

The Early Childhood Behavioral & Mental Health Workforce at New Hampshire's Community Mental Health Centers: An Overview

Key Findings

- Despite growing needs among the child population, New Hampshire's regional mental health systems serve only a fraction of children. The youngest children are especially underrepresented in the population served.
- The survey found that, while all respondents worked with young children at least some of the time, fewer than one in five reported working with children under age three.
- Even as racial-ethnic diversity continues to increase in New Hampshire, especially among the child population, the respondents who work with children were over 95 percent white.

Research has found that rates of children's mental, emotional, developmental, or behavioral conditions are higher in New Hampshire than rates nationwide,ⁱ but about half of New Hampshire children diagnosed with those conditions don't receive treatment or counseling.ⁱⁱ One important source of such treatment and counseling is the state's community mental health centers (CMHCs), but the ability to retain professionals in these centers is a reported challenge.ⁱⁱⁱ To better understand the issue, the following brief examines the results from the 2022 New Hampshire Preschool Development Grant's Children's Behavioral and Mental Health Workforce Survey, which focused on the capacity, constraints, and needs of this workforce. While this snapshot is limited to the CMHCs and does not assess all community behavioral health providers, by describing a subset of this population, we aim to inform statewide efforts to fortify the regional mental health systems as a key component of the state's early childhood-serving systems.

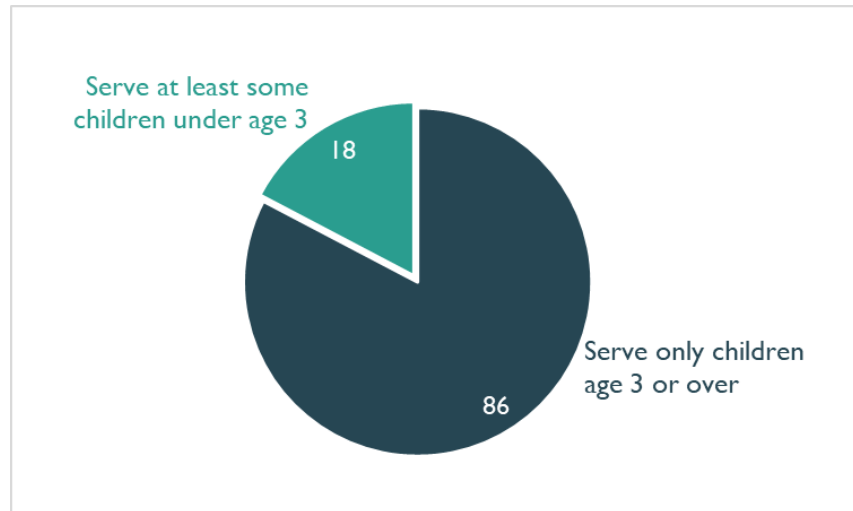
Few respondents focus solely on children under age nine, and even fewer on children under age three

Out of the 105 staff respondents who reported working with children under age nine, only one indicated that at least 80 percent of their work was with this population. Half of staff respondents estimated spending 40 percent or less of their hours working with these children. Directors of children's behavioral and mental health programs concurred about this lack of focus on young children: eight out of nine responding directors reported that ten percent or less of their staff work exclusively with children under nine. All directors who completed the survey reported that this age range constitutes less than a third of the children they serve.^{iv}

Four of nine reported 10-20 percent, three reported 20-30 percent, one reported 5-10 percent, and one did not answer the question.

When staff members were asked about the specific ages of children they serve, almost all respondents (102 of 104) reported working with children ages six through eight, while about half as many reported working with children three through five. However, respondents were substantially more likely to report working with older children than younger children, and most respondents serve no children aged under age three (see Figure 1).

Figure 1. Number of Responding Staff Who Serve Children Under Age Three



Note: Only 104 out of 105 responding staff answered this question.

Source: UNH Carsey School analysis of 2022 NH PDG CBMH Workforce Survey

Respondents have mixed levels of experience, but a share a commitment to New Hampshire

Respondents represented a broad mix of staff experience, with half of the respondents having been in the field for six or more years and half for under six years. Although about one-in-ten respondents have been in the field less than a year, nearly that many reported 20 years or more of experience (Figure 2).

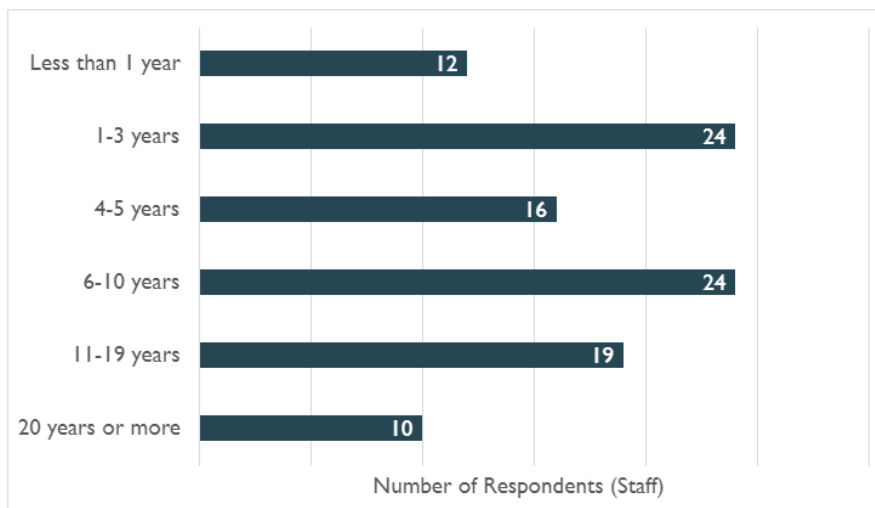


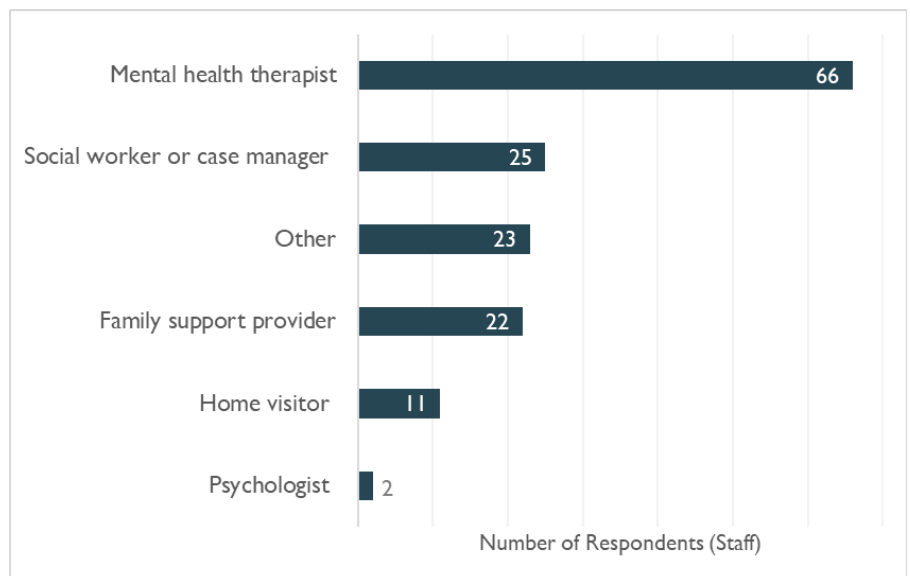
Figure 2. Reported Duration of Staff's Experience in Behavioral and Mental Health Services

Source: UNH Carsey School analysis of 2022 PDG CBMH Workforce Survey

Across levels of experience, respondents demonstrated consistent commitment to New Hampshire, with most respondents having provided services in the state for their entire careers. In addition, respondents have largely spent their careers providing behavioral and mental health services to children specifically: three-quarters reported serving children for as long as they have been in the field. While there is some evidence of career transitions—for instance, one-third reported more years experience in the behavioral health field than in children’s behavioral health—these were relatively rare. There were no differences in the levels of experience across centers in different regions of the state.

The most common staff role among respondents was mental health therapist (66 respondents) (see Figure 3). Eighty respondents, or three-quarters of those who responded, held a single role at their organization, while ten staff members had two roles, and 15 had three or more. Most of those with multiple roles had clinical duties plus management and/or supervisory duties.

Figure 3. Responding Staff’s Reported Roles



Note: Respondents could choose multiple, so categories do not sum to 105. The “other” category includes a wide range of write-in responses such as admissions coordinator, behaviorist, clinical manager, supervisor, and more.

Source: UNH Carsey School analysis of 2022 PDG CBMH Workforce Survey

Half of respondents are working toward licensure

Aligned with their reported staff roles, 68 of the 105 staff respondents had a master’s degree, and several others had a certificate of advanced graduate studies or a doctorate. There were no regional differences in educational attainment within the state.

Two-thirds of staff respondents (69 of the 105) reported holding no license from the state of New Hampshire. However, two-thirds of those without licenses—half of all respondents—indicated they are working to obtain one. Additionally, a small fraction of those who already held at least one license reported they are working toward another. With 22 respondents, the most common license being sought was for the role of Licensed Clinical Mental Health Counselor (LCMHC), which 15 staff members already have.

This pattern of low levels of licensed providers and high levels of licensing-in-progress may partially reflect the policy environment created by differences between private and public health

insurance. While New Hampshire's CMHCs serve roughly equal numbers of Medicaid- and private-pay patients,^v the requirements to treat the two populations are different. Unlike most private insurances, Medicaid allows treatment by unlicensed mental health providers. As a result, new professionals can gain employment as a master's level therapist at a CMHC and accrue the experience and supervision required for licensing. Once licensed, providers are drawn to less stressful, higher-paying positions in private practice organizations. These jobs often come with lower productivity requirements and a lighter administrative burden, leaving a dearth of licensed providers available at CMHCs. This presents a particular challenge for privately-insured patients seeking care at a CMHC since most private insurances require a licensed and credentialed provider for reimbursement. The low availability of these workers may increase wait times for care.

Respondents are mixed in age, but consistent in gender and race-ethnicity

Across both staff and directors, the respondents' average age was 38. More than one-third of respondents were in their 20s, with decreasing numbers of respondents in each subsequent 10-year age group. Most respondents identified as female (106 of the 111 who answered this question) and white alone (104 of 109 who answered). As New Hampshire's child population continues to diversify, it's worth considering strategies to build and retain a more diverse workforce.

Meeting New Hampshire children's needs

Internal system data from the state reveal that 687 children who are both enrolled in Medicaid and under age seven (the age group most comparable to the under nine population relevant to the NH PDG) were evaluated by CMHCs in 2021.^{vi} Consistent with the survey respondents' description of their time spent working with different age groups, fewer than 30 of those children were age three and under, while the remaining 657 were children aged four, five, or six. Altogether, children under age seven made up just 6.5 percent of the more than 10,000 children (under age 18) evaluated by CMHCs in 2021.^{vii}

Statewide, children under age seven make up 35 percent of the child population.^{viii} That only 6.5 percent of children evaluated at CMHCs are under age seven suggests that young children are greatly underrepresented. Although the need for mental health services may differ among younger children, it is likely that some unmet need exists. This unmet need is especially concerning, given the key developmental periods of early childhood.

One possible indication of unmet need is that 12 percent of New Hampshire children under age seven have experienced multiple Adverse Childhood Experiences, or ACEs.^{ix} For children enrolled in Medicaid, that estimated rate is between 50 percent higher and 100 percent higher.^x Further, the 2022 New Hampshire Preschool Development Grant Family Needs Assessment Survey includes a portion of respondents sampled in a way that represents parents of young children statewide. Those data show that at least half of New Hampshire parents have some concern about their child's behavior or development.^{xi} Finally, in state fiscal year 2021, almost 1,000 New Hampshire children under age eight had a founded case of abuse or neglect, 509 of whom were age three or younger.^{xii} Taken together, these insights from mental health professionals,

Box 1. The ACES Treatment and Prevention Act

In June 2022, NH Governor Chris Sununu signed Senate Bill 444-FN, called the “ACES Treatment and Prevention Act.” This law recognizes the impacts of Adverse Childhood Experiences and traumatic stress from birth to age six, and the “critical need for increasing the availability and capacity of social supports and mental health interventions that promote healthy social, emotional development for children who have experienced trauma or are at high risk for experiencing trauma.”

The legislation outlines a series of strategic actions to build workforce capacity in children’s mental health and family support settings, prioritize use of evidence-based practices for supporting young children, and enhance the continuum of care available to young children and their families, including strengthening the state’s prevention infrastructure. Recognizing the higher costs associated with more robust and specialized supports and intervention, the Act calls for an evaluation of the impacts of increasing Medicaid reimbursement for associated evidence-based practices and supporting access to mechanisms for early childhood mental health credentialing.

parents, and state officials provide considerable evidence of a growing need to strengthen the system of care serving young children in New Hampshire by expanding capacity and resources from prevention to intervention.

Less acute needs among younger children may mean fewer clinical services available

Both responding staff and directors made it clear that only a small portion of those served by New Hampshire CMHCs are young children, with children under three being particularly underrepresented. This may be, in part, a result of CMHCs having limited capacity and needing to “triage,” or serve those with the highest needs first. Since younger children tend to have less acute needs, they may end up waiting longer, or indefinitely, for services. In this way, higher staff vacancy rates—a phenomenon discussed in detail in “The Early Childhood Behavioral & Mental Health Workforce at New Hampshire’s Community Mental Health Centers: Staff Vacancies” brief—make it more difficult for staff to specialize in seeing younger children.

The ACES Treatment and Prevention Act (see Box 1)^{xiii} provides critical recognition of the impacts of Adverse Childhood Experiences, and accordingly, bolsters capacity-building and preventive efforts. Fewer than 700 children under age seven were served by CMHCs in 2021, representing less than five percent of Medicaid-enrolled children in that age group. This low figure suggests that services are reaching just a fraction of young children who could benefit from them.^{xiv} Increasing the array of coordinated services available to young children and their families and assuring the availability of developmentally-appropriate assessment, diagnosis, and evidence-based practices are essential actions to take.

However, this legislation alone will not address the service limitations that stem from workforce shortages. Strategies that address overarching workforce capacity issues within the CMHC system must precede real change in community capacity. Strategies such as building a pipeline of workforce development tactics and improving recruitment and retention^{xv} could make a difference, but they require resources. Increasing Medicaid reimbursement rates, for

evidence-based practices, such as Child-Parent Psychology (CPP) (see “Evidence-Based Practices Glossary”), could be one strategy for increasing revenues in CMHCs.

However, these changes don’t occur in a vacuum, and the potential strength of this strategy would need to be considered in a more comprehensive analysis of system costs and reimbursements. The New Hampshire Community Behavioral Health Association has begun some of these analyses, requesting that Governor Sununu’s 2024-2025 biennial budget include an increase to Medicaid reimbursement rates that would allow CMHCs to begin addressing staff shortages and long wait times.^{xvi} To fully address these gaps, a 21.5 to 23 percent increase would be required;^{xvii} the proposed budget includes a 3.1 percent increase,^{xviii} although it still faces revision and approval by the state legislature. Ideally, increasing revenue could expand CMHC capacity to improve staff compensation and, in conjunction with other types of support, play a role in enhancing staff satisfaction, reducing turnover, and fostering a better staffed, more experienced workforce within children’s behavioral health.

Aside from building and supporting the early childhood behavioral and mental health workforce, there are other system-wide opportunities to meet the needs of young children in New Hampshire. Chief among these strategies are efforts to enhance prevention and early intervention services available to young children and their families. One such effort underway is the establishment of the Early Childhood Enhanced Care Coordination program, which aims to enhance the quality and coordination of community-based services available to families and children facing behavioral health challenges.^{xix} Another effort from the ACES Treatment and Prevention Act is additional funding for family resource centers (FRCs) to serve children who have experienced trauma and their families.

The inclusion of funding for FRCs to support young at-risk children and their families is a recognition that addressing the full range of early childhood mental health needs is beyond the capacity of the CMHC system. These efforts require partnerships with community programs working in the realms of prevention, promotion, and family support. Additional strategies for drawing in these programs could include topic-specific staff training and further embedding early childhood mental health consultations into broader home visiting programs that traditionally focus on child development and parent education. In this model, trained and experienced early childhood mental health providers are essential, both for providing direct services to children and families in need and to provide training, support, and consultation to community partners working in non-clinical support and education roles. Although training duties put additional pressure on the behavioral and mental health workforce, strategic investment could help build capacity in the lower levels of the continuum of care and help reduce pressure on higher-level clinical services over time.

Evidence-based practices glossary

Child-Parent Psychology (CPP): “CPP is an intervention model for children aged 0-6 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including post-traumatic stress disorder. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories.”^{xxx}

About the survey

What was the survey? The New Hampshire Preschool Development Grant (PDG) Children’s Behavioral and Mental Health Workforce Survey collected data about employees of the community mental health centers (CMHCs) serving children age eight and under. The goal of the survey was to better understand the capacity and needs of this workforce.

Who was invited? To be eligible to participate in this survey, respondents had to work in a children’s program in one of the state’s CMHCs, and specifically had to either be a director of a children’s program at a CMHC or provide at least some services for children under age eight and their families. A member of the PDG and NH Department of Health and Human Services staff contacted directors of children’s programs at each of the state’s ten CMHCs by email, inviting them to participate in this survey and to disseminate the survey to their staff.

Who participated? One hundred and thirty-two people began the survey; 11 dropped out after reading the consent form,^{xxi} another six did not qualify due to their work only with older children, and one did not continue past the second question. Thus, this brief includes data from 114 respondents—105 staff and nine directors—of children’s behavioral and mental health programs at the state’s CMHCs. Respondents from nine of the state’s 10 CMHCs participated (see Figure 4).

What did participants do? Participants were asked to complete a one-time online survey about their role, expertise, education, and workforce challenges. To inform the early childhood systems work of the Preschool Development Grant, this survey was developed in partnership with the New Hampshire Department of Health and Human Services, the New Hampshire Department of Education, the Preschool Development Grant Leadership team, the UNH Survey Center, and the UNH Carsey School of Public Policy. The survey took a median of eight minutes to complete, and respondents were offered a \$20 Amazon gift card for their participation. Participants were surveyed between April 27 and June 2, 2022.

Are these data representative of this workforce? There is no definitive way to know. Because there is no directory of all young-child-serving employees within the state’s CMHC system, we cannot estimate a response rate to this survey. We attempted a complete census—that is, to gather data from every person in this workforce—although not everyone participated, and those who did might differ from those who did not. Therefore, this brief describes findings as among “respondents” rather than the whole workforce. However, results here can shed light on some of the skills, resources, and needs that are relevant to at least a portion of this workforce.

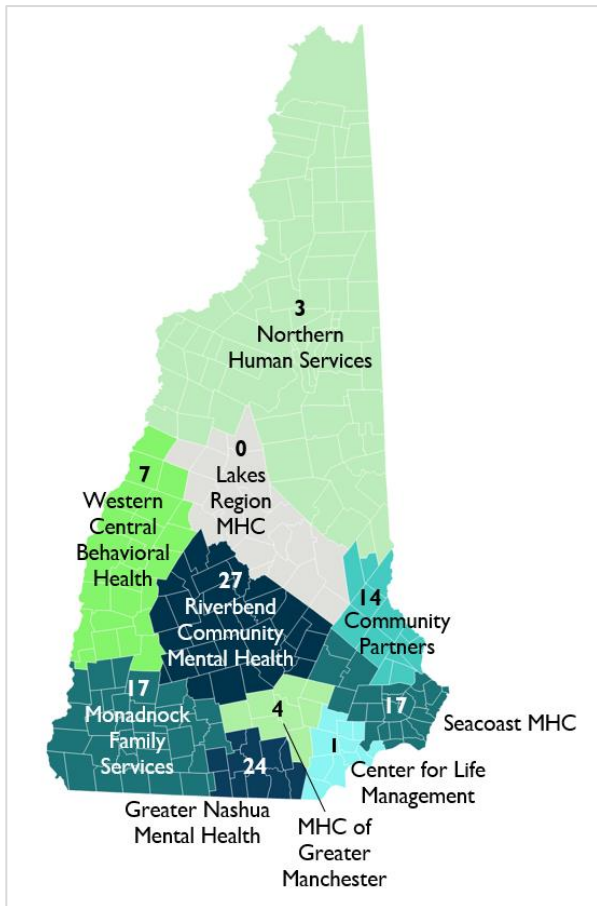


Figure 4. Number of Respondents to the 2022 New Hampshire Preschool Development Grant Children’s Behavioral and Mental Health Workforce Survey, by Mental Health Region

Note: Number of respondents includes staff and directors from each region. Regions are defined by the New Hampshire Department of Health and Human Services.

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This brief is part of a series of work related to the New Hampshire Preschool Development Grant’s 2022 Needs Assessment. Find related work at <https://carsey.unh.edu/center-for-social-policy-in-practice/new-hampshire-preschool-development-grant-project>. For more information on the NH PDG, see <https://chhs.unh.edu/early-childhood/preschool-development-grant>.

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ⁱ Tutko, Holly, Jo Porter, Erik Shessler, Bethany Swanson, Erica-Lyn Plante, and Amy Costello. 2022. “NH Children and Teens Experiencing Mental Health Disorders: An Analysis of 2019 Health Care Claims Data.” Concord, NH: University of New Hampshire. <https://scholars.unh.edu/cgi/viewcontent.cgi?article=1140&context=ihpp>.

ⁱⁱ Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 10/20/22 from <https://www.childhealthdata.org/browse/survey/results?q=8581&r=31>.

ⁱⁱⁱ “Mental Health Centers Deal with Lack of Providers, Staff.” WMUR News. March 21, 2021. <https://www.wmur.com/article/mental-health-centers-deal-with-lack-of-providers-staff/35814784>.

^{iv} One director reported that 10-30 percent of their staff work exclusively with children 0-8 and their families.

^v Kaiser Family Foundation. 2021. “Community Health Center Patients by Payer Source.” 2020 State Health Facts. <https://www.kff.org/other/state-indicator/chc-patients-by-payer-source>.

^{vi} Data were furnished to the Carsey School of Public Policy via the New Hampshire Preschool Development State of New Hampshire Department of Health and Human Services Coordinator. Data are derived from the state’s Phoenix (community mental health system) database. See <https://www.dhhs.nh.gov/reports-regulations-statistics/program-quality-integrity/data-analytics>.

^{vii} Carsey School of Public Policy calculation using data derived from the state’s Phoenix (community mental health system) database. See <https://www.dhhs.nh.gov/reports-regulations-statistics/program-quality-integrity/data-analytics>.

^{viii} Carsey School of Public Policy analysis of U.S. Census Bureau 2021 Population Estimates Program estimates for New Hampshire.

^{ix} Carsey School of Public Policy analysis of 2018-2020 National Survey of Children’s Health. Given the small state-level sample sizes, three years of data were pooled to create an adequate sample for estimation. Survey weights, adjusted for the multiple years of data, were applied in calculating this estimate.

^x Imprecision exists in the multiplier as a result of the margin of error attached to survey-derived estimates.

^{xi} Carsey School of Public Policy analysis of 2022 New Hampshire Preschool Development Grant Family Needs Assessment Survey. Estimates are weighted. Representative portion of the sample is comprised of respondents in the UNH Survey Center’s Granite State Panel.

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- ^{xii} New Hampshire Statewide Automated Child Welfare Information System. 2021. Concord, NH: State of New Hampshire Department of Health and Human Services, Division for Children, Youth, and Families.
- ^{xiii} “An ACT Relative to Childhood Adverse Experiences Treatment and Prevention.” NH Stat § SB 444-FN. (2022). https://gencourt.state.nh.us/bill_status/legacy/bs2016/billText.aspx?sy=2022&id=2133&txtFormat=html.
- ^{xiv} Estimates of the number of Medicaid enrolled children in this age group derived from Carsey School of Public Policy analysis of 2018-2020 National Survey of Children’s Health. Estimates are weighted.
- ^{xv} Endowment for Health. 2022. “Giving Care: A Strategic Plan to Expand and Support New Hampshire’s Health Care Workforce.” <https://endowment-assets.nyc3.digitaloceanspaces.com/images/Giving-Care-A-Strategic-Plan-to-Expand-Support-NHs-Health-Care-Workforce.pdf>.
- ^{xvi} Timmins, Annmarie. 2023. “‘System is Broken’: Mental Health Centers Seek \$30 Million to Add Workers, Bolster Treatment.” February 1, 2023. *New Hampshire Bulletin*. <https://newhampshirebulletin.com/2023/02/01/system-is-broken-mental-health-centers-seek-30-million-to-add-workers-bolster-treatment/>.
- ^{xvii} Ibid.
- ^{xviii} Timmins, Annmarie and Ethan Dewitt. 2023. “Pay Hikes, School Funding, Licensing Reform Highlight Sununu Budget Address.” February 15, 2023. *New Hampshire Bulletin*. <https://newhampshirebulletin.com/2023/02/15/pay-hikes-school-funding-licensing-reform-highlight-sununu-spending-plan/>.
- ^{xix} New Hampshire Department of State. 2022. “Governor & Executive Council Agenda, June 29, 2022.” <https://sos.nh.gov/media/bklh3moe/021-gc-agenda-06292022.pdf>. New Hampshire Department of State. 2022. “Governor & Executive Council Agenda, August 17, 2022.” <https://sos.nh.gov/media/kffizvtl/016-gc-agenda-08172022.pdf>.
- ^{xx} The National Child Traumatic Stress Network. 2022. “Child-Parent Psychotherapy.” Los Angeles, CA / Durham, NC: University of California, Los-Angeles / Duke University, National Center for Child Traumatic Stress <https://www.nctsn.org/interventions/child-parent-psychotherapy>.
- ^{xxi} In survey research, a consent form provides potential participants with written information about the proposed research to inform their decision to participate in the research study based on what participation would entail, the goals of the study, and any risks or benefits they might expect.