental health, early childhood education and development, and family support arose as a major challenge across the state. Participants attributed workforce shortages and high staff turnover to low wages and reimbursement rates and burdensome credentialing and training requirements. Participants indicated that provider shortages led to long wait times for services and families being bounced between providers due to turnover. The lack of consistency was perceived as disrupting care and making it difficult to continue with programs or treatment. Assessment participants largely agreed that, while the Early Childhood and Family Mental Health (ECFMH) credential training and reflective practice requirements are valuable, its larger impact is limited. Participants perceived that larger recognition of the credential was low across the state.

The high cost of evidence-based models prevented them from wide-spread implementation across the state. Participants identified several effective models, such as Healthy Families America (HFA) and Child-Parent Psychotherapy (CPP), currently being used in New Hampshire. Participants cited the high cost of trainings and the loss of billable time as preventing more staff from being trained in evidence-based models.

Recommendations

Recommendations from the assessment fall into four overarching categories: A statewide early childhood mental health system, workforce development strategies, increased availability of services, and reduction of structural barriers.

Develop a Statewide Early Childhood Mental Health System | To facilitate children and families accessing the care they need, New Hampshire should establish a coordinated early childhood mental health system of care, including infrastructure around training, monitoring, and administrative support to assure adequate reimbursement, as well as expansion of services across the continuum of care.

Strengthen State Level Credentialing | Advocates and legislators should partner with the New Hampshire Association for Infant Mental Health to develop and advocate strategies to elevate the ECFMH credential statewide. Potential strategies could include requiring the credential for specific provider levels or associating the credential with increased salary level or higher reimbursement rates. Offering scholarships or reimbursements from the state to cover costs associated with the training would also incentivize providers to take part in the training.

Increase Support for Training | Additional support for on-going provider training arose as a need. This could be done by offering subsidies for the cost of attending trainings and offering more trainings in rural areas. Increasing virtual training opportunities and improving the technological infrastructure needed should also be explored. Changes to billing rules to allow training attendees to bill for time spent at professional development opportunities would also incentivize more providers to participate in trainings.

Increase and Expand Payment and Reimbursement Rates | Assessment participants cited higher reimbursement rates as key to supporting training needs and strengthening the workforce. In addition to increasing reimbursement rates for services, improvement could be seen by advocating for an expansion of billable services to include more services offered by Family Resource Centers and home visiting programs. Workforce challenges could be addressed through increasing salaries for early childhood and family mental health providers. Financial incentives, such as tuition reimbursement or loan repayment, could be offered to recruit and retain providers.

Co-locate and Integrate Services | Participants recommended embedding mental health in systems that already serve children to improve access and increase awareness of available mental health services. This could be done by integrating mental health providers in Family Resource Centers, Family Centered Early Supports and Services, early care and education settings, and the Division of Children, Youth and Families.

Increase Availability of Services | The need for more services was identified across the continuum of care. Efforts to support workforce development would incentivize and support providers in increasing their offerings for the target age group. Participants recommended increasing the number of services offered in rural areas. Participants also recommended increasing Medicaid reimbursement for early childhood mental health care to enhance services for Medicaid patients.

Reduce Structural Barriers | Steps should be taken to reduce structural barriers to families accessing needed care. Recommendations include funding transportation credits (e.g., taxi credits), improving marketing of existing transportation programs to raise awareness among qualifying families, and providing subsidies for childcare. Increasing availability of home-based services and weekend or evening appointments would also reduce structural barriers.

Introduction

While mental health services have historically been targeted towards adolescents and adults, there is growing recognition of the need for increasing the availability and capacity of services and programs to promote healthy social, emotional development for young children and their families.¹ Research shows that traumatic experiences and stress during the first years of life can impact a child's brain development, educational achievements, and future economic opportunities.² Adverse experiences, including abuse and neglect, witnessing domestic violence, or growing up with substance abuse and/or mental illness in the household, have been tied to negative mental, behavioral, and physical health outcomes in adulthood.³

In December 2018, a broad range of stakeholders in New Hampshire met to explore state level strategies for financing assessment, diagnosis and treatment of infant and early childhood mental health. This convening identified the opportunities to:

- Change current Medicaid policy to allow for multiple diagnostic assessment sessions for a child under five years old;
- Expand the use of EPSDT for a more comprehensive benefit for Children with Special Health Care Needs birth to five years old; and
- Enhance workforce capacity to ensure Infant and Early Childhood Mental Health and Wellness.

To better understand how to ensure infant and early childhood mental health and wellness in New Hampshire, the Endowment for Health and the New Hampshire Children's Health Foundation commissioned an assessment of the capacity of the workforce serving this population. The objectives of the assessment were:

- To create an inventory of systems and provider networks providing early childhood and family mental health services (birth to five and their families);
- To establish a baseline of individuals with an Early Childhood and Family Mental Health credential (ECFMHC) or similar credentials and training;
- To identify gaps across the current systems providing early childhood and family mental health services; and,
- To identify barriers, beyond those of financing, to providing early childhood mental health services.

Health Resources in Action (HRiA), a non-profit public health organization, was hired to conduct the assessment.

The definition of early childhood mental health services used by this assessment includes clinical mental health services, early childhood and family strengthening programs, such as home visiting services, family supports and services, and family resource centers. The inclusion of prevention programs and

¹New Hampshire Department of Health and Human Services. (January 2019). *New Hampshire 10-Year Mental Health Plan*. Retrieved from <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>

²The Science of Early Childhood Development. National Symposium on Early Childhood Science and Policy Data Brief. Harvard University Center on the Developing Child.

³Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M.P., Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACEs) Study. *American Journal of Preventive Medicine*, 14(4), 245–258. doi: [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)

family support services, in addition to more traditional therapeutic and clinical mental health services, is consistent with the New Hampshire 10-Year Mental Health Plan, released by the New Hampshire Department of Health and Human Services in January 2019. The plan recommends the expansion of early childhood support services, including home visiting and parent education, as a strategy for prevention and early intervention in order to “prevent the emergence of and halt the progression of mental illness.”⁴ According to the Health Resources and Services Administration’s Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), home visiting models, which often include parent education components, “prevent child abuse and neglect, support positive parenting, improve maternal and child health, and promote child development and school readiness.”⁵ These outcomes can directly impact the emotional well-being and mental health of young children and their families and are therefore important components of the continuum of care for early childhood and family mental health.

While this report refers to these categories of services as an “early childhood mental health system,” there is no formal system of care in New Hampshire for this population. Programs, services, and professionals that interact with children and families and fall under the umbrella of early childhood mental health, as defined by this report, provide distinct, categorically funded, avenues of care without the support of coordinated, statewide infrastructure.

Assessment Methods

HRiA utilized a mixed-methods approach to provide a comprehensive assessment of the early childhood and family mental health workforce, services, and system in New Hampshire. Assessment methods included key informant interviews, focus groups, a survey of providers, and collection of secondary data.

Qualitative Data Collection

In September-October 2019, HRiA conducted 12 interviews and 5 focus groups with providers in the early childhood mental health field, early supports and services, and state agency contracted programs, including home visiting programs and family resource centers. Interviews and focus groups were conducted using semi-structured moderator’s guides. Interviewees and focus group segments were identified by staff from the Endowment for Health and the New Hampshire Children’s Health Foundation, as well as a licensed mental health clinician serving as a consultant for the assessment. Interviewees and segments were identified to represent the broad range of programs and services that provide early childhood mental health services in New Hampshire. Interviews and focus groups were facilitated by a trained moderator and detailed notes were taken during conversations.

The collected qualitative data was analyzed using NVivo 12 software. A trained qualitative researcher assigned codes to segments of text that represented the original meaning in the text. This process yielded a codebook that included several major inductive and deductive codes including: system challenges, gaps in the system, system strengths, workforce descriptions, training and credentials, evidence-based models, barriers to implementing evidence-based models, barriers to providing services, client barriers to accessing services, and recommendations for systems change.

⁴ New Hampshire Department of Health and Human Services. (January 2019). *New Hampshire 10-Year Mental Health Plan*. Retrieved from <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>

⁵Health Resources Services Administration Maternal and Child Health Bureau. (2019). *Program Brief: Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed*. Retrieved from <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf>

Provider Survey

An anonymous survey was developed and administered to providers of early childhood and family mental health services in New Hampshire. The survey was distributed through relevant professional list serves, including a list serv of Early Childhood and Family Mental Health credential holders. Interviewees were also asked to distribute the survey to their professional networks. The survey was open from September 9, 2019 to October 28, 2019. A total of 94 survey responses were received, however, after excluding respondents who were not currently working and not actively seeking employment or retired and responses that were mostly incomplete, the final sample was 89 respondents. Data was cleaned and analyzed using Microsoft Excel and SAS 9.4.

Respondent roles included: home visitor (31.5%); parent educator/family support staff (27.0%); licensed clinical mental health counselor (9.0%); psychologist (4.5%); nurse (3.4%); licensed clinical social worker (LCSW; 3.4%); marriage and family therapist (1.1%); psychiatric nurse practitioner (1.1%). Half (50.6%) of respondents selected “Other” when asked about their role within their practice or organization. When asked to specify, these other roles included: Director, program manager, program coordinator, supervisor, case manager, physical therapist, occupational therapist, administrator, quality improvement specialist, coach, special educator, early interventionist, infant mental health specialist, instructor of early childhood education courses, faculty, and advocate.

The survey collected data on the following: work related information including employment status, role, type of practice/organization, supervisory status, client ages, and credential information; familiarity and training of evidence-based models including psychotherapy models, home visiting program models and parent education curricula; challenges and barriers to providing and accessing services; respondents’ demographic information including education, age, race/ethnicity and location of primary practice. As an incentive, survey respondents had the option of entering a voluntary raffle after survey completion; four of these respondents were randomly chosen to receive \$50 Amazon gift cards.

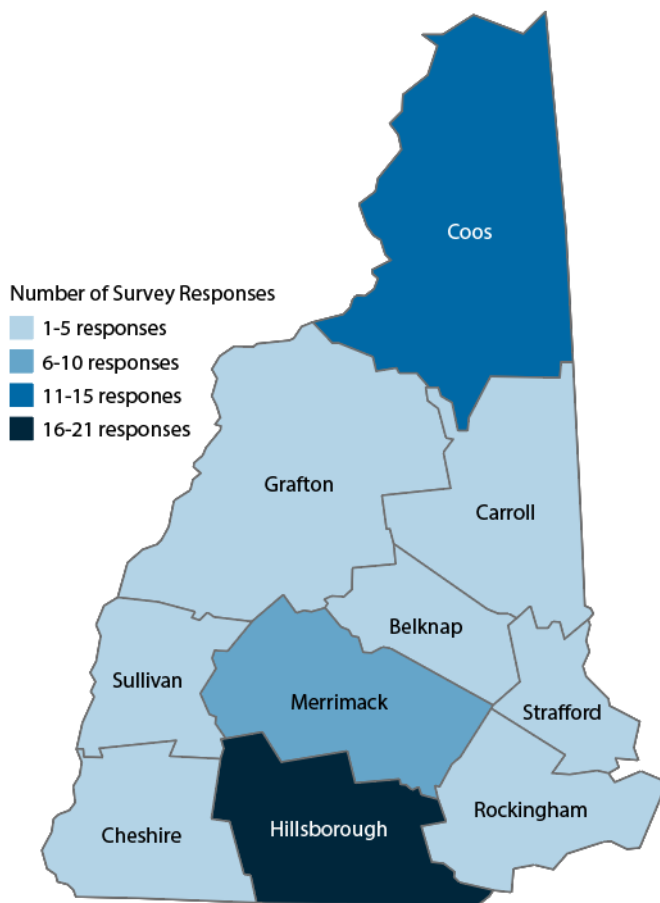
Among survey respondents (n=89), 55.1% indicated that they provide mental health services. Of those 89 respondents, 38.8% (n=19) indicated that they work in a mental health position that requires a professional license; 32.7% (n=16) reported working in a mental health position that does not require a professional license; and 28.6% (n=14) worked in another field that provided mental health services. An additional 44.9% (n=40) of respondents reported not working in a mental health field or providing mental health services. These respondents were included in the analysis as many indicated that they worked in fields included in the assessment’s definitions of early childhood mental health services, such as home visitors and parent educators.

Survey respondents represented the following categories of providers and services: Family-Centered Early Supports and Services (33.7%); Family Resource Center (33.7%); community mental health center (16.9%); other social service agency (6.7%); early childhood mental health consultation (6.7%); child care/pre-school (5.6%); preschool special education or K-12 education (4.5%); and state or local government agency (4.5%).

Approximately 3% of respondents reported working in secondary education (e.g., college or university; 3.4%); Early Head Start/Head Start (3.4%); general in-patient or out-patient hospital (3.4%); and community health center or Federally Qualified Health Center (3.4%). Child protective services (1.1%); faith-based organizations (1.1%); and private practice (1.1%) each represented approximately 1% of respondents. Moreover 9.0% of respondents indicated another practice or organization.

98.6% of respondents indicated that they were White and a majority (54.8%) reported their age as 45 years or older. A complete summary of respondent demographics is available in Appendix A. As shown in **Figure 1**, survey respondents' practices were concentrated in the southern areas of the state, which reflects areas of higher population.

Figure 1. Location of survey respondents' primary practice, (N=89)



DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

Review of Secondary Data

HRiA searched for existing data on the types and levels of licenses and credentials available for mental health providers in New Hampshire. Where available, data were identified specific to providers working with children birth to five and their families. Data are presented throughout the report.

Environmental Scan

A review of programs was done to assess the existing landscape of evidence-based models for early childhood psychotherapy, parent education, and home visiting. Models were limited to those specific to children birth to five and their families. Models were identified through a review of background materials, focus group and key informant interview participants, and responses to the provider survey. A detailed list of models identified during the environmental scan process can be found in Appendix B.

Assessment Limitations

As with all data collection efforts, there are limitations related to the assessment's methods that should be acknowledged. While efforts were made to engage a diverse and representative cross-section of individuals, participants may only represent a sub-set of early childhood and family mental health providers in New Hampshire. While the data do provide valuable insights and important context, findings may be limited in their generalizability to the overall system. It is important to note that interview, focus group, and survey data were collected at a single point in time so findings, while descriptive, should not be interpreted as definitive.

Key Findings

This report provides an overview of the early childhood and family mental health services and workforce in New Hampshire, including perceptions of the system in the current environment, barriers and facilitators to providing and accessing services, and the availability and delivery of evidence-based models. Through a review of secondary data, a provider survey, and interviews and focus groups with key stakeholders across sectors, the following key themes emerged.

Description of the System

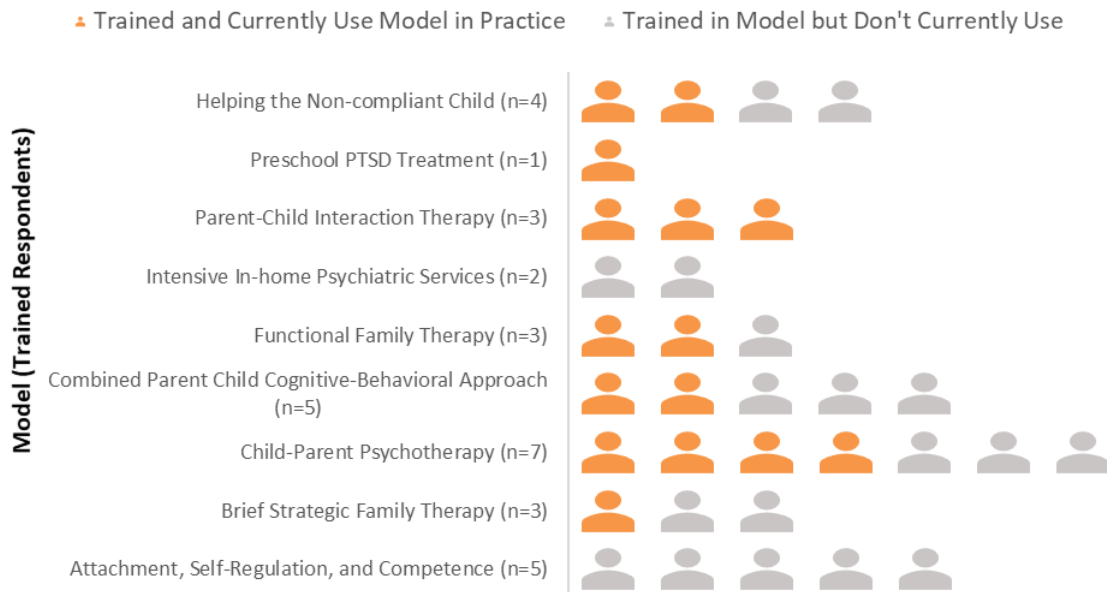
There is no one singular system of care designated to deliver infant and early childhood mental health services in New Hampshire. Use of “early childhood and family mental health system” in this assessment instead refers to the array of evidence-based and evidence supported models for child and family therapy, home visiting services, and parent education that are supported and delivered by organizations, such as mental health centers, family resource centers, early supports and services organizations, early childhood education, state agencies such as the Division of Children, Youth, and Families, and other social services agencies.

Evidence-Based Models for Child and Family Therapy

“Our team has been making an effort to deliver CPP in the community.” – Interviewee

Respondents were asked about their experience with several psychotherapy models. According to survey respondents, Child-Parent Psychotherapy (CPP) was the most commonly used model. The most common psychotherapy models that respondents reported having received training in included CPP, Combined Parent Child Cognitive-Behavioral Approach, and Attachment, Self-Regulation, and Competence. Respondents were also asked to indicate which models they have been trained in and currently use in their practice. As **Figure 2** illustrates, many respondents are not using models despite being trained in them. Barriers to implementation and use of evidence-based models are discussed below.

Figure 2. Psychotherapy Models, by Training and Current Use (N=77)



DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

Key informants identified several models currently being used, including Attachment and Biobehavioral Catch-Up (ABC), CPP, and Parent-Child Interaction Therapy (PCIT).

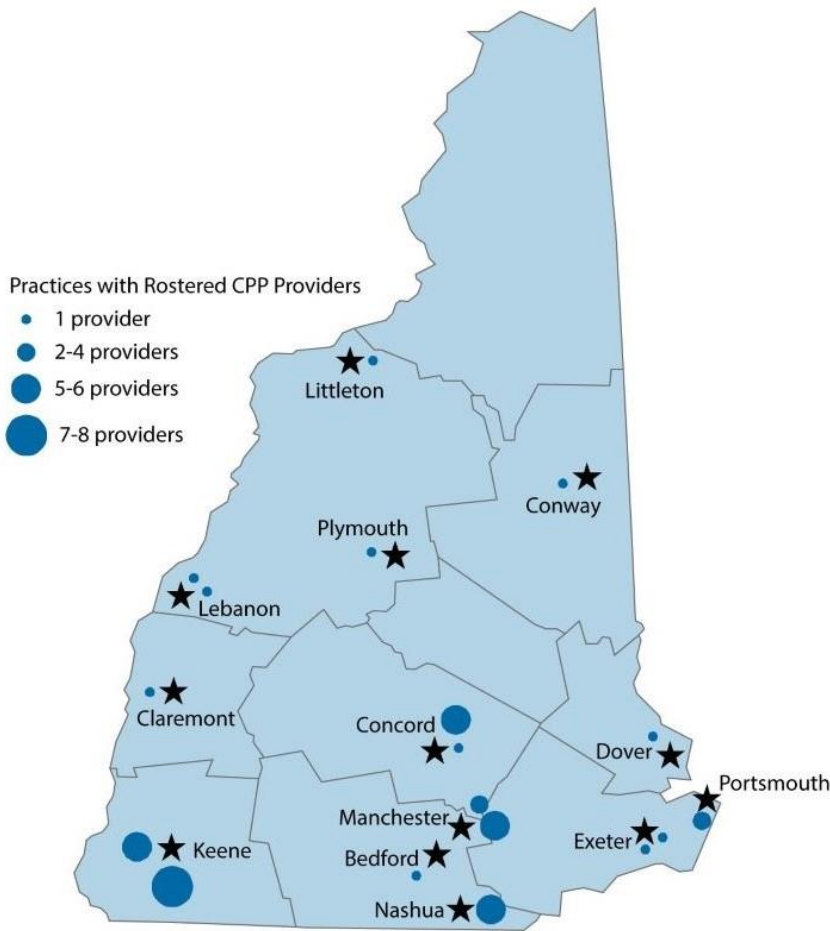
Several informants cited CPP as highly effective for treatment for young children and the most common form of treatment available for this population in New Hampshire. CPP is an evidence-based therapy model for children under the age of six who have trauma and/or attachment disruption. The primary focus of the model is the relationship between a child and their caregiver. Therefore, the model requires an actively involved parent, guardian, or another caregiver. As one interviewee explained, *“We have [evidence-based] models like Child Parent Psychotherapy – the time commitment and resources needed are high but the growth and potential for that model are really high. When we’re working with little ones, having a model that incorporates the parents is really essential.”*

Several informants described CPP as increasingly available through provider training and noted that most community mental health centers have a CPP-trained workforce. As one focus group participant described, *“[The] CPP cohort is strong and successful.”* According to another interviewee, *“Given what we’re dealing with in terms of the opioid crisis, there’s not really anything above CPP.”* Alongside perceptions that CPP is more available, one interviewee noted that the practice of CPP is constrained, *“Our local [Department of Children, Youth and Families] office sees it as beneficial and wants it in a lot of cases but the ability to provide it is really limited.”*

While participants perceived that the CPP model was increasingly available across the system, a review of currently rostered CPP providers indicates that CPP services are primarily concentrated in larger cities in southern and central New Hampshire (**Figure 3**). Rostered CPP providers are mental health clinicians that have completed the 7-day training. No rostered providers were identified in Coos County, the northern most county in the state. Interviewees familiar with the Coos County largely described it as having limited clinical mental health services for young children and their families.

Interviewees recommended more adult residential programs for substance abuse treatment that allow parents to bring their children with them. Another interviewee recommended that the Attachment and Biobehavioral Catch-Up model be incorporated into the Division of Children, Youth and Families' delivery of services.

Figure 3. Geographic Distribution of Rostered CPP Providers, 2019



NOTE: Each circle represents a practice that has at least one rostered CPP provider currently providing services. Some cities have more than one practice with CPP providers.

DATA SOURCE: New Hampshire Child-Parent Psychotherapy Network, Rostered CPP Providers in New Hampshire, <https://www.nhchildparentpsychotherapy.com/cpp-providers.html>

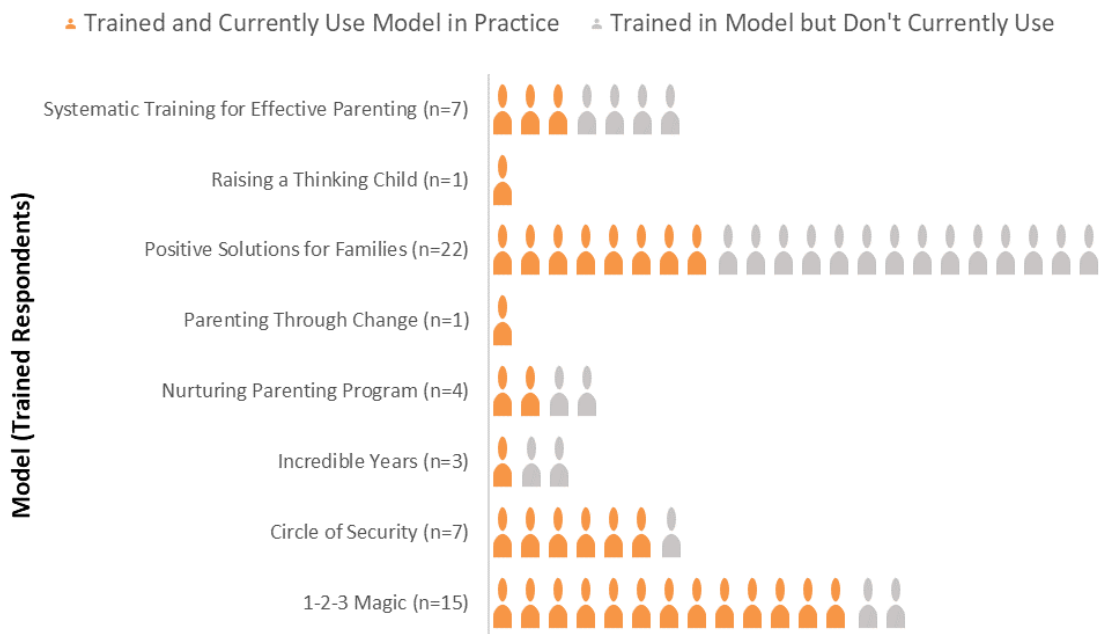
Evidence-Based Models for Parent Education

Positive Solutions for Families and the 123 Magic curricula were the most frequently selected parent education models that survey respondents indicated they had been trained in. These curricula, along with Circle of Community, were also the most commonly currently used models among those responding on behalf of their practice. Survey respondents indicated interest in receiving training in several other parent

education curricula including: Raising a Thinking Child, Circle of Security, Incredible Years Parenting Through Change, Systematic Training for Effective Parenting, and Nurturing Parenting Program (Figure 4).

Other models survey respondents reported they used or were trained in included: motivational interviewing, Ages and Stages Questionnaires, Mothering from the Inside Out, Strengthening Families, evidence-based Cognitive Behavioral Therapy, Pyramid Model, The Whole Brain Child, play therapy, Growing Great Kids, Zones of Regulation, Parents Interacting with Infants, and coaching models.

Figure 4. Parent Education Models, by Training and Current Use (N=77)



DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

Interviewees reported two parent-education models currently being used: Circle of Security and Growing Great Kids.⁶ Interviewees described limited providers delivering the Circle of Security model: *“There are a couple of people doing Circle of Security which is a good parent [education] model that should be expanded.”* One interviewee described the Growing Great Kids curriculum as a national model that is limited in its expansion in New Hampshire due to training costs: *“[The] one that we use here for [home visiting] is Growing Great Kids, which is across the nation. Our [family resource center] might have 30 employees and we only have 5 people trained in it. It’s a very expensive training, it’s a weeklong, and it’s not offered in our area.”*

Focus group participants recommended the Parents as Teachers (PAT) model as a form of parent education. One focus group participant shared, *“[We use] Parents as Teachers as sort of a baseline and then we use an eclectic collection of what does this family need and can pull different things out of our*

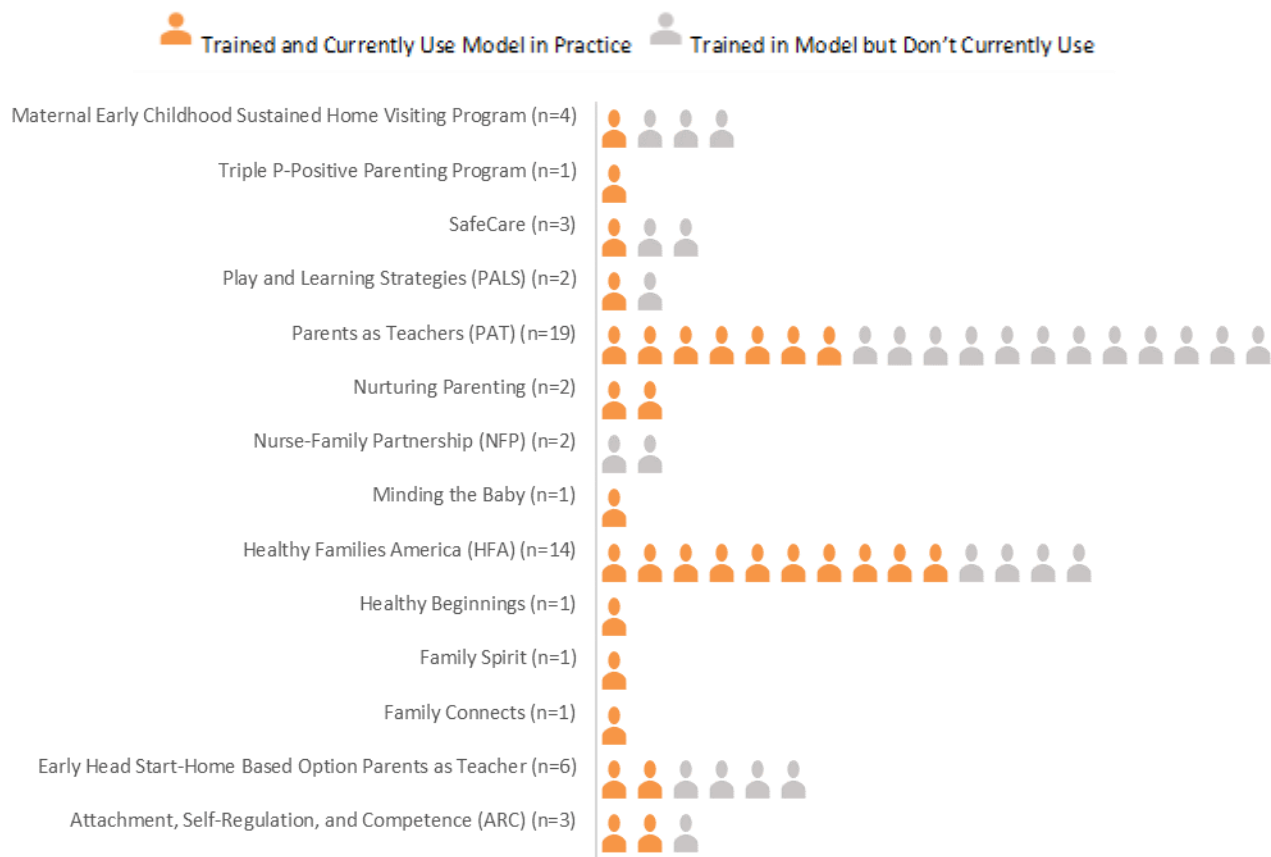
⁶ The survey tool was developed before the qualitative data collection was completed. Growing Great Kids, noted by interviewees, was not included as a response option in the survey tool. Healthy Families America (HFA) and Great Kids, Inc. have partnered for many years to integrate the Growing Great Kids curriculum in the HFA approach.

toolbox based on the individual family.” PAT is widely used across New Hampshire within Early Head Start and Head Start programs.

Evidence-Based Models for Home Visiting and Early Childhood Education

When asked about home visiting models, survey respondents most commonly reported training in Parents as Teachers (PAT) and Healthy Families America (HFA). Likewise, HFA and PAT were the most commonly applied models in respondents’ practices, followed by Triple-P-Positive Parenting Program and Nurturing Parenting.

Figure 5. Home Visiting Models, by Training and Current Use (N=77)



DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

NOTE: Though not selected by any respondents, the following home-visiting models were also included in the survey: Attachment and Biobehavioral Catch-up, Child First, Family Check-up for Children, Health Access Nurturing Development Services Program, and Home Instruction for Parents of Preschool Youngsters

HFA, funded through contracts with the NH Department of Health and Human Services, was the most commonly discussed home visiting program by key informants. Interviewees described HFA as an effective prevention model, albeit an expensive model to implement. According to one interviewee, “I endorse the HFA model because that’s what the state has endorsed and what folks are trained and credentialed in.” Another interviewee described, “It is pricy – it’s an amazing model, it’s demonstrated a lot of really amazing outcomes.”

Interviewees and focus group participants recommended implementing more home visiting models and the Pyramid Model, an early childhood education framework, in order to support healthy social-emotional development and reduce the likelihood of adverse childhood experiences (ACEs). One interviewee shared, *“The hope is that we can prevent ACEs and prevent those things from when a child is born. One thing we look at is parenting values and that’s such a powerful exercise that a lot of parents aren’t thinking about and can really motivate people to make positive changes. And just making sure that we’re supporting everyone.”* Another interviewee described the Pyramid Model: *“[The] Pyramid Model – the other set of evidence-based practices, [is] a more systemic way to have an impact on all children, teaching social and emotional skills, supporting children to learn these skills at a very young age.”*

Barriers to Implementing Evidence-Based Models

While requirements relating to rigorous evaluation and provider training are beneficial components of evidence-based models, participants acknowledged challenges associated with implementation, including the expenses associated with implementation, the substantial infrastructure and time required, and often non-reimbursable expenses associated with training. These challenges were identified for models in psychotherapy, home visiting, and parent education.

Evidence-Based Models are Expensive - Several interviewees described evidence-based models for early childhood mental health as expensive, describing costs associated with training and implementing evidence-based models, as well as costs associated with monitoring program implementation, maintaining fidelity, and measuring outcomes. As one interviewee shared, *“You run into similar programs that the cost of evidence-based practices is often quite expensive – you have to pay for materials and licenses and then in two years, you have to pay again to refresh those materials or because they released something new.”* Another interviewee described, *“Evidence based practice is expensive and the time it takes to train and implement the models. ... There are elements of maintaining fidelity and data collection and that takes time and money.”*

Infrastructure Required to Implement - Interviewees and focus group participants elaborated on the substantial infrastructure required to deliver and sustain evidence-based models. Key informants identified several inputs to implementing evidence-based models, including; training, supervision systems, and documentation. Interviewees explained that training and ongoing observation are not reimbursable expenses. For example, one interviewee explained, *“Three greatest obstacles are the training and ongoing observation [because they] are time intensive and ... expensive, and there’s not really anything that pays for that time.”*

Models are Time Intensive to Deliver - Several interviewees described evidence-based models as time-intensive to deliver, citing training, ensuring fidelity to evidence-based models, and data collection activities as expensive to maintain. One interviewee, also described that evidence-based models require significant commitment from families in order to achieve successful outcomes: *“It takes a year, which is a long time, but most families need a year and the model really works.”* Another interviewee explained, *“CPP [is] time intensive. The big push has been for short-term, brief interventions and it’s not that. It’s a year of weekly sessions with parents and their children and sometimes another session with just the parents.”*

Burdensome Training Requirements - According to interview and focus group participants, trainings are not accessible for all due to significant time and financial costs that are not reimbursable. Key informants cited several costs, including; accreditation processes, training, expenses related to traveling to trainings (e.g., hotels, food), loss of potential billable hours due to significant time in training, ongoing consultation, and the significant regulation of evidence-based models. As one interviewee explained,

“Healthy Families America takes some infrastructure to run smoothly. Reflective supervision is a required component of the model. Training is intensive, there are 12 modules and in addition to those, depending on your specific role there are additional weeklong trainings, as well as yearly training on cultural sensitivity and child abuse and neglect.” As one focus group participant described, *“CPP [includes a] requirement of time with the training. [With] the training time and then the time after to get certified, the agency has to absorb a lot of hours.”* Another interviewee shared, *“CPP is 7 full days of in person training ... it’s onerous.”*

System Strengths

“[There are] more groups and things coming up, [a] specific plan and stakeholder group, more of a push not only at the state level but also providers trying to saturate the state with treatment models.” – Focus Group Participant

“We just got a (New Hampshire) Bureau of Behavioral Health focused on [young] children, [and are] putting some effort and funding into that.” – Interviewee

System Improving Despite Continued Challenges - According to interviewees, the mental health system is improving despite continued challenges. Interviewees cited early childhood mental health models, efforts to bring organizations together, and increases in funding to support early childhood mental health services as important indicators of progress. As one interviewee shared, *“[The mental health system is] making a lot of progress. We’re working really hard to break down organization silos. More and more you’re seeing meeting[s] with representatives from different sectors sitting at the table. When we can have wraparound meetings for families that we’re serving, we can divvy up what everyone is doing and we can make sure that we’re not doing the same things.”* Another interviewee explained, *“There are more people looking at the issue, there’s more dedicate[d] funding.”*

Focus group participants and one interviewee perceived that the New Hampshire Department of Health and Human Services recognizes that early childhood mental health services are limited in the state. Informants cited the increase in services and dedicated funding as indicators of progress. One interviewee shared, *“I think the state as a whole has come together and recognized that there is a lack of services and supports so there’s a real focus on children right now. I do see a lot more services are popping up. They are trying to hire more staff.”* One focus group participant shared, *“There’s always been a desire in New Hampshire to have a more robust infant mental health care delivery system, and in the last 12-18 month[s], [there has been] more focus on this.”*

Increasing Awareness of ACEs and Trauma - Several interviewees and focus group participants described the mental health system as having an increased awareness of adverse childhood experiences (ACEs) and their impact on children and families. Informants identified several on-going activities in New Hampshire that have led to increased awareness of how ACEs can shape lifelong behavioral health outcomes. Identified activities for the prevention of ACEs included implementation of the Pyramid Model (branded in New Hampshire as iSocial) funded and supported by the state Department of Education, increased attention to social and emotional learning (SEL) in schools and other child-focused services, and the growth of individuals who are trained in Child Parent Psychotherapy (CPP). One interviewee explained, *“[There is] a lot of increased awareness about ACEs and trauma-informed systems. The pyramid model and SEL have improved the system dramatically.”* One focus group participant shared, *“[There is a] fairly robust CPP (child parent psychotherapy) child trauma care training [that] has been provided to many.”* Participants perceived that increasing awareness of the impact of trauma had led to more dedicated funding to support appropriate programs and services.

Participants highlighted an increasing commitment to expanding early childhood mental health services to provide training to the workforce in the use of appropriate assessment and diagnostic tools. One example of this is the funding of a statewide training opportunity in the use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). The training is being provided by the New Hampshire Association for Infant Mental Health, in partnership with a national organization, Zero to Three, and funded in part by the Endowment for Health.

Additionally, the Children's Bureau of Behavioral Health has been working with the office of the New Hampshire Medicaid Program to revise billing rules to allow for the use of DC: 0-5 diagnostic codes, more time for conducting and completing assessments, expanded services, and a broader eligibility for young children within the mental health system.

Other system strengths that emerged from interviews and focus groups highlighted the creativity by professionals due to scarcity and the strength of a small community. Participants shared that programs often share resources and staff time. As one interviewee shared, *"People are creative because of scarcity of resources."* Another interviewee explained, *"We're a small community, so we all know each other."*

System Challenges and Gaps

"We don't have any of these services in one place. We don't have a coordinated system."
- Interviewee

"I think the people involved are very highly qualified, there's just not enough of them."
- Focus Group Participant

"We're really just focusing on the at-risk families in New Hampshire because we're trying to keep up, but I think what gets dropped and lost is the families who maybe don't have those risk factors but could really benefit from some extra support." – Interviewee

Limited Services for Children Birth to Five - According to focus group participants and interviewees, the mental health system has limited services for children from birth to five years of age. Key informants described services as "dismal," "sparse," "under-resourced," and "non-existent." One interviewee noted that services for children from birth to three years of age are limited. A focus group participant described the consequences of limited services: *"It's really looked at as a behavioral problem and a parenting problem."* Other participants expressed concern that the few providers available do not have the training to work with young children. For example, one participant noted that children may not receive age-appropriate care: *"I hear from providers – they're lacking the actual bodies to put in those roles and when they are able to find people, they don't have the expertise of working with young children."* One participant noted that families travel far for care and/or experience long waits in the emergency department.

Key informants described currently available services as overwhelmed by need. As one interviewee shared, *"We're always grasping for resources that aren't available. More have been developed in the past year or two because there's been this increased focus on mental health for children, but it's always been a challenge."* One focus group participant shared, *"I hear all the time from families that they can't get in or that the waiting list is so long and they're struggling in the interim with how to best help their child."* Several key informants described the system as understaffed and lacking enough clinicians. Some key informants noted that the workforce is strained because staff – including home visitors, case managers,

and early childhood teachers – are not offered a living wage. As one focus group participant shared, *“Staffing is incredibly difficult at [Bachelor’s] and [Master’s] positions. [The] workforce is dwindling. When you have a [college-educated] person, it’s barely a livable wage. They can go work at other companies and make double.”* Key informants described several consequences of an understaffed system, including the need to prioritize treatment of older children: *“We don’t have enough people to see all the kids that need to be seen so we have to triage who needs to be seen and we end up prioritizing the older kids or people who are acting out and it’s hard to get to the kids that aren’t as symptomatic and younger kids tend to be less symptomatic.”*

System is Siloed and Disjointed - Participants described the early childhood and family mental health system as siloed and disjointed. While one interviewee highlighted several attempts to create an integrated system, other interviewees noted that the fragmented system of care contributes to a sense of competition for the same financial resources. One interviewee shared, *“I think that they try to work together but everybody is so focused on the pots of money they have and keeping them that it’s hard to move out of that and think about how we can work collaboratively.”* Additionally, participants attributed the disjointedness to the broad field of services that provide early childhood and family mental health services, including but not limited to clinical services, early supports and services, early childhood education, and family resource centers.

Limited Awareness of Need for Mental Health Services - Participants attributed system challenges partly to low awareness of the need for mental health services for children from birth to five years of age. As one focus group participant shared, *“We don’t often think of an 18-month old as having a mental health problem. Is there an awareness in the general population that there is a diagnosis of mental health in young children...and how is that different than a child just throwing a fit in the middle of the grocery store?”* Participants perceived that limited awareness was an issue at the state level as well, citing little investment by the State into prevention services during early childhood.

Need for Prevention and Intervention Services for Children under Five - One interviewee described a limited focus on prevention: *“Gaps exist because it has taken years for professionals to understand that we need to focus on children. Older adults and teens have been the focus of mental health work.”* Several interviewees characterized mental health services for children under five years of age and their parents as an important gap in the current system. As one interviewee described, *“Most of the system is focused on the older kids ... Historically, mental health started with adults and crept its way down to adolescents and just now is starting to make its way down to younger kids.”* Some interviewees emphasized the importance of mental health providers receiving training in mental health services for the infant to five years of age population.

Need for Services for the Whole Family According to one interviewee, there is a need for services that serve the whole family unit, not just young children. This interviewee shared, *“[Services] can’t just be on the child. So, when you talk about [child mental health] ... you’re addressing the needs of the entire family.”* Additionally, this interviewee noted that due to present resources, mental health services focus on families most at risk, while there is a gap in family-level services for families who would benefit from mental health services but may not qualify as being “at-risk”.

Need for Increased Involvement of Schools - Several interviewees described the importance of involving schools in addressing trauma-based systems of support. As one interviewee shared, *“If a child has a disability, they qualify for pre-school special education, but not if they have needs because they experienced trauma.”* Another interviewee emphasized the importance of supporting implementation of trauma-

informed approaches in schools: *“There’s training opportunities about the importance of being trauma-informed but there’s not necessarily that support to implement those strategies on a sustained basis. That’s where the change happens – not from the training but from the implementing and if there’s not someone to support us through the hard times at the beginning, we might just bag it.”*

Need for Services in Rural Areas – The availability of services in more rural parts of New Hampshire, particularly in the northern region, was described as limited and lacking. Participants perceived that mental health services for young children and their families are primarily concentrated in the southern, more populous part of the state: *“My sense is that ... the further north you get the more dire straits you’re in to get any service. The more north you [go] the services are fewer and farther apart, so the safety net gets even more stretched thin.”* One interviewee echoed the perception that mental health services vary across the state: *“[Services are] better in some parts of the state than in others.”* Challenges for rural areas are further discussed in the Workforce and System Capacity section of this report.

Members of the Early Childhood and Family Mental Health Workforce

“Low wages and high burn out [are the biggest challenges].” – Interviewee

“In this area, staff availability and capability are a big impediment...The need is there but there’s not enough people to provide the services.” – Focus Group Participant

Workforce challenges arose as a key barrier to the delivery of early childhood and family mental health services in New Hampshire. Participants described workforce shortages and perceived high rates of staff turnover as impacting the system’s ability to deliver timely and appropriate care.

High Turnover in Positions that Serve the Birth through Five Population - Interviewees and focus group participants described a high turnover in a wide range of clinical, therapeutic, support, and educational positions that serve children from birth to five years of age. One interviewee described the workforce as *“very young, female, underpaid and undereducated.”*

Informants cited the entry-level nature of positions, low pay, challenges of attracting staff to rural areas, administrative burden, and high volume of cases as factors that contribute to the high turnover and limited retention of staff and providers. As one focus group participant explained, *“[There is] lots of paperwork. Paperwork demands and salaries are people’s main reason to leave.”* One interviewee described these conditions as snowballing for remaining staff: *“And I think they’re overwhelmed with their caseloads. Which grow when someone else leaves and becomes more overwhelming, so it’s a cycle.”* This interviewee explained how high turnover disrupts behavioral health services for families with young children: *“When we lose someone, families miss 6 months with services – that’s a big chunk of time for a 3-year-old because they develop so much in that time. We have some families with 5-year olds who have had 5 or 6 case managers. You don’t have the time to build up a new relationship or trust.”*

Licensing Requirements for Organizations and Individuals - Participants noted that supervising, licensing, and credentialing new staff and providers is a significant investment on behalf of the employer. These investments do not always pay off for some non-profit or private agencies. Staff and providers often move from one agency to another seeking increased pay and taking the licensing/credentialing with them. As one interviewee shared, *“Clinicians turn over really quickly. We get the really green clinicians right out of grad school and they’re not licensed; they work here until they’re licensed and they move on to jobs that pay better. Families have had so many clinicians, so many case workers that they don’t even bother to*

learn the names.” One interviewee shared their vision for the future: “[The] ideal is [an] internal hire and support [for] the license – we can panel them earlier, but the licensed and paneling goes with them.”

Lack of Competitive Salaries - Several interviewees and focus group participants described the difficulties of providing competitive salaries as contributing to workforce challenges. One interviewee shared, *“We also have a rural state ... [It is] really, really hard to attract anyone to work and stay in New Hampshire. With what we pay, kids can’t address debt.”* As one interviewee explained, *“You’re going to see staff issues across the board – home visitor, case managers, early childhood teachers. I think a lot of it is about what we’re able to pay them for what we’re asking for. In a childcare center, we’re asking for someone with an [Associate degree] but we can’t pay them that much.”* Another interviewee shared, *“What we run into is do you hire someone who is more qualified and pay them more than we can really afford, or do you hire someone who is less qualified and costs less but you have to train them?”* Participants attributed the lack of competitive salaries to low Medicaid reimbursement rates and the lack of a tax-base to fund public services.

Participants also noted that, while providers may choose to live in southern New Hampshire due to the lower cost of living, many commute into neighboring Massachusetts for work where salaries are perceived as being higher and more competitive than those offered in New Hampshire; *“Whatever services we’re talking about, providers can make so much more the further south you go so folks can’t afford to be here.”*

Early Childhood and Family Mental Health Credential

“I don’t think we want to bring in another credential, but I think we need to elevate [the] status [of current credentials].” – Interviewee

“There’s a recognition of the credential if you’re an employer, if you have two applicants and one person has the credential and the other doesn’t, it’s an incentive for hiring in that way. It’s a recognition of the skills that one has.” – Interviewee

The Early Childhood and Family Mental Health (ECFMH) credential is a New Hampshire specific training and credentialing program available to early childhood professionals across fields. The credential is endorsed by the New Hampshire Association for Infant Mental Health and the New Hampshire Department of Health and Human Services Child Development Bureau. There are three levels of credential available; Intermediate, Advanced, and Advanced Reflective Practice Consultant (RPC). Intermediate credentials are targeted for providers in supportive roles in fields such as childcare, family support services, health education, and early supports and services. The Advanced credential is targeted at professionals providing clinical mental health interventions, supervision, consultation, and training around mental health issues, as well as direct support and services to children and families. Professionals that hold the Advanced RPC have the highest level of clinical and supervisory experience and provide consultation services to Intermediate and Advanced-level credential candidates.⁷

As of August 2019, there were 72 active ECFMH credentials. **Table 1** shows the distribution of credentials by level and by the field of the credential holder. Credential holders were primarily located in the state’s

⁷ New Hampshire Association for Infant Mental Health. (2017). *Early Childhood and Family Mental Health Credential*. Retrieved from <http://nhaimh.org/ecfmhc>.

larger cities, including Concord (n=16, 22.2%) and Manchester (n=11, 15.2%), as well as North Country (n=12, 16.7%), and Strafford County (n=9, 12.5%).

Table 1. Distribution of ECFMH Credentials, by Credential Level and Credential Holder Field, August 2019 (N=72)

Level of ECFMH Credential	% (n)
Intermediate	66.7% (48)
Advanced	19.4% (14)
Advanced Reflective Practice Consultant	13.8% (10)
Fields of ECFMH Credential Holders	% (n)
Nursing	2.8% (2)
Behavior Support Coach	4.2% (3)
Education	9.7% (7)
Early Care and Education	5.6% (4)
Early Head Start and Head Start	13.9% (10)
Early Supports and Services	9.7% (7)
Family Support	20.8% (15)
Home Visiting	5.6% (4)
Mental Health	26.4% (19)
Speech/Language	1.4% (1)

DATA SOURCE: New Hampshire Association for Infant Mental Health, August 2019

Of survey respondents, 16.9% (n=15) indicated that they hold an ECFMH credential. Of those respondents, 60.0% (n=9) have an Intermediate credential, 6.7% (n=1) have an Advanced credential, and 33.3% (n=5) have an Advanced Reflective Practice Consultant level credential.

Interviewees and focus group participants were asked specifically about the ECFMH credential. Key informants perceived that the training requirements of the credential were beneficial for increasing recipients’ knowledge and confidence in working with children and their families. Interviewees also shared that the on-going reflective practice credential requirements were beneficial for recipients’ professional development and for building networks of early childhood professionals in New Hampshire: *“If it’s your professional goal to serve this population, then it helps you feel confident in that work and provides you with a network of people doing that work and helps with that self-reflective piece that’s required.”*

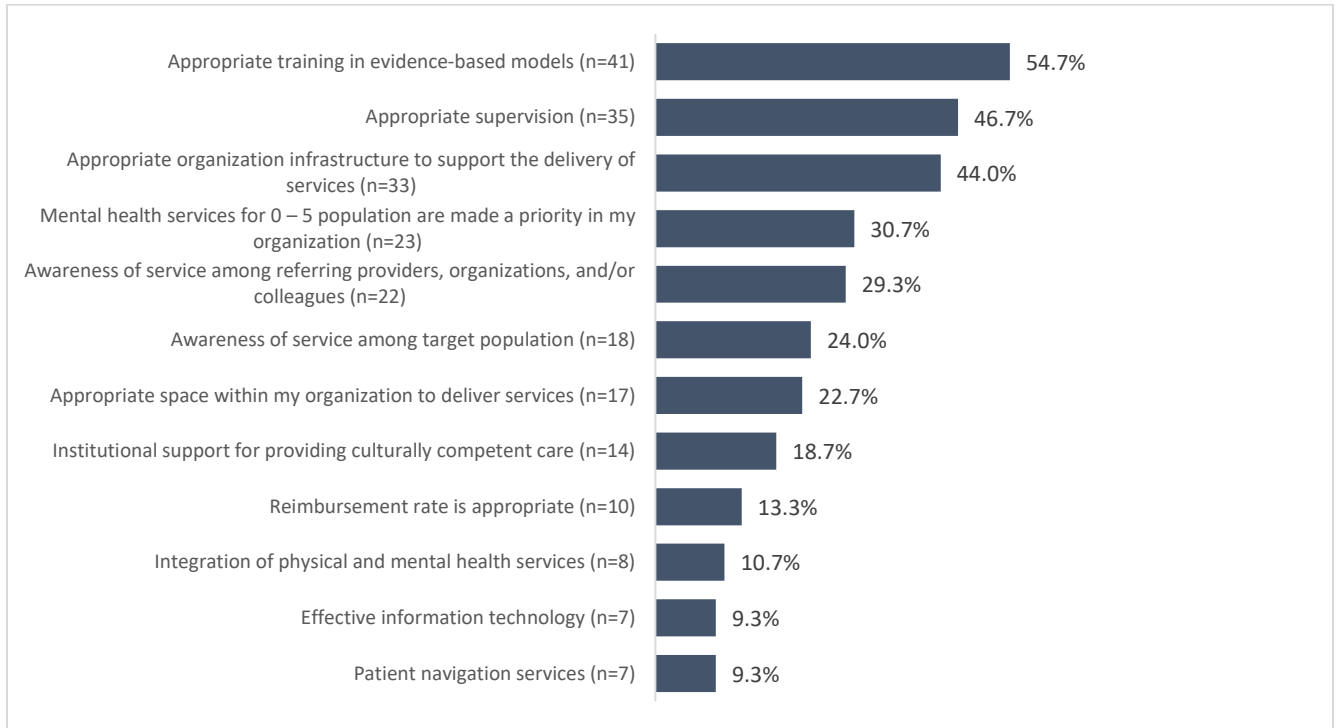
However, interviewees noted that beyond training, the credential itself holds little recognition and value within New Hampshire and among employers and agencies. One interviewee explained, *“The process of the ECFMH credential was so beneficial, the learning process was so helpful but actually ... not that many people know what it is... There’s almost no benefit to keeping it.”* Another interviewee characterized the credential as burdensome relative to the limited clout it holds: *“[The] ECFMH credential is a pain to keep up and doesn’t have any clout in our state.”* Assessment participants agreed that elevating the status and impact of the credential would be beneficial and would encourage more providers to complete the training process and keep their credentials active.

Facilitators and Barriers to Providing and Accessing Services

When asked about facilitators to providing mental health services to the birth to five population and their families, half of the survey respondents cited training in evidence-based models (54.7%). Approximately

two in five survey respondents reported available supervision (46.7%) and appropriate organization infrastructure to support the delivery of services (44.0%) as facilitators (**Figure 6**).

Figure 6. Facilitators to Providing Services, Provider Survey, 2019 (N=75)

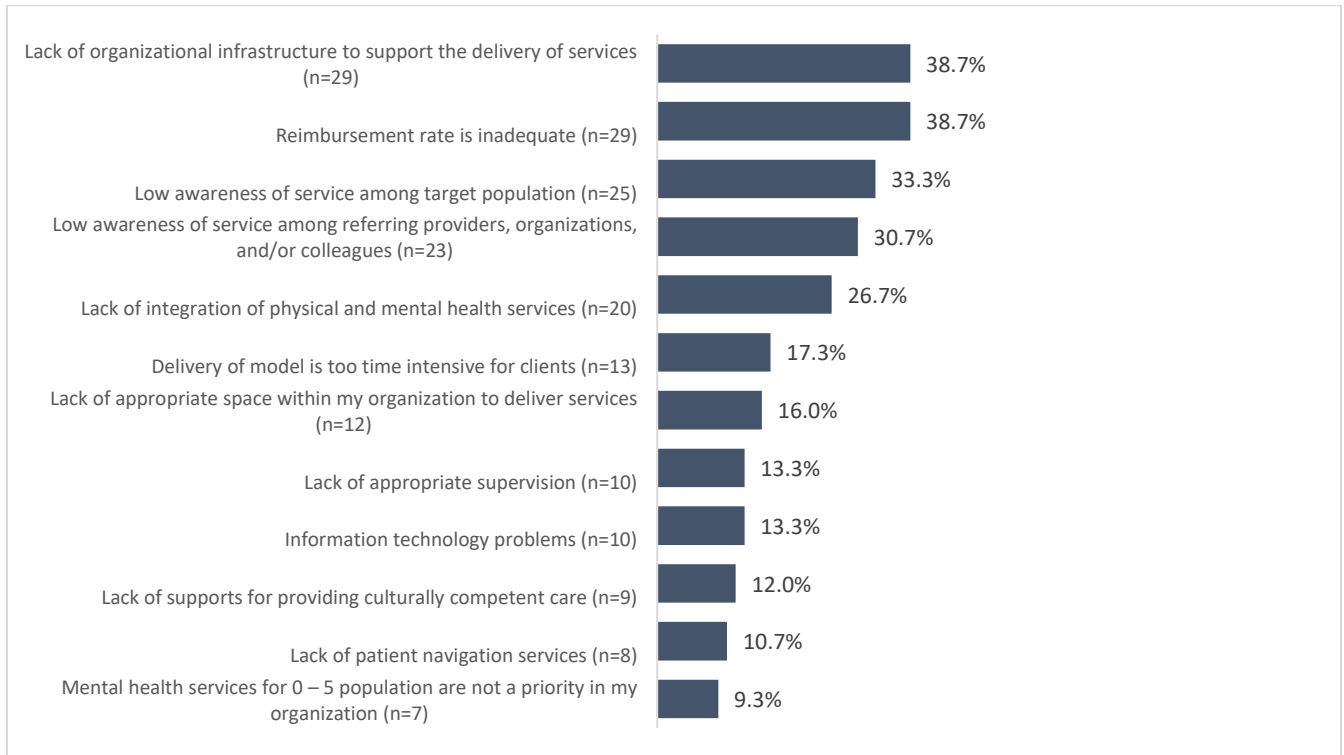


DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

Survey respondents reported specific needs for increasing services for families with children birth to five years of age, including; increasing the number of providers who accept Medicaid, work with low-income families, and work in rural areas; meeting with families in their homes; growing the workforce of highly trained early childhood mental health case workers; implementing play therapy; improving funding; addressing transportation barriers; supporting infant mental health; making the system less complicated to navigate; integrating care in community settings; offering services during evenings; reducing stigma; increasing awareness of services; offering early childhood mental health trainings; modifying curricula to be multi-cultural; eliminating wait lists; enabling scheduling for drop-in or open appointments; and communicating with ESS in New Hampshire.

When asked about current barriers to providing mental health services for the birth to five population and their families, at least one-third of survey respondents identified the following barriers: lack of organizational infrastructure to support the delivery of services (38.7%), inadequate reimbursement rates (38.7%), lack of training in evidence-based models (37.3%), low awareness of services among the patient population (33.3%), and low awareness of services among referring providers, organizations, and/or colleagues (30.7%). At least one-quarter of respondents identified lack of integration of physical and mental health services (26.7%) as a barrier to providing mental health services to the birth to five population (**Figure 7**).

Figure 7. Barriers to Providing Services, Provider Survey, 2019 (N=75)



DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

Of survey respondents, 16% reported a waitlist for mental health services for children birth to five and their families. Of these, respondents noted that waitlists ranged from a low of two to four weeks to a high of six months or longer. Most respondents reported wait lists lasting at least one month.

Salaries and Reimbursements - Focus group participants and interviewees described Medicaid reimbursement rates as a key barrier to organizations providing salaries and reimbursement rates needed to provide robust services. One interviewee explained, *“Part of what impacts staffing is salaries and Medicaid reimbursement rates, so that people don’t want to work for community health. They can get paid more elsewhere.”* One focus group participant linked low salaries with the challenges of attracting and sustaining staff in rural areas: *“Reimbursement rates, student loan forgiveness – I don’t know how they could incentivize people to come further north but whatever state incentives they could put together to get people to come to a rural area.”*

One focus group participant described the organizational-level impacts of low reimbursement rates: *“One thing I hear all the time is reimbursement rates. It’s such a loss for them and they can only afford to lose so much money on services.”* Another interviewee shared, *“Collaborating with the schools - no one gets paid for that. You can’t bill for that. [t] really limits the time you can put into it because it’s not billable time.”*

Diagnosis and Billing - Several key informants described restrictions on diagnosis and billing as administrative constraints to delivering mental and behavioral health services to young children. One interviewee described the loss of revenue associated with billing processes: *“We have to individually panel with every insurance company (currently 23 companies). [The] administrative burden ... is affecting our*

finances.” One interviewee explained that referral challenges are compounded by funding constraints: “Due to billing constraints or Medicaid, clinicians could do more with children and their families, but they can’t because they can’t bill for it.”

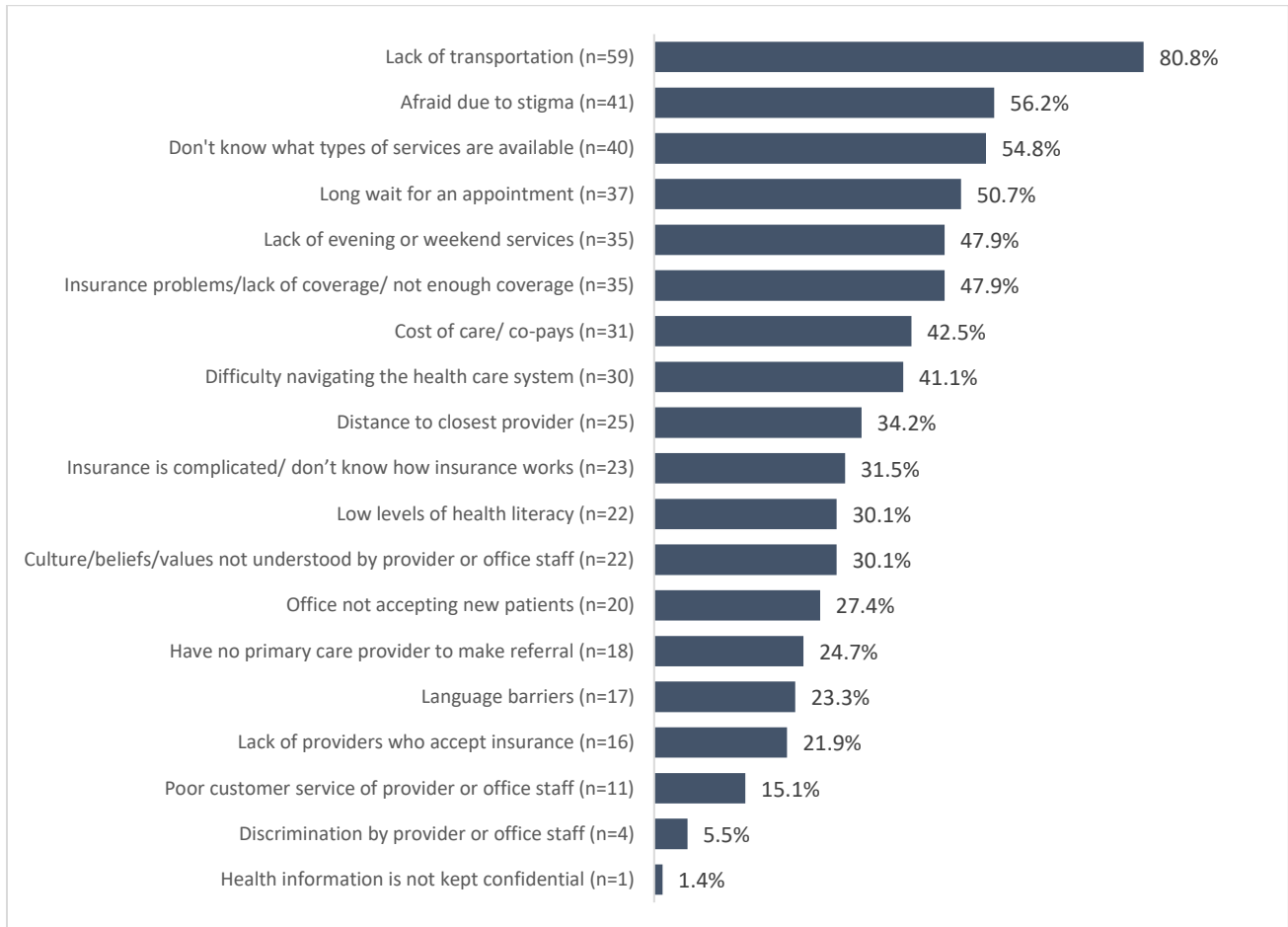
Additionally, some key informants described providers’ concerns about issuing a mental health diagnosis for young children. As one interviewee shared, *“It’s very difficult if you have a 3-year old who is demonstrating challenging behaviors and has a difficult family situation [that] is challenging because you have to give a big diagnosis to a 3-year old [in order to bill for services]. That can be threatening to families and providers are hesitant to do that.”*

Referral Network and Care Coordination Services - Several key informants characterized referrals as challenging and noted that there is no funding for care coordination between clinical services and early supports and services that families may benefit from receiving. Focus group participants and interviewees cited several referral-related challenges, including: lack of familiarity with evidence-based models and where to refer families, long wait lists for referrals for young children, hesitancy among some providers about issuing a mental health diagnosis for young children, and some services not qualifying as billable under Medicaid and other billing constraints. According to one interviewee, *“I don’t think many PCPs or pediatricians would have any ideas about CPP or where to send families.”* One focus group participant explained, *“Most master’s level clinicians don’t feel comfortable giving a 2-year old a mental health diagnosis.”* When referrals are issued, some key informants cited long wait lists as challenges. As one interviewee shared, *“When there’s an issue that arises, it’s difficult to get timely services for little ones. We have resources, but sometimes people are on a wait list and that can be difficult because there’s a window of opportunity and sometimes that window of opportunity closes before the appointment.”* Another interviewee described how referrals are constrained by limited funding: *“We do not have access to any mental health funding from the State because it all goes to the designated agencies. [As] a result, we don’t treat complex mental health cases. We do not have psychiatrists – referrals are not well coordinated, [there is a] shortage, waitlist.”* One interviewee described a disconnect between billing models and the need for coordinated care, *“One of the things that has worked in other places is understanding that kids are complex and you need the whole village and there isn’t the funding for coordinating the care or covering the services – you need to fundraise to coordinate care.”*

Barriers to Accessing Services

When asked about barriers to accessing mental health services for children birth to five and their families, a majority of survey respondents (80.8%) reported lack of transportation as a barrier (**Figure 8**). Approximately half of survey respondents cited stigma (56.2%), not knowing types of services available (54.8%), and long waits for appointments (50.7%) as barriers. At least four in ten survey respondents identified the following barriers: lack of evening or weekend services (47.9%), insufficient health care coverage (47.9%), cost of care or co-pays (42.5%), and difficulty navigating the system (41.1%).

Figure 8. Perceived Barriers to Accessing Services, Provider Survey, 2019 (N=73)



DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

Transportation - According to several key informants, limited transportation is a significant barrier to accessing regular mental and behavioral health services. One focus group participant shared, *“There’s no public transportation in our region so if you have inconsistent transportation or paying for gas is challenging or you work full time, that’s a major challenge.”* One focus group participant described how transportation is closely connected with housing affordability challenges in the region: *“Affordable housing can also be an issue and families get pushed to the outer surrounding towns and that further compounds the transportation. They’re farther away and the social isolation increases, the transportation issue increases, and the need for services increases.”*

While some key informants noted that Medicaid reimbursement may improve access to services, one interviewee described low awareness of an existing transportation system provided through Medicaid and noted that the service often runs late. Another interviewee described telehealth as mitigating transportation-related barriers to accessing care: *“[North Country has] huge challenges with transportation. But the telehealth has been huge – having access to services...The families that I know that have used telehealth have been so grateful because the stress of ‘How am I going to get my children to Dartmouth or Dover a 3 ½ [hour] trip for an hour appointment every month or quarter isn’t doable.”*

Child Care - Some interviewees described lack of regular childcare for young children as a barrier to accessing services, particularly for office-based services and services that require parents and guardians to attend and participate with the child receiving services. As one interviewee explained, *“The [community mental health] model is really set up for people to come in consistently for services so people with barriers to transportation or childcare or who have chaotic lives [experience barriers]. You need a model that can meet people where they are.”* Another interviewee shared, *“Childcare might be [a] challenge, if the family has a smaller child that might not be in school.”* To address this gap, one interviewee recommended childcare subsidies for parents and childcare workers.

Waitlists - Several key informants described waitlists as a barrier to accessing services for young children, which focus group participants and interviewees linked with shortages in staff trained to deliver care to young children and an overwhelmed mental and behavioral health system. As one focus group participant shared, *“Waitlists prioritize triage according to highest level of need. Most of the younger kids are not triage[d] at a high level because [they are] not at risk of loss of life. With staff shortage, it takes much longer to get to those kids.”* According to another interviewee, *“There are very few folks that focus in young children, often it’s the community mental health centers and they often have long wait lists.”* One focus group participant described the challenges that families face when waiting to receive care: *“I hear all the time from families that they can’t get in or that the waiting list is so long and they’re struggling in the interim with how to best help their child.”* Another interviewee described waitlists as constraining windows of opportunity to engage children and families in mental and behavioral health services: *“There’s a workforce shortage and when you call to make an appointment, you get your first appointment in 2-3 weeks. They’re ready at that time of the phone call – two weeks from now that may have changed.”*

Insurance and Cost - Several focus group participants and one interviewee described insurance as a barrier to families accessing mental and behavioral health services. Focus group participants described the limitations of private insurance, characterized Medicaid coverage as good, and shared that Tricare, the health care program for military personnel and their families, has long waitlists. As one focus group participant described, *“If it’s going to be \$100 out of your pocket every time, you’re not going to [see a provider] if you’re on a limited income.”* Another focus group participant shared, *“Insurance is hard. Medicaid is great. Tricare is going to be 6 months wait.”*

Accessibility/Care Navigation - Interviewees described several patient-level barriers to accessing care, including that the system does not support patients who cannot consistently make appointments, services are usually offered during work hours, and a lack of community-based services. One interviewee described how barriers to care compound for patients: *“Our current model does penalize people who can’t come consistently even if the family is in need. So, funding differently would be beneficial for the purposes of serving young children and their families.”* Another interviewee explained, *“It’s hard to get children to clinical services when mom and dad work Monday – Friday. Some centers have done some night or early morning services but not every center is able to do that.”*

In terms of identifying available services for young children, interviewees described challenges that families encounter. As one interviewee shared, *“[It is] hard for consumers to know how to access appropriate mental health services for kids 0-5. There isn’t any kind of data base or referral access point where people could go to find services.”* Another interviewee noted, *“Families not knowing who to reach out to, what to ask for, what’s out there to ask for. There’s a good amount of services. We don’t know what families don’t know and families don’t know that we’re there.”*

Other Barriers - Other barriers to accessing services that surfaced among interviewees include the role of family addiction, housing, and technology. According to one interviewee, *"[I]t's hard to get families with parents in addiction into treatment because of their fears of children protective services."*

One interviewee described the difficult financial choices families face in a tight housing market: *"The housing market is so tight in the state. You have to make \$23 an hour to have an apartment and be stable financially. Parents are constantly having to choose, 'Do I keep my child in childcare and keep working or do I stop working and take my child out of childcare and have stable housing?'"* Another interviewee shared, *"Some studies have shown that if you want to address behavioral needs you should start with stable housing."*

One interviewee described limited cell phone plans as a barrier to contacting mental and behavioral health services, *"Technology is a barrier – a lot of our families have internet only phones or message only phones and that makes it hard for them to contact providers."*

Key Themes and Recommendations

Findings from this assessment offer insights into the current system of early childhood and family mental health services in New Hampshire, including on-going challenges and barriers, as well as opportunities for improvement.

Key Themes

Limited workforce capacity arose as a major challenge across the system. This was in part attributed to workforce shortages due to low wages and reimbursement rates and burdensome licensing, credentialing and training requirements. Interviewees and focus group participants working at local mental health and family support and services organizations described high staff turnover as a major challenge to their delivery of mental health services to young children and their families.

Challenges to the system's capacity to implement and deliver evidence-based models also arose as a key theme in the assessment. Participants identified several highly effective models, such as HFA and CPP, currently being used in New Hampshire. However, they largely shared the perception that the high cost of evidence-based models prevented them from wide-spread implementation across the system. Results from the provider survey suggest that, while providers may be trained in certain models, other barriers prevent them from using the models in their practice.

Use of evidence-based models was also seen as limited by prohibitive training requirements. Interviewees and focus group participants cited the high cost of trainings and the loss of billable time as preventing more staff from being trained in evidence-based models for care. This was perceived to especially be a challenge for providers in more rural northern New Hampshire, as trainings are often held in the southern part of the state, requiring participants and their employers to cover the cost of transportation, housing, and food, in addition to the cost of training.

Assessment participants largely agreed that the ECFMH credential was valuable for the training components and reflective practice requirements. Credential recipients were perceived as benefiting from the knowledge gained through the training process and from developing a network of supportive professionals in their field. However, the credential's impact beyond the initial training was described as limited. Participants perceived that larger recognition of the credential was low across the state and that it had little impact on the hiring process. Given the low recognition and the time required to keep a credential up to date, interviewees perceived that there was low incentive for renewing the credential.

The barriers and challenges to delivering services were perceived as affecting families' ability to access appropriate services for their children in a timely fashion. Participants indicated that provider shortages led to long wait times for services and, when families were able to access services, they often end up being bounced between providers due to high turnover. This lack of consistency was perceived as disrupting the care that families were receiving and making it difficult for families to continue with programs or treatment plans. Challenges related to transportation and the location of services also arose as key barriers to accessing services.

Recommendations

“There are really positive changes that could be happening. The [Division for Children, Youth, and Families] funding, the PDG grant that’s just coming up, the system of care grant that Manchester just got. The general increase of understanding of the impact of ACEs on development. All of that is making me feel hopeful.” – Interviewee

“The anticipated changes to Medicaid billing and upcoming training in the use of the DC: 0-5 is an opportunity to really change the landscape of early childhood mental health in New Hampshire. The system will, for the first time, have the tools we need to really develop an early childhood mental health system of care. [What is] needed will be a financial commitment to back it up.” – Interviewee

This section presents recommendations to address the key themes and findings of the assessment. Recommendations are based upon findings from key informant interviewees, focus groups, and the assessment survey, as well as examples of how similar challenges have been addressed in other states. Many of the recommendations in this assessment also align with or are complimentary to those made in the New Hampshire 10-year Mental Health Plan (published in January 2019) produced by the New Hampshire Department of Health and Human Services. These overlaps are noted where appropriate. The recommendations included in this assessment are grouped into four overarching categories: A statewide early childhood mental health system, workforce development, increased availability and accessibility of services, and the reduction of structural barriers.

Develop a Statewide Early Childhood Mental Health System

“I would like to see one comprehensive early childhood mental health system ...And a place that families can go like a website or 211 that can help families figure out where to go in their region that provides those services.” – Focus Group Participant

Overall, participants in this assessment described the early childhood and family mental health system in New Hampshire as disjointed, siloed, and, in some cases, non-existent. Respondents detailed the difficulty that families routinely experience in finding, accessing, and navigating appropriate care for their young children. Additional challenges were perceived as arising from the lack of communication and coordination between the different types of services and providers that fall under the umbrella of early childhood mental health, causing families to potentially miss out on services that they may benefit from. To mitigate these challenges and facilitate children and families accessing the care they need, New Hampshire should establish a coordinated early childhood mental health system of care. The system of care should build upon the existing definition of “an integrated and comprehensive delivery structure for the provision of publicly funded behavioral health services to New Hampshire children and youth”⁸ to include infrastructure around training, monitoring, and administrative support to assure reimbursement, as well as the expansion and coordination of services across the continuum of care.

This would also align with the state’s 10-year mental health plan which calls for a “robust and cohesive [system]...[that] facilitates rapid access to a coordinated, high quality of localized services and supports

⁸ 2016 New Hampshire Revised Statutes Title X – Public Health

for all, through a centralized portal.”⁹ The 10-year plan recommends a hub and spoke model with a “Mental Health Portal” hub that centralizes information and helps individuals locate local services and connects with outpatient services, community education, prevention and early intervention, crisis and inpatient services, and step-up/step-down services. The early childhood mental health system could be built into this overarching system, ensuring that clinical services specific to young children, home-visiting, parent education, and other early supports and services are included as “spokes.” Developing a cohesive, integrated system could also address the unequal geographic distribution of services perceived by assessment participants and mitigating the amount of burdensome travel that patients and their families must do by creating and connecting them with more local services. Minnesota’s early childhood mental health system of care, which has developed an infrastructure to support “integrating services to include the many systems that serve young children and their families”¹⁰ should be looked to as an example of how to do this successfully.

Workforce Development Strategies

“Workforce issues and funding issues are pretty big because children’s mental health is chronically understaffed. We don’t have enough people to see all the kids that need to be seen.” – Interviewee

Participants described the importance of growing the mental health workforce in New Hampshire and shared the perception that a more robust mental health workforce would facilitate growth of community-based services: Recommended strategies for workforce development largely centered around developing a state-wide infrastructure to support the early childhood and family mental health workforce through trainings, credentialing, and payment structures. The recommendations in this section align with the New Hampshire Health and Human Services 10-Year Mental Health Plan recommendation to “develop a statewide, comprehensive, and integrated approach to growing the workforces in all healthcare professions, including those needed to serve individuals with mental illness.”¹¹

Strengthen the State Level Credentialing - Several key informants recommended state-level credentialing and training that focuses on age-appropriate assessments of mental health and mental health interventions. Potential strategies for improving state level credentialing include enhancing the existing Early Childhood and Family Mental Health credential. Many assessment participants described the credential’s training and supervision requirements as highly valuable but noted that there was minimal incentive for providers to receive and maintain the credential.

Advocates and legislators should partner with the New Hampshire Association for Infant Mental Health, the administrator of the credential, to develop and advocate strategies to elevate the ECFMH credential statewide. Potential strategies could include requiring the credential for specific provider levels or associating the credential with increased salary level. Alternatively, the credential could be associated with higher reimbursement rates to incentivize more providers to receive the specialized trainings. Offering

⁹ New Hampshire Department of Health and Human Services. (January 2019). *New Hampshire 10-Year Mental Health Plan*. Retrieved from <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>

¹⁰ Minnesota Department of Human Services. (April 2017). *Early Childhood Mental Health System of Care*. Retrieved from <https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/early-childhood-mh-system-care/>

¹¹ New Hampshire Department of Health and Human Services. (January 2019). *New Hampshire 10-Year Mental Health Plan*. Retrieved from <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>

scholarships or reimbursements from the State to cover costs associated with the training would also incentivize providers to take part in the training.

Increased Support for Training – Participants perceived that necessary workforce growth and development could be done through increasing availability of trainings and making them more accessible for providers to attend.

Interviewees identified a need for more training regarding currently used models, with a focus on early childhood development and trauma-informed care topics. As one interviewee shared, *“Attachment and infant and early childhood development as a construct are really important for trainings. Any model that focuses on those would be good one.”* Another interviewee explained, *“Making sure that anyone who is interfacing with young children and their families understand ACEs is a good thing.”* One focus group participant echoed the importance of trauma-informed care: *“We know [trauma-informed care is] increasing across the fields. I don’t know how much training PCPs are getting to know when and where to make those referrals.”*

Survey respondents also indicated desire for more trainings across evidence-based models. **Table 2** shows the five psychotherapy, home-visiting, and parent education models with the most interest in training from survey respondents. While the top models are presented here, respondents expressed interest in training for every model asked about in the provider survey.

Table 2. Top Models of Respondent Interest in Training, by Model Type (N=77)

Evidence-based Model	% of Respondents Indicating Interest in Being Trained in Model (n)
Evidence-based Psychotherapy Models	
Attachment, Self-Regulation, and Competence (ARC)	37.7% (29)
Helping the Non-compliant Child (HNC)	37.7% (29)
Parent-Child Interaction Therapy (PCIT)	28.6% (22)
Preschool PTSD Treatment (PPT)	24.7% (19)
Child-Parent Psychotherapy (CPP)	23.4% (18)
Evidence-based Home Visiting Models	
Attachment, Self-Regulation, and Competence (ARC)	36.4% (28)
Attachment and Biobehavioral Catch-Up (ABC)	28.6% (22)
Play and Learning Strategies (PALS)	27.3% (21)
Triple P-Positive Parenting Program - Home Visiting	26.0% (20)
Child First	24.7% (19)
Evidence-based Parent Education Models	
Raising a Thinking Child	33.8% (26)
Circle of Security	31.2% (24)
Incredible Years	24.7% (19)
Parenting Through Change	24.7% (19)
Systematic Training for Effective Parenting	24.7% (19)

DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

Additional efforts to make trainings less cost burdensome for attendees would also expand and increase the workforce trained in specific evidence-based models. This could be done through funds to subsidize the cost of attending trainings (registration fees, transportation, hotels, food, etc.) and funding training offerings in more rural parts of the state. Increasing virtual training opportunities and improving the technological infrastructure needed to participate in virtual trainings should also be explored as a strategy to reduce barriers to attending trainings. Changes to billing rules to allow training attendees to bill for time spent at professional development opportunities would also incentivize more providers to take part in more trainings.

Payment and Reimbursement Rates - Some focus group participants cited higher reimbursement rates as key to supporting training needs and strengthening the workforce. Another focus group participant explained, *“With higher rates, then we could get more staff, then be able to provide more services to more children.”* In addition to increasing reimbursement rates for services, improvement could be seen by advocating for an expansion of billable services to include more of the services offered by Family Resource Centers and home visiting programs, as well as traditional clinical services. Increasing reimbursement rates as a strategy to increase recruitment and retention of providers is also a part of the state’s 10-Year Mental Health Plan.

In addition to increased reimbursement rates, workforce challenges could be addressed through increasing salaries for early childhood and family mental health providers. Participants spoke to the challenges of recruiting and retaining qualified staff across the spectrum of services given the low wages available. Participants agreed that higher wages would increase the availability of providers and slow the perceived high turnover rate that the field currently experiences. Other financial incentives that could be offered to recruit and retain providers include tuition reimbursement and loan repayment programs. Improving the retention of staff will limit the disruption that families experience due to frequent provider turn over and provide higher quality of care overall.

Availability and Accessibility of Services

“To me, when we have systems that interact with kids, you should embed mental health in those systems. The separate system is a missed opportunity. Intervention needs to happen where the kids [and parents] are.” - Interviewee

Co-location and Integration of Services - Several key informants recommended embedding mental health in systems that already serve children to improve access for families and improve families’ awareness of available mental health services. To achieve these recommendations, key informants recommended integrating mental health providers in Family Resource Centers, Family Centered Early Supports and Services, and the Division of Children, Youth and Families. One interviewee shared their vision: *“A lot of the 0-3 goes to [Early Supports and Services] and they don’t typically have mental health care providers. Getting more mental health providers in Family Resource Centers would be really helpful.”*

One focus group participant emphasized the importance of creating strategies to enhance families’ awareness of mental health resources for young children, *“We need an organized way for families to find the services that they need.”* According to one interviewee, integrating services at one location may reduce barriers to consistent access to mental health services for families: *“I think that whenever we’re bundling services, we’re making life that much easier for our clients. If people must run around the city of Manchester to get 10 services in 10 different places, they just won’t.”* Another interviewee noted that integrating services would also strengthen connections and collaborations between organizations: *“There*

will be an integration of services and you're going to have organizations that really start working as one. I think you'll start seeing services imbedded. We're going to start working seamlessly together."

Increased Services for Age Group – A key finding of this assessment was the scarcity of services to address the mental health needs of the birth through five population and their families.

Assessment participants largely agreed on the need for an increased number of providers and services offering evidence-based models of care. The need for more services was identified across the continuum of care, including psychotherapy, home visiting, parent education, and other family supports and services. Efforts to support workforce development, discussed above, would lead to an increase in the number of services available, as providers would be incentivized and supported in increasing their offerings for the target age group. Assessment participants also recommended that more efforts be taken to increase the number of services offered in northern New Hampshire and other rural areas in the state, which they perceived as critically lacking in early childhood mental health care.

Assessment participants also identified a need for more services that accept Medicaid as this was perceived as an underserved population. This could be done by increasing Medicaid reimbursement for early childhood mental health care to facilitate more providers and programs offering these services. Medicaid reimbursement could also be expanded to include more of the non-clinical early supports and services. This was done successfully for home visiting models in New Hampshire and could be done for other support services.

Prevention Services - Some key informants emphasized the need for more prevention services, including additional parent education services. One interviewee noted that prevention is a growing area of emphasis nationally, *"I think in the next 3-5 years there's going to be so much more focus on prevention. I think that is where the field will go."* Another interviewee envisioned a strengthened focus on adverse childhood experiences earlier in the life course, *"I think people are starting to understand that ACEs are real and the earlier that we intervene the better it is for our communities as a whole."* A focus on communities at risk also emerged as a recommendation from one interviewee: *"So I think of the multi-level model of providing services – neighborhood services, services targeted at the at-risk community."*

One interviewee explained the importance of expanding parent education to strengthen parenting skills, and to build parents' capacity during crises, *"We're seeing less and less knowledge of parenting skills. We're having to teach more parenting skills. We have a ton of parent education classes, but it's difficult to put our finger on it and prevent that with the next generation. We're helping families in crisis but we're trying to prevent the next generation from experiencing the same crises."*

Some informants noted an increase in children's mental health needs linked with the opioid crisis. Several key informants emphasized the importance of understanding and addressing the impact of the opioid crisis on early childhood mental health. According to one interviewee, *"The opioid crisis created a surge of children with mental health needs that will continue to grow over the coming years."* Another interviewee described changes in family structure and dynamics linked with opioid use, *"We've seen a lot of change in the structure of families and what they need and that reflects the community's needs."* Focus group participants elaborated, sharing that in some cases grandparents or other kin network members are formally or informally raising children whose parents have been affected by the opioid crisis. One focus group participant explained, *"Some of the arrangements are formal and some are not...if it's not an open DCYF case they don't need to do anything legally to get custody of the children. They just raise them."*

Reduction of Structural Barriers

“At a family level, it’s [about] meeting the needs they have outside of the therapy session. Many [of the] social determinants of health are getting in their way of getting to therapy and having a healthy life.” – Interviewee

In addition to increasing the availability of early childhood mental health services and developing the infrastructure for a cohesive system, steps should be taken to reduce structural barriers, such as childcare and transportation, that make it difficult for families to access necessary care for their young children.

Transportation Services – Interviewees, focus group participants, and survey respondents indicated that lack of affordable, reliable transportation was one of the key barriers that New Hampshire families face in accessing services for their children. This was perceived as especially being a challenge for rural communities where families may have to travel longer distances to access services and public transportation systems may be less available, if at all, than they are in urban or suburban areas. Interviewees described that services, such as buses provided by Medicaid, meant to address these challenges are often not well publicized or do not run reliably. Recommendations to address transportation barriers include funding transportation credits in the form of taxi vouchers or reimbursements for ride share programs. This would help to relieve the financial burden placed on families that need to travel to services. Steps should also be taken to improve the existing services and better publicize them to qualifying families.

Childcare Subsidies - Lack of accessible and affordable childcare was described by assessment participants as an established issue in New Hampshire. This was perceived as particularly being a barrier to office-based services such as outpatient mental health services, as it is common practice for the intake appointment for children under the age of five to be with a parent or guardian alone. This makes initiating care difficult if a parent or guardian has multiple young children and are unable to find affordable childcare during the appointment window. To address this barrier, families could be provided subsidies for childcare services. Childcare providers could also be subsidized, encouraging more people to offer affordable childcare to reduce barriers for families and facilitate access to services.

Increase in Home-based Services – Barriers stemming from transportation and childcare could also be addressed through an increase in the availability of home-based services. Offering a service at home, instead of being office- or center-based, would eliminate the financial and time burdens that may be associated with traveling to services, as well as the need for families to arrange childcare for other children in the family. While providing in-home services may not be appropriate for every service or every family, efforts should be taken to increase organizational ability to offer services in patients’ homes. This could be done by changing reimbursement for in-home services and offering travel credits or make travel time billable for providers so that the hours are not lost, cost wise. When the state or individual organizations are considering new evidence-based models for implementation, special consideration should be given to those that are in-home or have the flexibility to be offered at home.

Incentivize Weekend and Evening Services – Structural barriers could be addressed by increasing the availability of weekend and evening services. Offering services outside of traditional hours would allow for guardians to bring children in without having to take potentially unpaid time off from work. It would also lessen the amount of school time that young children miss in order to attend appointments. Weekend and evening services could also help families with other young children or other caregiving responsibilities.

Appendix A. Survey Respondents Demographics

	n	%
Highest Level of Education (N=72)		
Less than high school	0	0.0%
High school graduate/GED	0	0.0%
Some college	5	6.9%
Associate degree or technical/vocational degree	1	1.4%
College graduate	30	41.7%
Graduate or professional degree	35	48.6%
Other	1	1.4%
If Respondent is Master's level or higher, licensing information (N=35)		
Licensed	14	40.0%
Unlicensed, license eligible	7	20.0%
Unlicensed, not license eligible	14	40.0%
Age (N=73)		
18-24 years	0	0.0%
25-34 years	15	20.5%
35-44 years	18	24.7%
45-54 years	12	16.4%
55-64 years	16	21.9%
65-74 years	11	15.1%
75 years or more	1	1.4%
Race and Ethnicity* (N=71)		
White	70	98.6%
Black or African American	1	1.4%
Hispanic or Latino	1	1.4%
Asian	1	1.4%
Native Hawaiian or Other Pacific Islander	0	0.0%
American Indian or Alaskan Native	0	0.0%
Other	0	0.0%

DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

NOTE: Questions denoted with a * allowed respondents to select more than one answer.

Appendix B. Environmental Scan

Model	Organization/ Program Name	Practice Location	Program Details	Contact Information
Psychotherapy Models				
Child-Parent Psychotherapy (CPP)	TLC Family Resource Center	Claremont	ECFMHC credentialed provider;	Melony Williams, melony@tlcfamilyrc.org
	Riverbend Community Mental Health	Concord, Franklin	ECFMHC credentialed provider; Some services in the Children's Services program are offered at schools, in home and throughout the community	603-228-1600
	Mental Health Center of Greater Manchester	Manchester		Child Impact Program: 603-668-4111 x6468
	Waypoint	Concord, Lebanon, Exeter, and Dover	Therapeutic services are offered in conjunction with groups, home-based services, and community programs; ECFMHC credentialed provider	1-800-640-6486
	Monadnock Family Services	Keene		603-357-4400
	Community Bridges	Concord	Serves children birth to three with developmental issues, including social emotional concerns	603-225-4153
	Dartmouth Hitchcock Medical Center - Psychiatric Associates	Lebanon	Part of the Children's Hospital	603-354-6666
	Warren Street Counseling	Concord		603-226- 1999
	Riverbend Community Mental Health Center	Concord	Has certified PCIT Masters level clinician	603-228-0547
	Families in Transition	Manchester		603-641-9441
	West Central Behavioral Health	Claremont, Lebanon, Newport		603-863-1951 (Newport) 603-542-5449 (Claremont) 603-448-5610 (Lebanon)
	Hanover Psychiatry	Concord, Hanover	Faculty practice of the Dept. of Psychiatry at Dartmouth	603-513-2742

Parent-Child Interaction Therapy (PCIT)	Resilience Counseling and Training Center	North Conway	Offers services using Skype, in addition to in person, for clients that can't travel to office	603-730-5467
	Lilac City Counseling, Inc.	Rochester		603-743-4004
Helping the Non-Compliant Child (HNC)	Green House Group, PA	Manchester		603-668-3050
Home Visiting Models				
Healthy Families America (HFA)	Family Resource Center at Gorham	Coos County, Northern Grafton County		Jen Buteau, 603-446-5190 x303 familysupport@frc123.org
	Central NH VNA and Hospice	Laconia; Wolfeboro	Partner with Community Action Partnership to provide Home Visiting New Hampshire as well as HFA	603-524-8444 (Laconia) 603-569-2729 (Wolfeboro)
	Waypoint	Manchester		
	TLC Family Resource Center	Claremont	TLC has ECFMHC credentialed provider; Referrals from obstetrician or family physician, family, self, or community agencies	
	Community Action Partnership	Dover		Family Wellness Program, 603-435-2500 x8108
	Community Action Program	Belknap County		Siobhan Connelly, 603-528-5334x125 sconnelly@bmca-lrfa.org
Parent Education Models				
1-2-3 Magic	Family First Sea Coast	Portsmouth and Somersworth		603-422-8208 x 6
	The Upper Room	Derry		(603) 437-8477 x 12
Circle of Security	TLC Family Resource Center	Claremont	Free classes led by trained parent educators	603-542-1848; crystal@tlcfamilyrc.org
Nurturing Parenting Program	Monadnock Family Services	Keene, Troy	6- week session, Cost is \$10 per family for entire session	Mary Frazier, 603-313-0396
Positive Solutions for Families	Family Resource Center at Gorham	Coos County, Northern Grafton County		Jen Buteau, 446-5190, ext. 303 or familysupport@frc123.org
	Riverbend Community Mental Health	Greater Merrimack County	8 week parent education and support program	603-228-0547
	Family First Sea Coast	Portsmouth and Somersworth		603-422-8208, x 6

The following is a list of evidence-based models and services identified as being used in New Hampshire from the assessment survey, but researchers were unable to identify if and where they are being implemented:

Psychotherapy Models

- Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse
- Functional Family Therapy
- Intensive In-home Child and Adolescent Psychiatric Services
- Preschool PTSD Treatment (PPT)
- Attachment, Self-Regulation, and Competence (ARC)
- Brief Strategic Family Therapy
- Child First
- Early Head Start-Home Based Option Parents as Teacher
- Family Check-up for Children

Home Visiting Models

- Family Connects
- Family Spirit
- Health Access Nurturing Development Services (HANDS) Program
- Healthy Beginnings
- Home Instruction for Parents of Preschool Youngsters (HIPPIY)
- Minding the Baby
- Nurse-Family Partnership (NFP)
- Parents as Teachers (PAT)
- Play and Learning Strategies (PALS)
- SafeCare
- Triple P-Positive Parenting Program - Home Visiting (Triple P-Home Visiting)
- Maternal Early Childhood Sustained Home Visiting Program

Parent Education Models

- Incredible Years
- Parenting Through Change
- Raising a Thinking Child
- Systematic Training for Effective Parenting