Coös Coalition Behavioral Tactical Team

Early Childhood Behavioral Health Needs Assessment

August 2025

Coös Coalition for Young Children and Families

Behavioral Health Improvement Institute | Keene State College

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Background

Young children & families' behavioral health needs

Coös County families with young children (birth through eight) with behavioral health concerns lack access to adequate supports and services to effectively address their needs and bolster protective factors. Access to clinical behavioral health services is limited by workforce shortages, lengthy wait times, stigma around mental health treatment, lack of knowledge about how to navigate behavioral health systems, and access issues such as transportation, child care, and other structural barriers. Early care and education programs are often too under-resourced and under-staffed to comprehensively address significant behavioral health challenges. Community-based, accessible supports are either insufficient, poorly matched to children and families' needs, or families are unaware of or have trouble accessing such supports.

Coös Coalition for Young Children and Families

The Coös Coalition for Young Children and Families (the Coalition) works to build a sustainable system of supports for families and children birth through eight that centers family experience and encourages positive social, physical, emotional, and cognitive growth for optimal child development. Its partners collaborate to provide coordinated services in support of shared outcomes.

Recognizing the strain on clinical behavioral health services in the region, the Coalition's Behavioral Health Tactical Team adopted a strategic focus on expanding non-clinical supports and services within the region. The team engaged the Behavioral Health Improvement Institute (BHII) at Keene State College in March 2025 to inform this effort with meaningful data and support the team's facilitation and planning efforts.

Definition of "non-clinical supports"

Non-clinical community supports include providers, programs, and resources that offer prevention, education, and access support to families with young children that are struggling with behavioral health concerns. Non-clinical supports can be provided by trained organizations, groups, peers, or other individuals with or without clinical behavioral certifications or licensure, including paid or volunteer community leaders, educators, peer support specialists, community health workers, and other para-professional roles. Supports are lower cost or free and can include a focus on:

1. Bolstering children and families' protective factors for behavioral health;
2. Educating families about behavioral health systems and resources;
3. Connecting families to needed behavioral health services;
4. Enhancing families' coping and problem-solving skills; and
5. Streamlining referrals and reducing access barriers.

Non-clinical supports can also include universal and tiered prevention systems implemented in preschool and other early care and education settings (e.g., Conscious Discipline, Pyramid Model, MTSS).

Methodology

Guiding evaluation questions

In supporting the needs of young children with behavioral health concerns in the Coös County region:

1. What are the most pressing needs of families/caregivers and early care and education (ECE) providers?
2. What non-clinical supports are currently available for families/caregivers and ECE providers?
3. Which of these supports are families/caregivers and ECE providers able to access/currently accessing?
4. How helpful have these supports been?
5. What non-clinical resources are missing or would better support families/caregivers and ECE providers?

Methods

From May to June 2025, BHII collected data from families, support workers, and early care and education providers throughout the region using the following methods:

Interviews of non-clinical, community-based support providers

Nine key informants participated in eight, 45-minute interviews. All interviews were conducted during business hours over Zoom.

Focus group of family members/caregivers

Two key informants attended a 60-minute focus group for family members/caregivers of young children (0-8) with behavioral health concerns. The focus group was conducted in the evening over Zoom by two BHII staff members: one facilitator and one notetaker. Participants were given a $25 gift card incentive.

Focus group of ECE providers

Nine key informants attended a 60-minute focus group for administrators and teachers with experience working with children with behavioral health concerns. The focus group was conducted during business hours over Zoom by two BHII staff members: one facilitator and one notetaker. Participants were given a $25 gift card incentive.

Method	Role	#	Affiliation
Interview	Community-based support provider	1	NH Association of Infant Mental Health
		2	North Country Peer Support Center
		2	Community Builders Hub
		1	Family Resource Center of Northern NH
		1	Coos County Director Network
		1	NFI North
		1	Boys and Girls Club of Central and Northern NH
Focus group	Family caregiver	2	
Focus group	ECE provider	1	Mini Mounties Preschool
		1	North Country Health Consortium
		1	Boys and Girls Club
		3	Tri-County CAP Head Start
		1	Berlin School District
		2	Gorham Community Learning Center

Findings

Young children and their families increasingly need support for self-regulation

Caregivers continue to grapple with the aftereffects of COVID-19, including greater isolation, fewer natural supports, and limited knowledge as they manage their young children's behavioral health challenges. Providers of infant and early childhood mental health services report that children often present as developmentally younger than their chronological age, with widespread behavioral dysregulation across settings. This trend is more pronounced than it was pre-COVID. Caregivers echo this shift, expressing confusion over behaviors they don't recognize from their own childhoods with sentiments like, "I didn't behave this way when I was a kid." These patterns reflect the ongoing rise in anxiety and emotional dysregulation since the pandemic disrupted early care and education.

Access to clinical services is limited

Many caregivers are unaware of available clinical resources; one provider estimated only 25-33% of children and families receive the help they need. Among those who are aware, access is often blocked by stigma, scheduling constraints, and lack of financial or transportation support. These barriers disproportionately affect families with the greatest need, where caregivers who struggle to adequately feed and house their young children struggle to proactively attend to complex behavioral health challenges. Promising practices to mitigate these barriers exist, such as Child-Parent Psychotherapy providers who expedite the referral pathway for high-need families involved in Wraparound and DCYF.

Early childhood policies are outdated and unrealistic

Early childhood policies have not kept pace with rising developmental delays, leaving current teacher-student ratio requirements inadequate for effective classroom management. Children who struggle with self-regulation often benefit from one-on-one support, yet paraprofessionals are in short supply. Current outcome measures still utilize developmental norms that no longer reflect the social-emotional and behavioral realities seen across the early childhood population, not just those with the highest needs.

Families need validation, connection, and natural supports

Many caregivers who raise children with behavioral health needs experience isolation, shame, and stigma. They often lack time for self-care and need opportunities for respite. They would benefit from physical spaces where their children can engage in play-based activities while they connect with others facing similar challenges. These peer connections may normalize struggles, offer guidance for navigating complex systems of care, and provide hope, connection, and belonging.

A range of non-clinical supports and services are available

While clinical services often have four- to five-month waitlists, non-clinical supports and services are generally available more quickly. Most are offered outside of school hours and serve children (e.g., social-emotional learning and other behavioral health education), caregivers (e.g., socialization and support groups, training), and families (e.g., case coordination and management, resource navigation, wraparound support, home visiting). Though more accessible, these services are often insufficient in both scale and duration. Notable gaps include medication assistance and programming for fathers.

Caregivers experience challenges transitioning to school-based services

While parents praise the accessibility of early intervention services, many caregivers feel excluded from the IEP process once their children enter kindergarten, despite their deep knowledge of their child's needs. Others struggle to advocate when their views don't align with the district's, often describing the experience as being in constant "fight mode." This prolonged stress, often without adequate support, can take a toll on their employment, finances, and overall wellbeing. Once clinical services begin, parents often feel sidelined rather than engaged as partners in their child's growth. Some families face greater difficulty than others ensuring coordination between in-school and community-based services. Caregivers would benefit from greater access to advocacy and peer support throughout their child's public school journey.

Providers and caregivers would benefit from training and coaching

Caregivers need support developing effective coping and disciplinary strategies through updated education and skill development to meet their child's needs. Some caregivers resist feedback, expressing a "don't tell me what's wrong" mindset, which can leave them unprepared for their children's behavioral health challenges and providers struggling to offer effective support. Providers hope to offer evidence-based principles such as applied behavior analysis, self-reflection techniques, and child development education in a supportive, accepting, and approachable setting. Informal parent mentoring and coaching during structured playtime settings is one suggested way to build these skills.

Meanwhile, providers face escalating child needs, often linked to increased exposure to trauma and DCYF involvement, without adequate support. They would benefit from learning strategies to manage and prevent disruptive behavior through tailored training and coaching. While models such as Conscious Discipline exist, they remain underused. Buy-in can be improved through stronger leadership support, data illustrating clear need, blame-free environments, integration into administrative time, and piloting with champions.