



NEW
HAMPSHIRE
CHILDREN'S
HEALTH
FOUNDATION

20 REVISITING NEW HAMPSHIRE'S 26 EARLY CHILDHOOD AND FAMILY MENTAL HEALTH SYSTEM:

Updating the New Hampshire Children's Health
Foundation's 2019 – 2020 Assessment

Contents

Executive Summary	i
Introduction	1
Assessment Methods	2
Key Findings.....	4
Describing the System Today	4
Integration with Other Early Childhood Systems.....	5
Breaking Down Silos.....	6
Workforce Capacity, Training, and Credentialing	6
Early Childhood and Family Mental Health Credential.....	7
Addressing Structural Barriers.....	9
Emerging Challenges	10
Political Landscape	10
Increasing Fear and Distrust.....	11
Expansion, Integration, and Improved System Access	12
Trauma Informed Care in Pediatric Practices	13
ACERT.....	16
Child-Parent Psychotherapy.....	18
Access ECFMH Services.....	21
Future of the System	22
Anticipated Challenges	22
Changes at the Federal Level.....	22
Funding Changes.....	23
Hopes for the Future.....	23
Focus on Prevention.....	24
Greater Collaboration and Integration	25
Conclusion	26
Growth of the System	26

Importance of Cross-Sector Collaboration.....26

Structural Challenges for Families Persist 27

An Eye Toward Prevention.....27

Executive Summary

Introduction

From 2018 through 2025, the New Hampshire Children's Health Foundation (NHCHF) prioritized preventing and reducing childhood trauma, with a focus on building community systems that strengthen resilience for children and caregivers. In 2019, in partnership with the Endowment for Health (the Endowment), NHCHF commissioned an assessment of the state's early childhood and family mental health (ECFMH) system. The assessment report revealed a fragmented system with limited workforce capacity, low recognition of credentials, and structural barriers to access.

These findings shaped NHCHF's investments from 2020-2025, emphasizing statewide system coordination, workforce development, expanded service availability, and reduced systemic barriers for families. In 2025, NHCHF commissioned a follow-up assessment to understand current system conditions, evaluate progress since 2020, and identify emerging needs in the ECFMH landscape. To conduct this assessment, NHCHF engaged Health Resources in Action (HRiA), a non-profit public health organization.

Key Findings

Describing the System Today

When asked to describe the ECFMH system, interviewees reported a significant increase in awareness of early childhood mental health over the past five years, particularly within the mental health and primary care fields, driven largely by the impacts of the COVID-19 pandemic. This heightened awareness has contributed to a shift toward more community-based services for young children, with greater mental health integration in programs. Pandemic-related funding, especially through the American Rescue Plan Act (ARPA), was described as critical in sustaining and expanding these services.

Integration with Other Childhood Systems

Interviewees described growing integration between the ECFMH system and early education settings, driven by increased recognition that children's mental health is shaped not only at home but also in childcare and school environments. This collaboration has led to a more preventive approach, with both early education providers and mental health professionals expressing interest in deeper partnerships. However, progress varies across regions, and limited capacity within early education continues to be a major barrier to further integration.

Breaking Down Silos

Despite intentional efforts to reduce fragmentation in the ECFMH system, many silos identified in the earlier assessment persist, and progress has been gradual. The creation of a children's behavioral health system of care highlighted an important step forward, even as it remained a work in progress. Interviewees emphasized that deeper integration with health care and early education remains a priority, noting primary care providers underutilize community resources.

Workforce Capacity, Training, and Credentialing

Workforce capacity remains a major challenge in the ECFMH system, with interviewees describing only partial progress since the original assessment. While entry-level hiring has improved due to reduced credentialing burdens and expanded training infrastructure, significant barriers persist for roles that require master's level degrees, largely because low reimbursement rates push providers to practice in other states.

The Early Childhood and Family Mental Health Credential (ECFMHC) has expanded access through the addition of a Foundational-level pathway, but funding instability has halted new cohorts for the first time in over a decade. Interviewees emphasized that although the credential provides valuable skills, its limited recognition, particularly the lack of reimbursement increases, continues to undermine its impact. Some suggested tying the credential to reimbursement rates as a potential solution, but previous legislative attempts were unsuccessful.

Addressing Structural Barriers

Interviewees emphasized that structural barriers, such as long wait times, insurance limitations, and transportation challenges, continue to impede access to mental health services for children and families. While patients in some regions experience shorter wait times, families in rural areas still face significant delays, with telehealth offering little relief for services that rely on in-person, relationship-based work. Many interviewees also noted rising food insecurity and housing instability, which force families to prioritize basic needs over addressing mental health concerns.

Emerging Challenges

Over the past five years, two significant challenges have shaped the ECFMH system: a shifting political environment and rising distrust of medical and mental health services. Many interviewees described declining federal and state support, frequent legislative turnover, and heightened polarization around children's behavioral health as major obstacles to sustaining and expanding services. The expiration of ARPA funding has further strained programs and created uncertainty about future resources and leading to more competition for private funding.

At the same time, fear among families, driven by concerns about immigration status or child protective involvement, has grown and lead to some avoiding service altogether. Distrust of

mental health treatment more broadly has also increased, with providers noting that some families don't understand the need for early childhood mental health services.

Expansion, Integration, and Improved System Access

The New Hampshire Bureau of Children's Behavioral Health has continued developing a statewide system of care model intended to unify publicly funded behavioral health services for children, though interviewees noted that success varies by location. Co-location and integration of services, particularly embedding behavioral health in primary care and education settings, have expanded access by meeting families where they already are.

NHCHF-funded initiatives such as UNH's Trauma Informed Care in Pediatric Practices project have strengthened trauma-responsive workflows, broadened training access via asynchronous modules, and shifted focus toward positive childhood experiences as a preventive strategy.

The ACERT model has also grown substantially, expanding to 12 teams serving 19 communities, supported by strong partnerships with police departments, and in some cases, sustained municipal funding. However, new communities continue to face barriers due to limited long-term funding and the absence of an evidence-based designation.

Access to Child-Parent Psychotherapy (CPP) has increased dramatically, rising from 11 agencies in 2019, to 40 agencies in 2025, with providers now present in all ten counties which is a change that interviewees attributed to state-backed funding for training, supervision, and implementation. Expanded referral pathways, including the launch of the 988 Rapid Response Access Point and the work for the Center for Trauma Responsive Practice Change, have further improved families' ability to connect with CPP providers. Interviewees widely described these CPP investments as among the most impact systems change since the previous assessment.

Future of the System

Anticipated Challenges

Interviewees anticipated that the ECFMH system will face significant challenges in the coming years, driven largely by federal policy changes and a shrinking funding landscape. Many expressed deep concern about upcoming Medicaid cuts, noting that reduced coverage, higher copays, and lower reimbursement rates could increase family stress, limit access to care, and strain providers across mental health centers. They also worried that cuts to SNAP, childcare support, and other basic-needs programs will intensify hardships for families, potentially increasing mental health needs.

At the same time, long-standing federal and state grants that have supported early childhood mental health services are being reduced or eliminated, pushing organizations to rely on

increasingly competitive private funding. Interviewees fear that these combined pressures could reverse many of the system's recent gains.

Hope for the Future

Interviewees expressed two primary hopes for the future of the ECFMH system: a stronger emphasis on prevention and more seamless collaboration across systems. Many noted the current system is too crisis-driven and wanted a shift toward proactive, upstream supports that help children and families before they reach a breaking point. They emphasized that prevention not only promotes healthier development into adulthood but can reduce long-term costs by decreasing the need for intensive services.

Alongside prevention, interviewees hoped to see more integration between early education and behavioral health, noting that teachers and schools are often the first to observe children's mental health challenges and need stronger support from the ECFMH system.

Conclusion

Findings from this retrospective assessment show meaningful growth in New Hampshire's ECFMH system over the past five years, alongside persistent and emerging challenges. Investments from state, federal, and private sources, especially those supporting CPP, significantly expanded service availability, with more than 150 providers now trained and agencies in all ten counties offering CPP. Workforce capacity improved at the entry level through reduced credentialing barriers and expanded training, though shortages of master's level clinicians remain low due to low reimbursement rates.

Cross-sector collaboration also strengthened, illustrated by the expansion of ACERT and increased co-located services, yet interviewees emphasized that silos persist and collaboration is still dependent on individual relationships rather than system-level structures.

Structural barriers such as transportation, food insecurity, and housing instability continue to impede access and participants expressed concern that cuts to programs like SNAP and Medicaid will intensify challenges.

Looking ahead, interviewees stressed the need for a stronger focus on prevention and upstream support, paired with deeper integration across early education, health care, and community systems to build a more resilient and equitable ECFMH system.

Introduction

From 2018 through 2025, New Hampshire Children's Health Foundation's (NHCHF) priorities have included the prevention and reduction of childhood trauma. Under this priority area, NHCHF aimed to create a New Hampshire where *"communities have policies, systems, and environments in place that are intended to improve outcomes and support resilience for children and their caregivers."*¹

In 2019, the New Hampshire Children's Health Foundation (NHCHF), in partnership with the Endowment for Health (the Endowment), commissioned an assessment of the early childhood and family mental health (ECFMH) system in New Hampshire. This assessment followed the release of New Hampshire Department of Health and Human Services' Ten-Year Mental Health Plan in January 2019, which included recommendations related to the expansion of early childhood supports and services.² The assessment report, released in February 2020, identified the following findings related to the ECFMH system:

- The early childhood and family mental health system is disjointed, siloed, and, in some cases, non-existent.
- Workforce capacity is limited due to low wages and reimbursement rates, burdensome licensing/credentialing, training requirements, and staff turnover.
- The system has limited capacity to implement evidence-based models because of high costs, prohibitive training requirements, and burdens created by geographic availability.
- While training and reflective practice requirements of the ECFMH credential are beneficial, the impact of the license is limited due to low recognition.
- Structural barriers, such as long wait times, disruptions to care due to provider turnover, and transportation barriers, limit access for families.

The key findings and recommendations from the ECFMH assessment report informed the work of NHCHF and their partners from 2020 through 2025. Recommendations included:

- Develop a statewide early childhood mental health system that expands and coordinates services across the continuum of care and includes the infrastructure for training, monitoring, and administrative support.

¹ New Hampshire Children's Health Foundation. (n.d.) *Preventing childhood trauma*. <https://nhchildrenshealthfoundation.org/preventing-aces/>

² New Hampshire Department of Health and Human Services. (January 2019). New Hampshire 10-year mental health plan. <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/10-year-mh-plan.pdf>

- Focus on workforce development by strengthening state level credentialing, increasing support for training, and improving payment and reimbursement rates.
- Improve the availability and accessibility of services by offering co-located/integrated services and increasing services across the continuum of care.
- Reduce structural barriers for patients and their families by addressing transportation (e.g., taxi vouchers, ride share reimbursement).

In 2025, NHCHF commissioned a follow-up to the original assessment, with the purpose of:

- Understanding the current state of the ECFMH system and the key projects NHCHF has invested in
- Learning how the ECFMH system has changed since the completion of the previous assessment
- Identifying emerging challenges and needs of the ECFMH system.

Both assessments were conducted by Health Resources in Action (HRiA), a non-profit public health organization.

Assessment Methods

To conduct this assessment, HRiA collected data through interviews with key informants working across the ECFMH system. Between September – October 2025, HRiA conducted 13 interviews with 16 participants, identified by NHCHF staff. Four of the participants had been interviewed for the 2019 – 2020 assessment. In addition to their insights and expertise in the ECFMH system overall, eight interviewees represented projects or programs that received direct support from NHCHF. These interviewees provided updates on the status of their activities, which included the following:

- Early Childhood and Family Mental Health Credential
- Adverse Childhood Experiences Response Teams
- Child Parent Psychotherapy
- University of New Hampshire's Trauma Informed Care in Pediatric Practices project.

Interviews were conducted by a trained moderator, and detailed notes were taken during these conversations. A qualitative researcher coded and thematically analyzed interview notes using NVivo 14 software. Key themes were identified based on the frequency and intensity with which they appeared in interview notes.

Where available, HRiA staff updated secondary data from the original assessment to understand change over time. The secondary data focused on the implementation and availability of evidence-based models, including Adverse Childhood Experiences Response Team, Child Parent

Psychotherapy, and the University of New Hampshire's Trauma Informed Care in Pediatric Practices project.

Key Findings

Findings from this retrospective assessment provide insights into the evolution of the ECFMH over the past five years, including the impacts of investments and systems changes, persistent challenges and barriers, and opportunities for continued improvement.

Describing the System Today

When asked to describe the ECFMH system today, interviewees generally agreed that, in the last five years, they have seen a growth in awareness of early childhood mental health and understanding of the need for services specific to the zero to five age group. This awareness was described as growing especially within the mental health field: “There’s more emphasis on evidence-based practices specifically for children and getting providers and community-level folks trained in those [practices].”

The growing awareness of early childhood mental health was attributed largely to the COVID-19 pandemic, which was described as both exacerbating and spotlighting mental health challenges faced by children and their families. An interviewee shared how this increased need was seen across systems:

“Because of COVID, there was an increased interest in treating children’s mental and behavioral health. Not just from behavioral clinicians but from primary care. They were seeing more mental health cases come through and wanted to be able to better support those children and their families. I think we saw an increased interest and understanding of what trauma is...and in doing the work to address it.”

Interviewees perceived that the increased awareness across systems has brought about a shift away from strictly office or clinic-based services for young children and movement towards more community-based services: “[Young children] are now largely served through family resource centers, home visiting programs, and early supports and services in our state. I think those programs have had more mental health infusion.”

Funding that emerged during the pandemic, especially from the American Rescue Plan Act (ARPA), was described as having helped facilitate this growth. An interviewee speaking about home visiting programs³ and other early intervention services within federally qualified health

³ Early childhood home visiting is a voluntary, evidence-based service strategy pairing expectant parents or families with young children (usually ages 0–5) with trained professionals, such as nurses or social workers.

centers explained: “When I look back to the early 2020s, ARPA money had a really big impact on so many of these...Because there was money, we were able to continue the [home visiting] program.”

Integration with Other Early Childhood Systems

Interviewees were specifically asked about integration between the ECFMH system and early education and early supports and services in New Hampshire. They described a growing awareness of the important role that early education and early supports and services can play in addressing young children’s mental health needs: “Before, it was family-centered with the child at the center. Now, we think about the child’s environment too because they’re not just at home. They spend six or more hours at school or childcare, so we’re starting to include those entities in the [ECFMH] system.”

Interviewees noted that integrating mental health services in these systems has allowed an increased focus on prevention: “It feels a lot more proactive and preventive. A lot of times, this system feels reactive, but working with early childhood feels much more focused on the preventive.” The drive for this integration was described as coming from both systems: “I talked to early learning center directors and asked them what their wildest dreams were, and they named having community health workers from the mental health centers be connected with the [early learning] centers and the families.”

While the impact of this integration has been growing in recognition, interviewees described progress as mixed and varying between regions and school districts within the state. The limited capacity of the early education system was described as the key barrier to further integration. As one interviewee explained, “We have a hard time getting our message into daycares. I think people working in those centers are over capacity right now and don’t have the space to do one more thing or hear about one more service.”

Additionally, several interviewees also noted that the wages and benefits paid to childcare workers are low and do not reflect the complexity of the work. An interviewee shared: “I teach a class where most of the people are childcare workers, and they are struggling. They’re struggling to pay their bills, they don’t get health insurance, so asking them to do anything extra isn’t possible.” Another added: “Looking at a deeper level, we severely undervalue and underpay people who work in [the childcare] sector...We’re asking the people who are the most undervalued to manage the most distressing behaviors.”

Breaking Down Silos

One of the key findings of the previous assessment was that the ECFMH system was “disjointed, siloed, and, in some cases, non-existent.” While there have been intentional efforts over the past five years to break down silos, interviewees described that progress has been slow, and many of those silos and separations remain. Several interviewees noted that the state-level initiative to create a system of care for children’s behavioral health through the New Hampshire Department of Health and Human Services’ Bureau of Children’s Behavioral Health has been a key driver of progress around this finding:

“We’re making progress on the first one, with the Bureau of Children’s Behavioral Health becoming its own system. We haven’t perfected it, but we’ve made progress.”

Interviewees named integration between different systems, particularly with health care and early education, as areas of focus going forward. One interviewee explained: “Where there’s still room for improvement is how the physicians and primary care centers involve community resources. I don’t think they’re as connected as they could be. I don’t think they utilize resources like early intervention or family resource centers. I think it’s still disjointed there.”

“I do think there are still silos, but I do think... we’re trying to bridge those gaps and make warm handoffs and do wraparound services. They’re still there but we needed to notice those gaps in order to address them.”

– Interviewee

Workforce Capacity, Training, and Credentialing

Limited workforce capacity, attributed to low wages and reimbursement rates and burdensome licensing, credentialing, and training requirements, arose as a major challenge from the initial assessment. Barriers to accessing available training include time for training, distance to training, and associated travel costs for food and lodging. Participants in the original assessment described these training challenges as contributing factors to perceived high rates of staff turnover in the ECFMH system.

Interviewees reflected that over the past five years, results have been mixed on how these barriers have been addressed. They shared that there has been an increase in creating and filling entry level positions in the ECFMH system in part by lessening credentialing burdens for these roles. Interviewees also described additional investments made by the state into infrastructure for trainings that have broadened the offerings:

"At the bachelor's level, the community providers, that's been less of a struggle over the last five years. That's been great. Theirs is more specialized training for that staff level to match what clinicians are providing. [The Center for Trauma Informed Practice Change] has offered it. MATCH⁴ [at NH DHHS] has offered it for community providers or even teachers, so it matches what they're doing in therapy. That has been great for recruiting staff because they feel supported."

Some interviewees expressed concerns that changes to license requirements may have unintended impacts in the future. An interviewee explained their concern: "I understand why [licensing requirements] were a challenge for some but as someone who has dedicated their life to professional development and education, I think it's worth that effort. Children and families benefit from having people who know the latest information."

Interviewees described less progress for filling roles that require master's degrees or higher levels of credentialing. An interviewee put it plainly: "It's hard for everyone to get the master's level clinicians." This was largely attributed to persistent low reimbursement rates for the services provided by this part of the field, driving providers to practice in other states with higher reimbursement. Interviewees shared concerns that further cuts to Medicaid at the state and federal levels could worsen this challenge.

Early Childhood and Family Mental Health Credential

The Early Childhood and Family Mental Health Credential (ECFMHC) is a training and credentialing program overseen by the New Hampshire Association for Infant Mental Health. The ECFMHC is open to early childhood professionals across fields and systems and available at four levels:⁵

- **Foundational:** Open to entry level positions (those that do not require a bachelor's degree) that provide direct services to children and families with supervision.
- **Intermediate:** Open to direct support providers who address children's and families' mental health needs on an on-going basis, with support and review by supervisors.
- **Advanced:** Open to licensed or certified providers that provide clinical mental health interventions and/or support (e.g., supervision, consultation, training) to other mental health service providers.

⁴ Modular Approach to Therapy for Children (MATCH) is an evidence-based model for cognitive behavioral therapy for children age 6 -17.

⁵ New Hampshire Association for Infant Mental Health. (n.d.). *Early childhood and family mental health credential*. <https://www.nhaimh.org/ecfmh-credential2>

- **Reflective Practice Consultants:** Open to individuals at the highest level of clinical and supervisory experience that support holders of the Intermediate or Advanced credential.

The Foundational-level credential was introduced as an additional pathway since the 2019 – 2020 assessment. The goal of adding this entry-level pathway was to expand the reach of the credential beyond traditional mental health roles (e.g., childcare providers). An interviewee involved with the ECFMHC program explained: “[The Associate for Infant Mental Health] realized that we have a lot of folks in the field who do not have bachelor’s degrees. They’re entry level and originally the credential was only for bachelor’s or higher. So, we wanted to create a pathway for people with an associate’s degree who were looking for a pathway to advancement.”

Through a partnership with University of New Hampshire, recipients of the Foundational-level credential were able to have the ECFMHC count as some credit toward a bachelors’ degree, which interviewees described as a positive partnership and opportunity. However, at the time of data collection, the credit program had “stalled because funding [from the state budget] didn’t come through.”

During the height of the COVID-19 pandemic, the ECFMHC program was the recipient of federal funding related to preschool development that, in addition to state funding, was used to cover the cost of five additional cohorts of participants. At the time of data collection, that funding was not available, and its future was uncertain. An interviewee explained:

“There’s still an interest, as long as people don’t have to pay for it...Unfortunately, this year, there’s no funding from any of our partners at the state so we will not be offering any cohorts. This is the first time in 12 years that we won’t be about to offer any cohorts...People are really disappointed.”

Interviewees agreed that funding was a persistent challenge for the ECFMHC, with one interviewee explaining “traditionally [funding] has been piecemeal. How do we get sustainable funding for a certain amount of cohort per year?”

Another challenge for the ECFMHC, which also arose in the 2019 – 2020 assessment, was its recognition within the larger system. While interviewees during both assessments emphasized the benefit of the training, reflective practice, and peer support that ECFMHC holders gain, they noted that the credential itself has low recognition and does not appear to result in changes to pay or professional opportunities. One interviewee shared: “We continue to face a barrier of lack of recognition. People who complete the credential continue to be really satisfied with the skills they’ve acquired. The reflective practice model is really effective...But there’s no change in recognition, no change in pay or reimbursement... That’s something where we’re in the same place as five years ago.”

“I did the credential when it first rolled out. It was really helpful; I really enjoyed the whole process but...there’s nothing after that. It’s professional development, it doesn’t translate to more pay or a different position.”

– Interviewee

Several interviewees raised the idea of tying the credential to reimbursement rates as a solution to the challenge of recognition. One interviewee based in a clinical setting explained: “I think we could get more staff to do it if there was a tradeoff, like we were able to bill in a different way. Then the agency would be able to look and see if maybe we could pay people a little differently.” Interviewees noted that there have been legislative attempts to tie the credential to increased reimbursement rates, but none have been successful so far.

Addressing Structural Barriers

“Wait times have gone down, but there are still wait lists so that’s still a barrier. It will be a barrier until we can say ‘come in tomorrow.’”

– Interviewee

Structural barriers, such as long wait times, insurance limitations and costs, and lack of transportation, have remained barriers to accessing services for children and their families. In the five years since the original assessment, interviewees described seeing some improvements in the times that children and families were waiting to initiate

treatment. However, many described this improvement as geographically dependent, with residents in more rural areas, especially the northern region of the state, still facing long wait times for care.

Access to reliable transportation remains a persistent barrier for many families trying to access mental health care. Families that lack access to a car often also do not have access to public transportation, especially in rural areas. Interviewees noted that there are some options for taxi services that are reimbursed by Medicaid but that those are often limited. While the COVID-19 pandemic increased access to virtual mental health care for many adults, interviewees noted that telehealth is not a solution for most children and families: "With young children and their families, you do really want to see them in person. When you're working on attachment and building relationships with mom, you really can't do that virtually."

When discussing structural barriers, many interviewees raised concerns that food insecurity and housing needs have increased since the previous assessment, which interviewees attributed to the pandemic and cuts to federal benefits such as SNAP. Interviewees noted that, when families are struggling to meet these basic needs, addressing mental health is often deprioritized.

Emerging Challenges

Interviews also explored new challenges that have emerged for the ECFMH system over the past five years. Across these discussions, two key themes emerged – the impact of the current state and federal political landscapes and growing distrust of medical systems, including the ECFMH system.

Political Landscape

Interviewees largely shared the perspective that support for the services and programs that make up the ECFMH system has been waning at both the federal and state-levels, creating barriers for the expansion and evolution of the system. Several interviewees named that the structure of the New Hampshire state legislature, which only pays members \$100 a year, makes it difficult to retain what one interviewee described as "bold, smart people to serve as...advocates" for early childhood and family mental health services. Interviewees shared that this means that there is often turnover and loss of knowledge and understanding of ECFMH issues and services: "The challenge of having sustained knowledge and leadership in the legislature is the hardest thing. It took a lot of

"The big three [challenges] are lack of transportation, lack of housing, and food insecurity. Just about every family we're seeing has some kind of food insecurity."

- Interviewee

"We're just on the edge of not knowing if there will be funding for any grant funded projects. It's such a political issue. It's really hard to do the work that we do."

- Interviewee

work to educate [politicians] about what we mean by [early childhood mental health].” Interviewees also perceived that mental and behavioral health, especially when related to children, has become more polarized in recent years: “The landscape has become more politicized. Like you can’t talk about social-emotional learning. If you do, you risk falling into the trap of something becoming left or right. We’re trying to make it clear that things for families aren’t left or right.”

The end of pandemic-era federal funding programs, such as the American Rescue Plan Act (ARPA) and additional supports for childcare providers, was raised as another political change impacting the ECFMH system. Participants described these funding programs as having supported the expansion of services, which were now facing uncertain futures:

“We’re at this point now where ARPA dollars have stopped, and our funding is limited. We have to be really careful and meet our deliverables and do nothing more than that. And that’s really frustrating because we all want to be doing more than that.”

These challenges are compounded by further uncertainty about future funding from the state and federal government. Interviewees described that the future of many grants and funding streams was unclear, as was the potential impact of cuts that had already occurred: “We never know what it’s going to be like biennium to biennium [in the state budget]. Same with federal funding and the cuts to Medicaid – that’s a question a lot of us have.” Interviewees

“I think that the question is going to be what parts of the system can we sustain in the current trends of state and federal funding. How do we adapt the system to survive what would be a complete upheaval of this work?”

- Interviewee

described this as fostering an increased sense of competition for private funding sources: “We’re not going to find funding from government agencies. We’re going to have to go to private funders and they’re already being approached to step in as funding for other services are cut.”

Increasing Fear and Distrust

Interviewees named fear of accessing the ECFMH system as having grown since the previous assessment. Participants described families as being afraid to access mental health services out of concerns related to immigration status or involvement with the child protective system. Interviewees described this fear as coming from both patients and providers: “The level of fear [from families] about accessing mental health systems, the level of fear from clinicians about potentially exposing families to risk is certainly present.” Interviewees described families as opting to no longer receive services, at both the clinical and community level, out of fear that it could jeopardize their family’s safety.

Additionally, interviewees described that many families do not understand or accept the need for ECFMH services: “The newer challenge is how do you do this work in a field where you don’t know if there will be a baseline acceptance of mental health treatment and families seeking it.”

Expansion, Integration, and Improved System Access

The New Hampshire Bureau of Children’s Behavioral Health has continued to develop and implement a system of care model, which is described as “an integrated and comprehensive delivery structure for the provision of publicly funded behavioral health services to New Hampshire children and youth...A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health challenges and their families.”⁶ The State’s focus on this

“The Bureau of Children’s Behavioral Health has their system of care that they’ve been trying to do. They’re trying to have different tiers to target the different levels of care that families need...They’ve been working on it.”

- Interviewee

model was recognized as furthering the integration and unification of the ECFMH system but slow in its process. Interviewees described how there are efforts to create local or regional systems of care, but that success has varied by location. Some raised the need for more integration between these local and regional systems and the statewide effort: “I think having the statewide ECFMH system is really important, and it needs to include the area agencies and systems of care. Some regions are doing it better than others, so it’s still really fragmented.”

Integration or co-location of services was another recommendation that saw progress since the original assessment. Interviewees described this most frequently as the co-location of behavioral health services in primary care offices and the integration of ECFMH services with the education system. These efforts were described as helping to support access by putting services where children and families already are – schools, after school or summer programs, or pediatrician’s office.

⁶Behavioral Health Improvement Institute, Keene State College. (2020). *An act to implement a system of care for children’s behavioral health in New Hampshire: System of care law Year 4 report*. Report prepared for New Hampshire Department of Health and Human Services and the New Hampshire Department of Education.

Trauma Informed Care in Pediatric Practices

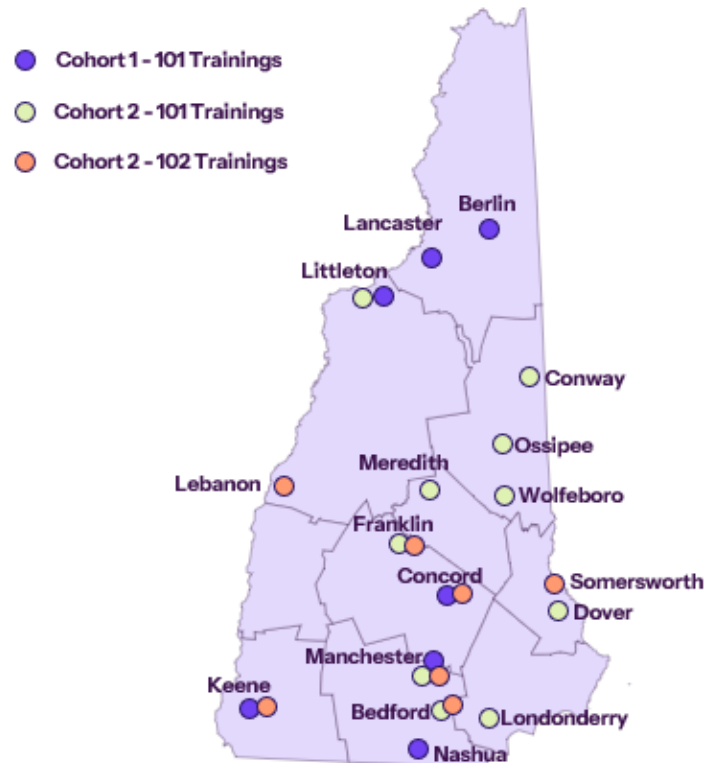
The Trauma Informed Care in Pediatrics project is an initiative of University of New Hampshire's Pediatric Improvement Project (UNH PIP) and received funding from NHCHF. The two goals of the project are to:⁷

- Increase pediatric general practitioner knowledge about trauma informed care and existing tools to support addressing trauma in primary care settings
- Support pediatric primary care clinics in using quality improvement principles to pilot process(es) to detect and respond to patients experiencing toxic stress

UNH PIP staff provide training to a pediatric practice on trauma informed care practices and then provide support and technical assistance over a 12-month period. These activities included supporting practices to implement a workflow for screening and responding to adverse childhood experiences (ACEs) during office visits. Figure 1 shows the communities across the state where at least one pediatric practice participated in a Trauma 101 or Trauma 102 training through this project.

⁷ University of New Hampshire Pediatric Improvement Partnership. (2026). Trauma Informed Care in Pediatrics Project. <https://www.nhpiip.org/trauma-informed-care-pediatrics-project>

Figure 1. Towns with Participating Pediatric Practices, University of New Hampshire Pediatric Improvement Project's Trauma Informed Trainings

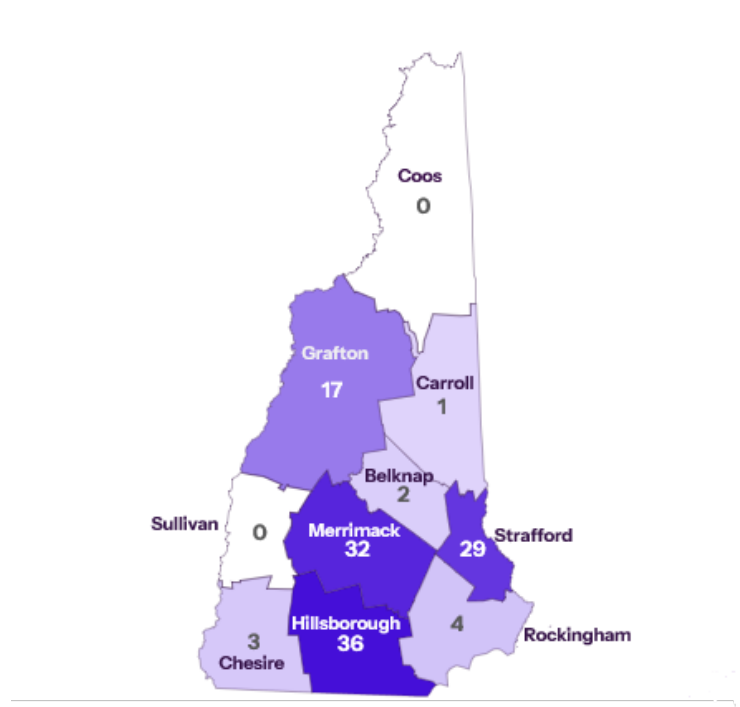


Data Source: University of New Hampshire Pediatric Improvement Project, February 2026

Reflecting on the evolution of the project, interviewees engaged with the work described the implementation of those workflows and associated resources as having improved over that five-year period: "I think health care institutions have become more efficient with regards to implementation. They're engaged in getting more meaningful, accurate data." Interviewees also described a shift in focus from ACEs and responding to trauma to positive childhood experiences (PCEs) as a prevention method: "Focusing on those positive experiences – those are really the mitigating factors. They're a community way of helping with trauma in children."

In addition to implementing the training and technical assistance model, the UNH PIP project team launched on-demand training videos focused on trauma informed care and implementation in primary care settings. An interviewee explained: "[UNH] offered up training and education that doesn't require a specific time –it's more asynchronous and allows [providers and practices] to learn as their schedule and workload allow it so they can continue to develop their skills." Figure 2 shows the distribution of participants in these asynchronous trainings across New Hampshire.

Figure 2. Number of Participants in UNH PIP's Asynchronous Trainings, by County, as of February 2026



Data Source: University of New Hampshire Pediatric Improvement Project, February 2026

Interviewees from health centers that had participated in the UNH PIP training described the experience positively and noted that it had helped improve collaboration between the wrap-around services offered through their health centers and resources in their communities. One interviewee whose practice had been through training expressed concerns that changes to the system over the past five years, particularly reduction of funding, would limit more practices from being able to participate: "I think about the trauma informed care pilot at [the health center] and think about the capacity it takes to do something like that. Capacity has been hit hard in the last five years."

Looking towards the future of the work, interviewees associated with the project expressed an interest in expanding the model beyond pediatric practices and working with OB/GYN clinics to focus more on prevention: "We're looking to go more upstream into OB/GYN and women's health to help women and people giving birth address their trauma before they even give birth." Interviewees added that they see opportunities for this upstream work to also occur in the pediatric practices: "I think people understand that there is a lot of room to address mental health in OB spaces, but I think there's room to normalize those conversations. I think there's more room for pediatrics to have those conversations with mom."

ACERT

The Adverse Childhood Experiences Response Team (ACERT) is a model that brings together local police departments, social service providers, and community organizations to support children who have been present at police calls by connecting them and their families with services and resources in their communities. The model originated with a partnership between the Manchester, New Hampshire police department and Amoskeag Health. NHCHF has played a key role in supporting the development and growth of ACERT by providing funding and support for the Manchester pilot and the ACERT Technical Assistance Center.

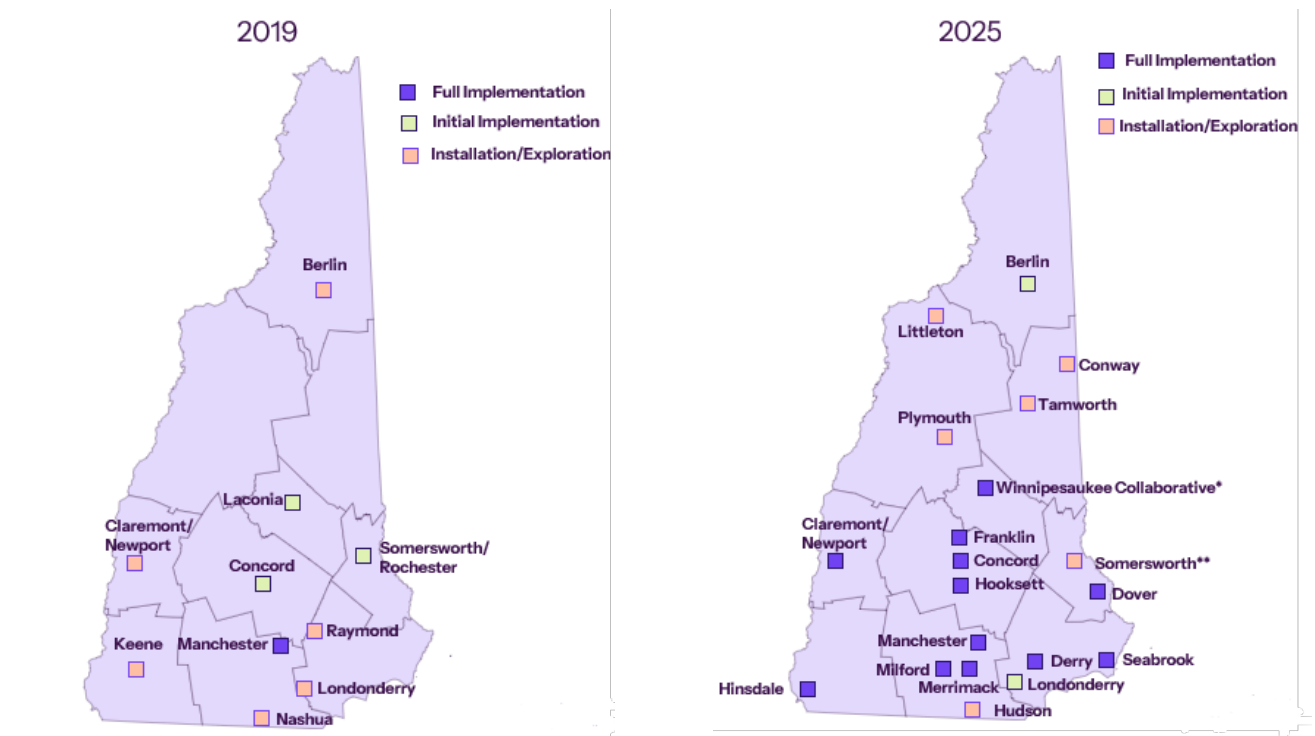
Since its inception in 2015, the model has been duplicated across communities in New Hampshire, supported by the ACERT Technical Assistance Center, housed at Amoskeag Health. As of 2025, there were 12 active ACERTs in New Hampshire, serving 19 communities. Figure 3 shows the growth that occurred between 2019 and 2025.

Individual ACERT programs have grown and expanded as they have implemented the model. Interviewees who were involved in their community's ACERT described how they have been able to bring in new staff and new partners, which has allowed them to expand the reach of ACERT. In some cases, this has included bringing new towns under the umbrella of their ACERT. One interviewee explained: "Our overarching goal [for ACERT] was always expansion and now we're starting to see that. We have a new coordinator at the county and now with the social worker in the police department, it allows the coordinator to spread herself out more over the county."

"ACERT is a prevention model...The system often focuses on 'after.' ACERT is after an interaction with police but it's trying to help children before they need those more serious mental and behavioral health services."

- Interviewee

Figure 3. ACERTs, by Implementation Status, 2019 and 2025



Data Source: ACERT TA Center, Amoskeag Health, 2019 and 2025;

*The Winnepesaukee Collaborative includes the following communities: Laconia, Belmont, Meredith, Center Harbor, Gilford, Tilton, and Sanbornton;

**While Somersworth began initial planning for an ACERT in 2019, staff turnover and external factors caused delays. Planning and implementation were picked up in 2025 and continues to move forward.

The main factor supporting this growth was identified as sustained funding sources for ACERT. In some cases, this has included the costs of ACERT being absorbed into municipal budgets or identifying long-term grant funding. Strengthening relationships with community partners, particularly with police departments, were also described as key factors to the growth and evolution of individual ACERT programs. One interviewee shared: "It's definitely evolved...We had a relationship with our local police department before, but it was nothing like it is now – it's very warm and personable. We have a contact at every station in our catchment area." Another interviewee described how strengthening relationships with community partners has supported the sustainability of their community's ACERT: "It has become more systemized... [Community partner] has a role in their organization who is an advocate for ACERT. While that individual has the historic knowledge, it's embedded in their system because she's been training other people and has made that role a role."

While funding has helped with growth for established ACERTs, it has been a barrier to new communities starting and sustaining ACERTs. Funds from the Department of Justice administered through the state has supported initial implementation of ACERTs, but sustained funding for ACERTs has been a long-standing challenge for many. An interviewee associated with the ACERT Technical Assistance (TA) center shared: "We have communities reach out to us in

"Every year, for the past four years, they've introduced legislation about ACERT, and it won't go through. It would make ACERT national which would be amazing. They'll introduce it again, but if it didn't get through under the last administration, it's not going to get through now."

- Interviewee

interest and then ask if we have grant money...but we can't help them and they say 'okay, while we'll do something like that, but we won't call it ACERT.'" Interviewees also expressed concerns about impact on the TA center without a sustained funding source: "If [the ACERT TA center] goes away, communities will continue to reach out to other communities to say, 'how do you do it?' and the assistance will come out in drips and dregs." There have been attempts at the federal and state level to pass legislation to grow and support the ACERT model, but none have been successful to date.

In addition to sustained funding sources, interviewees expressed a desire to see ACERT recognized as an evidence-based best practice. An interviewee involved with their community's ACERT explained the impact of not having an evidence-based model: "There's a question around fidelity to the model. This is where it would be helpful to have guidance. There are times when the social worker has time to meet with a family, but there isn't an officer – is that then not fidelity to the model?" The same interviewee added, "Over time, as resources change, communities are starting to face this question of adapting to less capacity...If ACERT becomes an evidence-based model, it increases revenue and becomes more sustainable." Interviewees associated with the ACERT TA center echoed they too would like to see the model become evidence-based: "I do still dream that we can identify as a best practice. That takes research." However, this would take more funding to support the growth of an evidence base.

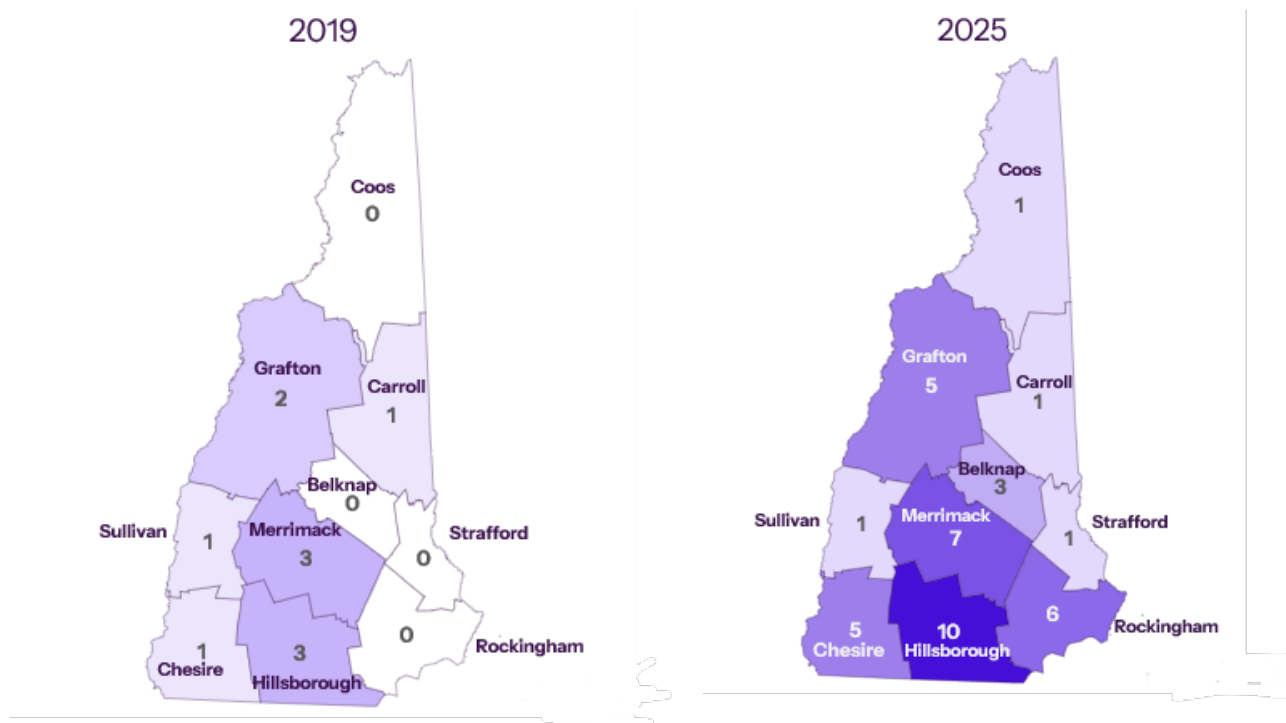
Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is an evidence-based, therapeutic approach aimed at children aged birth through 5 years who have experienced trauma or significant stress. It focuses on strengthening the emotional bond between the child and their caregiver, addressing the impact

of trauma on the child’s development, and promoting healthy emotional and behavioral growth.⁸

At the time of data collection, the Center for Trauma Responsive Practice Change, the CPP trainer in New Hampshire, listed 40 agencies across the state that had at least one CPP rostered provider (Figure 4) and stated they have trained over 150 practitioners.

Figure 4. Number of Agencies with at Least One CPP Rostered Provider, by County, 2019 and 2025



Data Source: Center for Trauma Responsive Practice Change

⁸ The National Child Traumatic Stress Network. (2025). *Child-parent psychotherapy*. <https://www.nctsn.org/interventions/child-parent-psychotherapy>

This was an increase from 11 agencies at the time of the 2019 assessment. During this time, there was also geographical growth in the availability of CPP providers. In the 2019 assessment, six out of ten New Hampshire counties had an agency that could provide CPP. In 2025, all ten counties had at least one agency providing CPP.

This growth has been facilitated by state-backed support, including the ability to pay providers for participating in the training and paying supervisors to provide the required supervision component of becoming CPP rostered. This addresses a challenge that emerged in the 2019-2020 assessment, as many providers named the loss of income as a key barrier to pursuing additional training. The Center for Trauma Responsive Practice Change is also able to provide the continuing education units required for providers to maintain their status and covers the costs associated with an agency offering CPP (e.g., purchasing the toys utilized during sessions).

In addition to increasing the availability of CPP across the state, there have been efforts to increase referral pathways to those providers. The Center for Trauma Responsive Practice Change is leading this effort, working across the ECFMH system to increase awareness of the needs and the available resources:

"[The Center] is training hundreds of folks across systems in early childhood trauma treatment, CPP, and early childhood sexual abuse and training them in how to make referrals...We've created the role of the Engagement Specialist who is a specialist that connects people with CPP. The majority of those connections are made so that the child is seeing a clinician within 30 days."

Interviewees across the system described seeing an increase in the number of families seeking and receiving CPP, as well as an increase in their own ability to connect people. One interviewee shared:

"Families in my program are typically at the level where they would need CPP so we're often making referrals...The Center has been great about – if we're having trouble getting someone connected – helping us. We have good communication with them."

"Building capacity for early childhood mental health supports is certainly better. [The Center for Trauma Responsive Practice Change's] work has definitely increased capacity by having more therapists that are CPP trained."

- Interviewee

This intentional effort to increase the availability and awareness of CPP was described by interviewees as having been one of the most impactful changes to the system since the previous assessment.

Access ECFMH Services

Access has also been improved by increasing and improving the referral pathways to ECFMH services. Interviewees described the 2022 launch of the national 988 line as a key success in this area for New Hampshire. In addition to serving as a suicide and crisis line, 988 in New Hampshire serves as a “Rapid Response Access Point” to connect residents with same-day or next day appointments at community mental health centers: “I do think that 988 being created has been a resource in those moments of crisis and helping to get a referral faster. We’ve seen a really positive impact from that.”

Referral pathways have also been positively impacted by the passage of Senate Bill 444 in 2022, “An Act relative to childhood adverse experiences (ACEs) treatment and prevention.” This legislation created an ACEs prevention and treatment pilot program implemented by the Center for Trauma Responsive Practice Change. The program focused on building the state’s capacity to provide Child-Parent Psychotherapy (CPP). Interviewees described the direct support for the model as having increased access and resulted in more providers becoming trained in CPP.

“SB444 passed and [the Bureau of Children’s Behavioral Health] was tasked with overseeing that CPP workforce expansion that happened... They have used that money as it was intended- to increase and enhance that workforce.”

- Interviewee

Future of the System

Interviewees were asked to reflect on the future of the ECFMH system in New Hampshire, both identifying anticipated challenges facing the system and discussing what their hopes were for the system going forward.

Anticipated Challenges

Interviewees expressed concerns that changes and cuts at the federal level to existing services and social support, particularly upcoming changes to Medicaid, will have dramatic impacts on the ECFMH system in New Hampshire. Relatedly, ongoing cuts to grants that have supported mental and behavioral health services are contributing to concerns that funding for the system will become increasingly sparse and unable to fully meet the needs of children and their families.

Changes at the Federal Level

Across the ECFMH system, interviewees were concerned about the impact of changes to federal support and services for families, such as SNAP benefits and financial support for childcare: “The unravelling of supports and systems for families, social determinants of health [will be a challenge]. The dismantling of those systems will increase family stress.”

These changes to basic needs programs were perceived as exacerbating problems faced by families and potentially leading to increased mental health needs. Participants in this assessment were especially concerned about the impacts of upcoming changes to Medicaid, anticipating that cuts to the health insurance program will have ripple effects throughout the system. At the time of data collection, changes to Medicaid had not yet been implemented, so the potential impacts for families and the ECFMH system were noted as hard to predict and even harder to plan for. Increased medical costs could lead families to make decisions to forgo medical and mental health care in order to meet their basic needs: “Families are really going to struggle with

“Anything that impacts families’ resources and stress is going to have an impact on their mental health.

“I think that there will be increased challenges for families as Medicaid and SNAP cuts come into being. That will place more pressure on their mental health. People will be struggling if the administration’s policies are fully enacted and that will put pressure on the agencies that provide these services because they will have more families with more needs and fewer resources and capacity to support them.”

- Interviewee

Medicaid and having to pay more copays. It will force their challenges to be more severe when they have to make decisions like 'do we go to the doctor and pay a copay or do we buy dinner tonight?'"

Medicaid cuts were also seen as a challenge for the system itself. Interviewees were concerned about the impacts of changing reimbursement rates and service coverage:

"[Medicaid changes] will have a significant impact on any place where we have providers – whether that's mental health centers, federally qualified health centers, even private settings. It's going to be even harder for providers that serve people with Medicaid or who were covered by Medicaid. It's going to end up being either a lot of uncompensated care or people will end up in the emergency room. And neither of those are good options."

Interviewees noted that many of the positive changes that have occurred in the past five years may be undone by these upcoming changes. For example, the increased availability and reach of CPP could end up rolling back due to lowering reimbursement: "CPP clients are largely Medicaid funded. Given that, when that rate changes, that could have impacts for [provider] reimbursement and availability."

Funding Changes

Changes to the funding landscape for ECFMH services and resources also emerged as a key challenge for the future of the system through this assessment. Interviewees raised that the field largely depends on grant funding from the state and federal government, as well as from private funding sources. At the time of data collection, a number of these long-standing federal grants had been cancelled, cut, or were in danger of being so: "We're just on the edge of not knowing if there will be funding for any grant funded projects. It's such a political issue. It's really hard to do the work that we do."

This has turned more of the system to look toward private funders, making these sources increasingly competitive. Even with private sources, interviewees perceived a shrinking funding landscape: "People who supported this early childhood trauma work aren't putting out RFPs anymore. The sell gets harder. I think people still care about little kids, but the case is harder to make."

"With New Hampshire's projected revenue, I don't think we're going to have a lot of funding to support [ECFMH] projects."

- Interviewee

Hopes for the Future

Across interviews, two main hopes for the future of the ECFMH system were named:

- A focus more on prevention and upstream interventions.
- Continued growth in collaboration and integration of services.

Focus on Prevention

Many interviewees, working across the field, described wanting to see the ECFMH system focus more on prevention in coming years. Several described the system as focused more on crisis intervention than on preventing children and families from reaching a crisis point in the first place: “I’d like to get out of this reactive place that we end up being in as child and family serving systems and get to a more proactive place.” They described a focus on prevention as not just helping to prevent children and families from reaching a crisis but as helping to create healthy adults in the future: “We’re being challenged with...focus being more on what is immediately in front of people and what it takes to help people be healthy right now in childhood, instead of what it takes to keep someone healthy.”

“My wildest dream is to put money on the prevention side of things that we know can make a difference. Most of the focus is on downstream but what can we do so people don’t even reach that point?”

- Interviewee

Interviewees echoed the sentiment that focusing on prevention is often seen as less of a priority to focusing on immediate needs: “We have this amazing work we’d like to share around trauma informed care, but all the venues are looking for ‘What are you doing to address lead in your water? What are you doing to improve vaccines?’ not ‘What are you doing to keep people healthy 30 years from now?’” In addition to creating healthier adults, interviewees pointed out that focusing on prevention and lessening the need for crisis services can be a cost saving effort: “If we’re talking monetary, that’s how we’re going to spend the least amount of money – by addressing those things from the get-go.”

Interviewees shared that they’d like to see the system view ECFMH services as something available across the lifespan as a prevention approach. One individual shared:

“My pie-in-the-sky hope for the system is that your child turns three and you have your three-year checkup, you’re assigned a mental health provider. You’re assigned a PCP for your whole life; couldn’t we all benefit from that for mental health?”

Several shared a wish for prevention services to start during the prenatal period and work with expecting parents to “help set them up for success.”

Greater Collaboration and Integration

Interviewees want to see the continued growth in collaboration and integration across the ECFMH system, building on improvements made over the past five years. Of particular note was collaboration between early education and the ECFMH system to better meet children and families where they are: “I would really like to see early education and early behavioral health be more integrated. If we could support families or teachers there, in their school or their home, that would be so helpful. Teachers need support, parents need support.” Schools and teachers were often noted as the places and individuals most directly seeing the impact of children’s mental health challenges and that the ECFMH system needs to do more to support schools and teachers.

“There needs to be a continued increase in the integration of mental health providers in any of the places where people tend to be. Like at colleges, elementary schools, childcare centers – being a staple in those buildings.”

- Interviewee

Conclusion

Findings from this retrospective assessment offer insights into the ECFMH system in New Hampshire and how it has evolved over the past five years, including what challenges have persisted and which have emerged, as well as opportunities for continued evolution and growth.

Growth of the System

Investments in the system, from state, federal, and private sector sources, have had direct impacts on the growth of the ECFMH system over the past five years. Many of these investments were attributed in part to a growing recognition of and the importance of addressing the mental health needs of young children and their families. Assessment participants highlighted the growth of CPP in the state as one of the most impactful changes of the past five years. This growth was facilitated by policy and systems change implemented at the state level. One of these changes was the ability to pay providers to participate in the CPP training, directly addressing challenges that emerged in the initial assessment. This has facilitated more than 150 providers being certified in CPP throughout the state.

Workforce capacity was also improved by lessening credential requirements for entry level positions and increasing training opportunities. Challenges for recruiting and retaining higher level roles, those that require a Masters' degree or higher levels of credentialing, are ongoing. These persistent challenges were largely attributed to low reimbursement rates by assessment participants. There have been attempts to address these rates but none that have had the level of impact participants hoped to see. Opportunities exist to continue advocating for these changes, especially as cuts to Medicaid further exacerbate these challenges.

Importance of Cross-Sector Collaboration

The assessment highlighted the importance of cross-sector collaboration to advance the ECFMH field. The success and growth of the ACERT model is an example of the power of cross-sector collaboration for addressing these issues at a community level. Strong collaborations benefit families as they support navigation of the ECFMH system by creating opportunities for warm handoffs between services, coordination of services, and reduction of systemic barriers.

There have been efforts since the original assessment to build out these collaborations across the system by improving referral networks, particularly for CPP, and increasing the availability of co-located services, such as mental health services within schools or childcare. However, many interviewees agreed that there is more work to be done as silos still exist within the ECFMH

system. There is a need for these collaborations to become more systematized, so they are not dependent upon personal relationships and lost due to staff turnover.

There are opportunities to support further growth in cross-sector collaboration, particularly between the ECFMH system and early education and supports services. While there is interest in this collaboration from both fields, interviewees largely agreed that the capacity of early education is a key barrier. Financial and other support and resources for early education and childcare providers to take on this collaboration were identified as important investments to see this collaboration grow.

Structural Challenges for Families Persist

In the initial assessment, structural barriers, particularly those related to transportation, emerged as a major barrier to children and families accessing ECFMH services. Assessment participants raised that changes to the system over the past five years, such as growth in service availability and referral pathways, have reduced barriers for families related to wait times and access.

Less change has been seen with other structural barriers, particularly around transportation. Assessment participants named transportation as a challenge for many in their communities. Additional challenges around other basic needs, such as access to food and stable, safe housing, emerged as increasing issues for many families across New Hampshire. Assessment participants expressed concerns that these challenges will only be further exacerbated by cuts and changes to state and federal social support programs, particularly SNAP and Medicaid.

In addition to addressing the direct impacts of these challenges by supporting direct services, such as food pantries, there is a recognized need to address the root causes of these issues. That includes advocating for policy and systems changes and further support for initiatives that are working to address poverty, trauma, and other challenges in their communities.

An Eye Toward Prevention

Looking towards the future of the ECFMH system in New Hampshire, a focus on prevention emerged as the key hope from assessment participants. Focusing on prevention and upstream interventions will help to alleviate challenges facing the system today, as it would help to reduce the need for crisis services and alleviate capacity challenges for these services. Assessment participants also raised that a focus on prevention would help to create healthier children, adults, and communities in the future. They perceived that emphasis on addressing immediate needs can be a challenge to increasing support for prevention and upstream interventions. In addition to providing support for these programs, there are opportunities to raise awareness of

the importance and impact of prevention and lifting up the organizations and programs already doing this work.