

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

Key Findings

- As a result of program capacity and staff training needs, New Hampshire's community mental health centers are limited in their ability to meet the needs of young children with social-emotional and behavioral concerns.
- Respondents to this survey who work with young children in community mental health centers may not have the training and tools needed for appropriate diagnosis and effective intervention.
- Strategic support for training and investments that align with the state's Children's Behavioral Health System of Care, including provisions from recent legislation, could have positive impacts for New Hampshire's young children and their families.

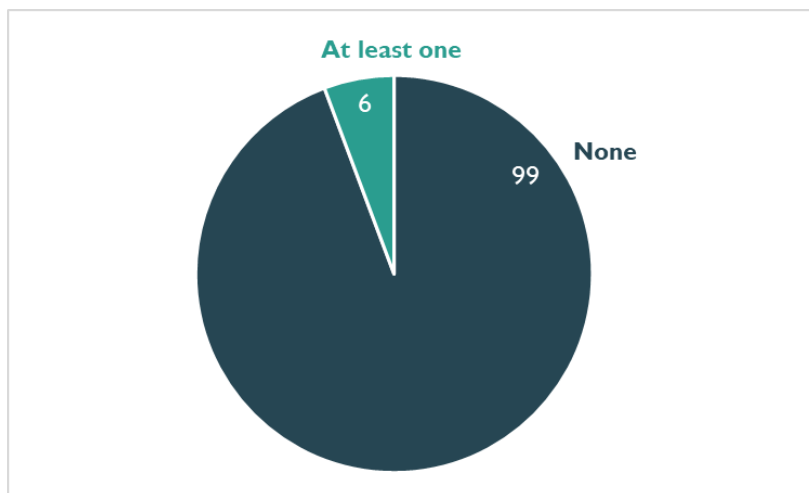
With increasing recognition of young children's mental health needs comes a corresponding urgency to support this population's providers with the right tools and skillsets. Part of the workforce supporting this population is the staff of children's programs at New Hampshire's community mental health centers (CMHCs). The following brief draws from the 2022 New Hampshire Preschool Development Grant's Children's Behavioral and Mental Health Workforce Survey to explore participants' responses around existing areas of strength, as well as places where additional investment in training could support effective diagnosis and treatment of the youngest Granite Staters. While this snapshot is limited to the state's CMHCs and therefore does not assess all community behavioral health providers, by describing a subset of these providers, we aim to inform statewide efforts to fortify the children's behavioral health system of care as a key component of the state's early childhood-serving systems.

Early childhood certifications, credentials, and endorsements among survey respondents

To get an initial understanding of the workforce's strengths and capacities in the area, CMHC staff were asked to describe their experience with a set of early childhood mental health-focused certificates, credentials, and endorsements. Specifically, survey respondents were asked about their experience with: (1) post-graduate early childhood mental health certificate programs, (2) early childhood mental health consultant certificate programs, (3) New Hampshire's Early Childhood and Family Mental Health Credential, and (4) early childhood professional development specialist credentials within New Hampshire's Early Childhood Development Professional System. Although these credentials represent the most common and

accessible endorsements available for mental health professionals serving young children, only six respondents had an early childhood credential, while the remaining 99 respondents reported none (see Figure 1).

Figure 1. Respondents Holding Early Childhood Mental Health -Specific Certificates, Credentials or Endorsements



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

Building workforce capacity by increasing the number of people holding these credentials will likely become increasingly important statewide in the coming years: effective July 1, 2022, the state enacted new legislation (the “ACEs Treatment and Prevention Act”; see Box 1)ⁱ that encourages the Children’s Behavioral Health System of Care to focus on mitigating the impacts of and preventing adverse childhood experiences for New Hampshire children. The law specifically aims to evaluate the benefits of elevating these kinds of early childhood and family mental health credentials by considering requirements for certain providers or increasing compensation or insurance reimbursement rates for those with credentials.ⁱⁱ

Growing capacity for assessment and diagnosis

In 2022, the State of New Hampshire’s Department of Health and Human Services’ Bureau for Children’s Behavioral Health launched the statewide Enhanced Care Coordination program to support young children and their caregivers with developmentally appropriate assessment, diagnosis, and treatment.ⁱⁱⁱ One related tool is the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5), the only diagnostic system specifically developed for use with young children. Less than 60 percent of respondents to this survey had heard of the DC: 0-5, although the share increased to nearly 70 percent among those respondents who report working at least sometimes with children under age five. Of those who had heard of the tool, 30 percent (18 people) reported using it, most of whom (14) had been trained in its use. An additional seven people expressed an interest in receiving DC: 0-5 training.

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.”

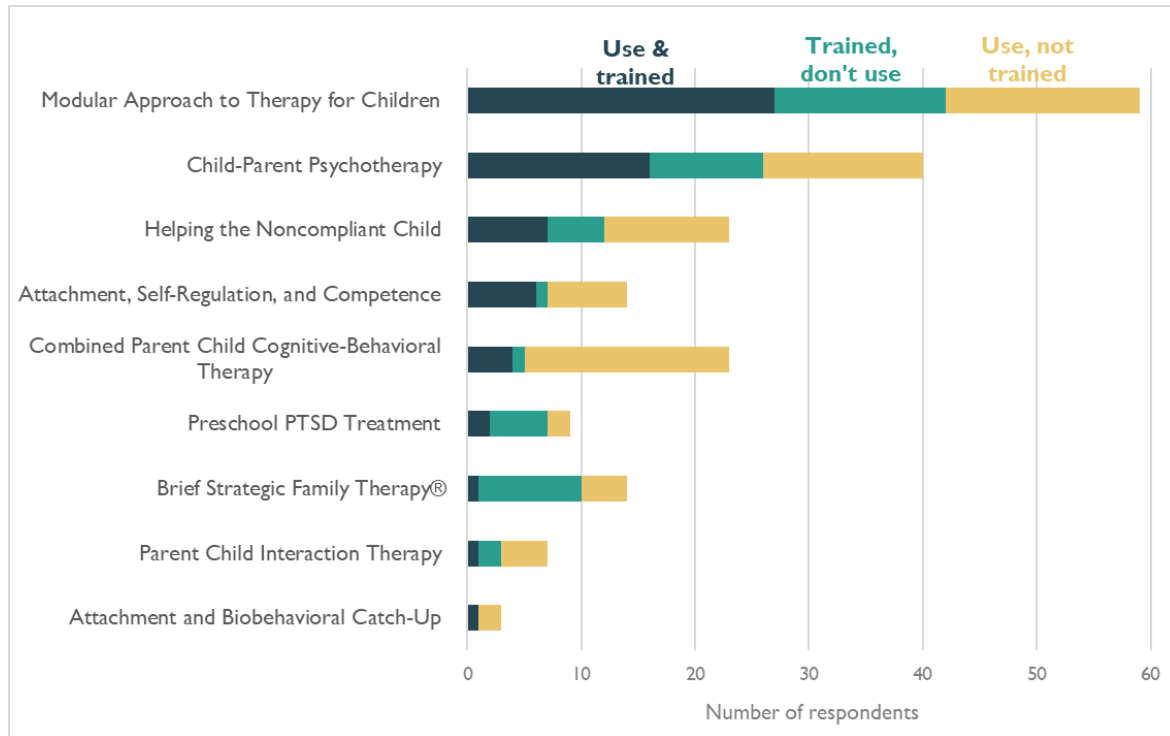
The legislation outlines a series of strategic actions to build workforce capacity in children’s mental health and family support settings, prioritize use of evidence-based practices for supporting young children, and enhance the continuum of care available to young children and their families, including 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.

While the DC: 0-5 is the recognized gold standard for mental health assessment and diagnosis of children under six, there have been barriers to its broad utilization in New Hampshire. Most significantly, the state’s insurance reimbursement system does not recognize DC: 0-5 codes and instead requires the use of existing diagnostic codes for billing purposes, which were developed for adult use.^{iv} While there is a key for translating codes across systems, using the DC: 0-5 assessment process for diagnosis and treatment plus the DSM-V or ICD-10 assessment for billing purposes takes time and contributes to the high administrative burden on an already strained workforce. A second barrier is that undertaking an optional training, like for DC: 0-5 use, is difficult in a productivity-driven environment and can add job stress. By requiring planning for reimbursement differentials, the ACES Prevention and Treatment Act can offer an opportunity to address these barriers.

Respondents report using a wide variety of intervention models

By far, the evidence-based psychotherapy model that respondents were most likely to be trained in was the Modular Approach to Therapy for Children (MATCH) (see Figure 2, and “Evidence-Based Practices Glossary” for more details). About two in three respondents who were trained in MATCH utilized the model in their current position, and just as many reported using MATCH without being trained in it (17 respondents). After MATCH, the second highest number of respondents reported using Child-Parent Psychotherapy (CPP), a model designed for children under six who have experienced trauma or “are experiencing mental health, attachment, or behavioral problems.”^v CPP is specifically prioritized in the ACES Prevention and Treatment Act, as unresolved traumatic experiences elevate children’s risk for mental health, social, and academic concerns.^{vi}

Figure 2. Use Of, and Training In, Different Psychotherapy Models Among Survey Respondents



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

The high prevalence of engagement with MATCH demonstrates that the Children’s Behavioral Health Bureau’s recent efforts to support and promote widespread implementation of this model within the CMHCs were successful.^{vii} Further effects from statewide investments in CPP^{viii} can be seen in the high reports of use and training among respondents here, which corresponds with state records. For instance, a statewide CPP database catalogs 150 CPP-trained mental health clinicians, half of whom (75) are employed at CMHCs, including every CMHC in the state.^{ix} While investments in training are important, it should also be noted that the pathway of referral, diagnosis, assessment, and treatment depends on a workforce that is not just well trained, but also adequately staffed. In addition, prior research shows that implementing evidence-based practices in CMHCs can be expensive, and the administration intense.^x A 2020 assessment of New Hampshire’s early childhood and family mental health workforce suggests that barriers to implementing evidence-based models in the Granite State are similar to those nationwide, including the cost of program-related materials, the infrastructure required for training, implementation, monitoring, and the fact that training time is often non-reimbursable.^{xi} Additional assessments of the feasibility of implementing certain models in specific settings continue statewide, but administration and training costs are durable challenges.

Interest in expanding credentials is higher among respondents newer to the field

Respondents showed openness to continued learning, a finding that bodes well for the ACEs Prevention and Treatment Act’s goals of elevating early childhood mental health credentials in the state. Just under half of respondents (47 of 105) indicated interest in eventually obtaining an

early childhood certification. The Intermediate or Advanced Early Childhood and Family Mental Health Credential and early childhood mental health consultant certification each garnered interest from more than 30 respondents. Importantly, the group most interested in new credentials were respondents who were newest to the field (see Figure 3). As specialty certifications and credentials indicate capacity to provide specialized training and consultation, the considerable interest levels among newer-to-the-field respondents suggests the state may be able to build out longer-term capacity in this area.

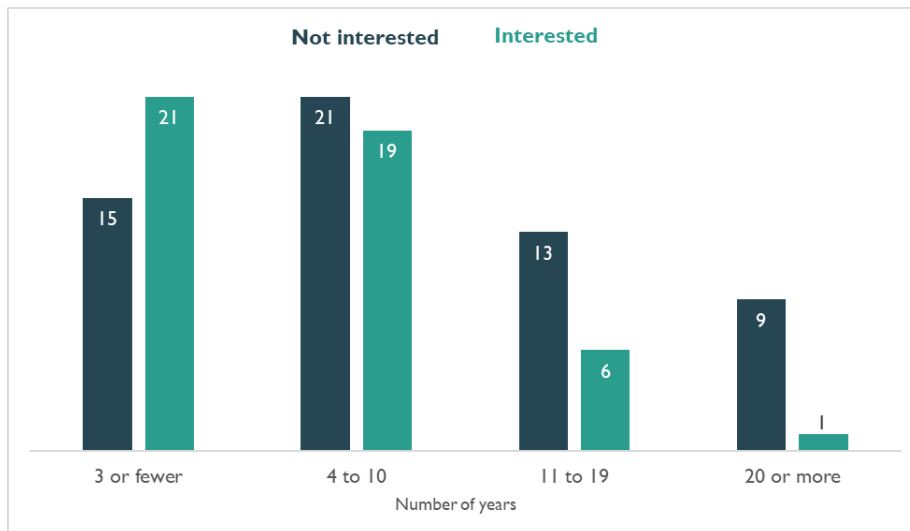


Figure 3. Number of Respondents Interested in Obtaining Early Childhood Credentials, Certificates, or Endorsements, By Length of Time in Field

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

Training in specific models may still be needed

Results from this survey indicate there may be some significant gaps between model usage and training. More than half of respondents who report using a specific psychotherapy model in their work have no training or certification in that model.

In general, respondents' interest in being trained in specific models strongly correlates with the (non)use of those models: respondents want training in tools that they are not (yet) using. For instance, five or fewer respondents reported using Preschool PTSD Treatment or Parent-Child Interaction Therapy, but 49 respondents expressed interest in being trained in each of these models. Conversely, the fewest number of respondents (only 17) were interested in MATCH training. This suggests that MATCH may be among the best distributed trainings in this sample, likely due to the high level of investment in this model's training by the state's Bureau for Children's Behavioral Health and CMHCs. For those in need of greater training supports, the state's recently-established Children's Behavioral Health Resource Center supported by University of New Hampshire's Institute on Disability will be an excellent resource for learning specific evidence-based practices, finding information on how to pursue training, or getting other technical assistance.^{xii}

Balancing need for training with time pressures of an understaffed workforce

Respondents identified the pressure of enhancing professional skillsets while managing existing required workloads as a challenge. Perpetual workforce shortages exacerbate the time crunch,

with one participant noting, “It is difficult to complete trainings before being thrown into the role of therapist...there is not enough time [before] we are needed to start seeing clients.”

Staff report challenges in balancing important professional development with the productivity expectations related to their standard duties. One person explained, “It would be great to get credit for attending trainings, [as] it can really mark down productivity when you have to miss a few days of clinical work.”

Finally, it is important to acknowledge that these time pressures are compounded for respondents who not only serve children and families, but are themselves parents, with one respondent noting: “As a working parent finding the time for secondary [education] and affiliated trainings/[certifications] [are] difficult to achieve.”

Legislation offers significant opportunities, but more workforce supports may be needed

The ACEs Prevention and Treatment Act lays out some significant steps toward strengthening access to, and the quality of, services for trauma-impacted children. By building out the infrastructure around workforce capacity, the continued adoption of evidence-based practices, attention to reimbursement structures, and efforts to strengthen the continuum of care, this legislation may help to meet some of the challenges facing New Hampshire’s young children and the systems that serve them. There is also potential for strengthening capacity within children’s behavioral health system of care to inform the approaches of other child- and family-serving settings—including early intervention, child care, and Family Resource Centers—in growing their own prevention-focused efforts. None of these identified opportunities are new, and in fact, the New Hampshire Children’s Behavioral Health Workforce Development Network has written extensively and compellingly about the importance of “concentrating professional development resources within a System of Care framework” as a pathway to improving service delivery and strengthening the workforce.^{xiii}

Yet challenges remain for the children’s behavioral and mental health workforce, currently staffed by professionals who navigate intensive caseloads, difficult work, and uneven compensation. CMHCs may need support in securing professionals qualified to deliver the evidence-based practices that are prioritized by the state’s new legislation. Training staff from community programs and bolstering the well-trained, qualified early childhood mental health workforce so they are capable of meeting children’s and families’ needs will require commitment, resources, and a long-term plan that balances existing workloads with new expectations.

Evidence-based practices glossary

Attachment and Bio-behavioral Catch Up (ABC): For children birth to 24 months, ABC “is a parent/child treatment approach designed to help caregivers provide nurturing care and engage in synchronous interactions with their infants. ABC helps caregivers re-interpret children’s behavioral signals so that they can provide nurturance through parent coaching sessions. It was developed primarily for use with low-income African-American, Hispanic, and

non-Hispanic White families who have experienced neglect, physical abuse, domestic violence, and placement instability.”^{xiv}

Attachment, Self-Regulation, and Competence (ARC): For children ages 2 to 21, ARC “is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency. Designed to be applied flexibly across child- and family-serving systems, ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers.”^{xv}

Brief Strategic Family Therapy® (BSFT®): BSFT “uses a structured family-systems approach to treat families with youth (6 to 18 years) who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency.”^{xvi}

Child-Parent Psychotherapy (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 posttraumatic stress disorder. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories.”^{xvii}

Combined Parent Child Cognitive-Behavioral Therapy (CPC-CBT) for Children and Families At-Risk for Child Physical Abuse: This is a short-term “strengths-based therapy program for children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies. These families can include those who have been substantiated for physical abuse, those who have had multiple unsubstantiated referrals, and those who fear they may lose control with their child. Children may present with PTSD symptoms, depression, externalizing behaviors and a host of difficulties that are targeted within CPC-CBT.”^{xviii}

Helping the Noncompliant Child (HNC): HNC “is a skills-training program aimed at teaching parents how to obtain compliance in their children ages 3 to 8 years old. The goal is to improve parent-child interactions in order to reduce the escalation of problems into more serious disorders (e.g., conduct disorder, juvenile delinquency). The program is based on the theoretical assumption that noncompliance in children is a keystone behavior for the development of conduct problems; and that faulty parent-child interactions play a significant part in the development and maintenance of these problems.”^{xix}

Modular Approach to Therapy for Children (MATCH): Designed for children ages 6-17, MATCH is “an evidence-based treatment designed for multiple disorders, rather than focusing on a single disorder. Therapists trained in this approach can treat over 70% of typical symptoms. Families also benefit from a better understanding of their child’s challenges and tools to help.”^{xx}

Parent Child Interaction Therapy (PCIT): PCIT “is an evidence-based treatment program designed for caregivers and their young children (2 to 7 years old) who are experiencing social, behavioral, and/or emotional difficulties...integrating components of social learning theory,

attachment theory, developmental theory, behavioral principles, and traditional play therapy. The goal of PCIT is to improve the quality of the parent-child relationship by helping caregivers adopt an authoritative parenting style.”^{xxi}

Preschool PTSD Treatment (PPT): Targeted to children ages 3 to 6, PPT is a “cognitive-behavioral therapy protocol to treat very young children with posttraumatic stress disorder (PTSD) and trauma-related symptoms. The sessions are either with the therapist working individually with the child (with the parent observing via a video feed) or with the parent and child together.”^{xxii}

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 ages 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 this survey; 11 dropped out after reading the consent form,^{xxiii} another six did not qualify due to their work only with older children, and one did not continue past the second question. Thus, this series of snapshots includes data from 114 respondents—105 staff and nine directors—of children’s behavioral and mental health programs at the state’s CMHCs, although this particular brief uses only staff responses. 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.

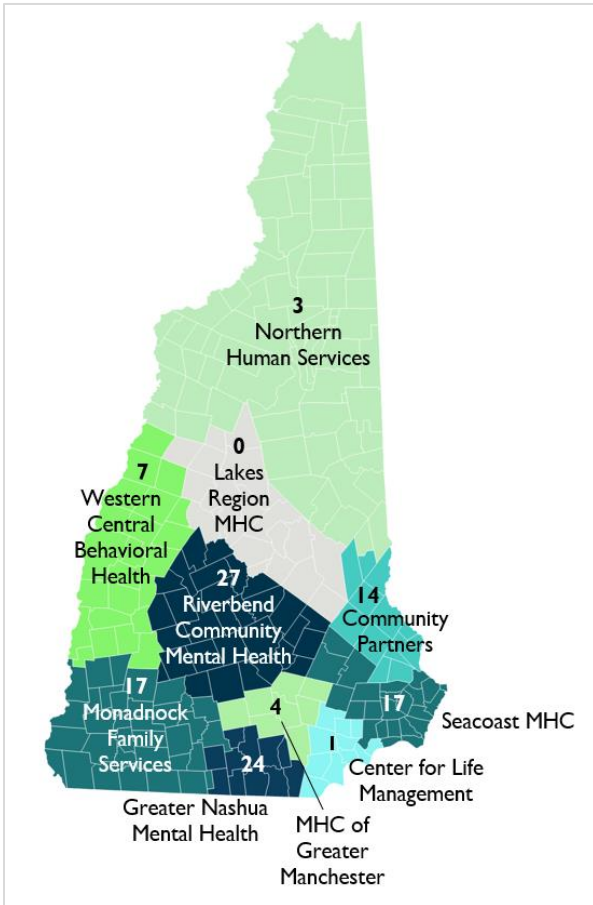


Figure 4. Number of Respondents to the 2022 New Hampshire Preschool Development Grant Children’s Behavioral and Mental Health Workforce Survey, by Mental Health Region

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

About the Authors

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ⁱ “An ACT Relative to Childhood Adverse Experiences Treatment and Prevention.” NH Stat § SB 444-FN. (2022). https://encourt.state.nh.us/bill_status/legacy/bs2016/billText.aspx?sy=2022&id=2133&txtFormat=html.

ⁱⁱ Ibid.

ⁱⁱⁱ 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>.

^{iv} Existing codes include those from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, or DSM-5-TR, or International Classification of Diseases, Tenth Revision, Clinical Modification, or ICD-10-CM. This challenge is not unusual; see, for instance, Child Health and Development Institute. 2020. “Ensuring Young Children Receive Mental Health Services: Barriers to Billing and Proposed Solutions.” *Issue Brief 73*. Farmington, CT: Child Health and Development Institute. <https://www.chdi.org/publications/issue-briefs/issue-brief-73-ensuring-young-children-receive-mental-health-services>.

^v It is worth noting that by investing in CPP, appropriate for children ages birth to six, and MATCH, appropriate for children ages six through 15, the state is demonstrating a commitment to children’s mental health from infancy through adolescence.

^{vi} Centers for Disease Control and Prevention. 2019. “Adverse Childhood Experiences.” *Vital Signs, November 2019*. <https://www.cdc.gov/vitalsigns/aces/index.html>.

^{vii} New Hampshire Department of State. 2022. “Governor & Executive Council Agenda, January 23, 2019.” <https://sos.nh.gov/media/uxtla0pu/021-gc-agenda-012319.pdf>.

^{viii} “A transformative therapy model helps parents and children Heal.” <https://nhchildrenshealthfoundation.org/a-transformative-therapy-model-helps-parents-and-children-heal/>

^{ix} Data are derived from the New Hampshire CPP Provider Network, housed under the non-profit Center for Trauma-Responsive Practice Change. The Center’s national trainer is required to record data about providers who undertake and complete this training, but has extended beyond required efforts to create the New Hampshire CPP Provider Network. The network manager keeps current records on who practices and where for the purpose of fielding referrals and offering ongoing consultation to providers. Data obtained via email communication with Preschool Development Grant Department of Health and Human Services Coordinator, the NH CPP Network Manager, and the Director of the Center for Trauma-Responsive Practice Change, September 27, 2022 and January 18, 2023.

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- ^{xii} Institute on Disability. 2021. "IOD to Lead Development of New Children's Behavioral Health Resource Center." Durham, NH: University of New Hampshire. <https://iod.unh.edu/blog/2021/11/iod-lead-development-new-childrens-behavioral-health-resource-center>.
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- ^{xviii} "Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT). 2022. The California Evidence-Based Clearinghouse for Child Welfare. <https://www.cebc4cw.org/program/combined-parent-child-cognitive-behavioral-therapy-cpc-cbt/>.
- ^{xix} "Helping the Noncompliant Child (HNC)." 2022. The California Evidence-Based Clearinghouse for Child Welfare. <https://cebc4cw.org/program/helping-the-noncompliant-child/detailed>.
- ^{xx} Center for Effective Therapy. 2022. "MATCH". The Baker Center for Children and Families. <https://www.bakercenter.org/programs/children-and-families/center-for-effective-child-therapy/types-of-treatment/match>.
- ^{xxi} "What is PCIT? Parent Child Interaction Therapy." 2022. <https://www.parentchildinteractiontherapy.com/what-is-pcit>.
- ^{xxii} "Preschool PTSD Treatment (PPT)." 2022. The California Evidence-Based Clearinghouse for Child Welfare. <https://www.cebc4cw.org/program/preschool-ptsd-treatment/>.
- ^{xxiii} 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.