



Implementing IECMH Services within the Certified Community Behavioral Health Clinic: A Companion to the Certification Criteria



ZERO to THREE
Early connections last a lifetime

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Purpose

The aim of this document is to support Certified Community Behavioral Health Center (CCBHC) leadership capacity to provide services to individuals and integrate person- and family-centered services by incorporating infant and early childhood mental health services (IECMH) into the existing clinic infrastructure.

The document aligns with the “Substance Abuse and Mental Health Services Administration. Certified Community Behavioral Health Center (CCBHC) Certification Criteria. Published February 2023. Accessed August 2025, at Certified Community Behavioral Health Clinics (CCBHCs)|SAMHSA”. ([Certified Community Behavioral Health Clinic \(CCBHC\) Certification Criteria Updated March 2023](#)). It is structured around the six Key Program Requirements for certification: staffing, availability of services, care coordination, scope of service, quality and other reporting, and organizational authority and governance, and provides recommendations for how IECMH principles, services, and supports can be incorporated.

Background

The prenatal to age five (P–5) period is a critical window for children’s emotional, cognitive, and social development. During these foundational years, secure attachments, nurturing environments, and responsive caregiving are essential to healthy development and IECMH. Because infants and young children rely heavily on their caregivers, IECMH is closely tied to the well-being of those caregivers. Beginning in the prenatal period, caregivers’ mental and physical health directly affect the children in their care. Proactive mental health support — such as therapy referrals during pregnancy and integrated prenatal care — can strengthen caregiver resilience and promote child well-being. A comprehensive CCBHC supports the mental health of the entire family by offering IECMH services across the [full continuum](#) — from promotion to treatment.

Continuum of IECMH Supports & Services



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Introduction

Promotion, prevention, assessment and diagnosis, and treatment are the pillars of a responsive behavioral health system. For CCBHCs, they support cost-effective, family-centered care across the lifespan. Integrating IECMH services helps ensure that CCBHCs meet the needs of the whole family.

States can integrate IECMH into their CCBHC frameworks through various pathways. One approach is to **embed IECMH principles directly into the CCBHC state manual** — clarifying service expectations, staffing needs, and screening and assessment protocols specific to early childhood. Alternatively, states may **develop a standalone guidance document focused on enhancing services for the P–5 population and their caregivers**. No matter what the approach, incorporating IECMH into CCBHC infrastructure strengthens family-centered care and supports systems that prioritize whole-family well-being from the start. In this document — and in the field more broadly — the terms IECMH, social-emotional development and early relational health (ERH) often are used interchangeably to describe similar concepts. States are encouraged to use terminology that best aligns with their values, priorities, and local context. Regardless of the specific terms used, they all reflect shared foundational principles of early childhood well-being and convey the same core meaning.

KEY TERMS

Infant and Early Childhood Mental Health refers to the developing capacity of the infant and young child to form close and secure relationships; to experience, manage, and express a full range of emotions; and explore the environment and learn — all in the context of family, community, and culture.

Dyadic Treatment is a form of psychotherapy that treats the infant or young child together with their primary caregiver (often a parent). It focuses on enhancing the parent-child relationship, improving attachment and emotional regulation, and repairing relational disruptions or trauma. The “dyad” (two-person unit) is the client, not the child alone or adult alone.

DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) is a diagnostic classification system for infants and young children, birth through 5 years old. It was created to provide developmentally specific diagnostic criteria and information about mental health disorders in infants and young children. The updated DC:0–5™ Version 2.0 arrived in 2021 and enhances the professional’s ability to diagnose and treat mental health problems in the earliest years by identifying and describing disorders not addressed in other classification systems and by pointing the way to effective intervention approaches.

Program Requirement 1: Staffing

Specialized leadership and staffing in IECMH are necessary for integrating developmentally appropriate care for infants and young children in a CCBHC. IECMH professionals bring deep expertise in child development, attachment, co-regulation, and responsive caregiving practices, and are specially trained to provide mental health care to young children and their caregivers. Additionally, IECMH staff can guide CCBHC strategic planning and policy development to align with the needs of infants and young children, support staff training and consultation, and ensure that the organization can effectively respond to the complex needs of infants, young children, and their families.

Key Strategy: Enhance needs assessments to include information about IECMH services.

To identify service needs for infants, young children, and their families, the CCBHC could incorporate an IECMH-specific section into the required needs assessment. Additionally, CCBHCs could leverage IECMH information by gathering existing needs assessments conducted by the community, state, and local early childhood providers in the departments of health, education, early intervention, and early childhood interagency councils, or reports by information and referral systems (Help Me Grow, UniteUs, 211, FindHelp, etc.). These IECMH-focused assessments can provide a foundation for IECMH services by revealing community strengths (such as caregiver support and early learning programs) and surfacing opportunities to expand access to interventions like dyadic therapy and parent education programs. A focus on behavioral health needs across the IECMH continuum can inform policy and practice improvements that enhance delivery of required CCBHC services.

Key Strategy: Train existing staff across departments, including crisis teams, adult mental health, and substance use staff in IECMH concepts.

All CCBHC staff benefit from gaining a greater understanding of the basics of IECMH — even those whose primary roles are not clinical (e.g., administrative staff, peer support specialists) or who do not regularly interact with infants and young children (e.g., adult clinical staff or substance use clinicians). These adults may still interact with or be responsible for the care of infants and young children, either directly or indirectly. Additionally, understanding infant and early childhood development can provide valuable insight into an adult patient's own childhood experiences and how these may influence their current mental and physical health. For clinics with an established IECMH team, training can be conducted internally. For those still building IECMH expertise, leadership may consider bringing in external partners to facilitate training. Areas to build knowledge and skill across the organization include:

- Understanding of attachment theory, co-regulation, and reflective practice
- Knowledge and skill in conducting age and developmentally appropriate screening and assessments
- Experience with DC:0–5 diagnostic classification
- Familiarity with cross-systems collaboration such as child welfare, home visiting, and early intervention services
- Infant and Early Childhood Mental Health Endorsement®

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Key Strategy: Recruit and train IECMH staff to maintain a dedicated IECMH clinical team.

CCBHCs can recruit and train specialized IECMH staff to be housed within the CCBHC. A dedicated IECMH clinical team fulfills core requirements for delivering evidence-based services to the entire family across the lifespan. Once hired, IECMH professionals will have ongoing training needs and requirements depending on their level of education, license type, and other certifications, including IECMH Endorsement (i.e., continuing education and reflective supervision). Maintaining IECMH staff may require support for continuing education for license renewal and other professional development, and ongoing reflective supervision and IECMH endorsement. The costs incurred to recruit, train, and certify IECMH staff in evidence-based intervention models — along with the provision of reflective supervision or infant and early childhood mental health consultation (IECMHC) — can be included in the development of the CCBHC's payment rate.

Key Strategy: Consider case ratios, productivity, and staffing patterns for the IECMH team.

Because of the unique clinical needs of infants and young children, evidence-based IECMH practices often require or recommend a significantly smaller caseload than similar treatments for older children and youth. For example, Child Parent Psychotherapy requires a caseload of four families for a trainee and 10-12 for a fully trained clinician. These differences in caseloads have important implications for how many clinical and clinical support positions are needed to fully staff a CCBHC and cost of service calculation.

Key Strategy: Identify staff to coordinate the IECMH strategy and facilitate communication about systems alignment and cross-sector work.

To help a clinic build, sustain, and integrate IECMH capacity, CCBHCs could assign responsibility for IECMH services to an administrative leadership position. Given the unique and urgent needs of the P-5 population, this role should ideally be held by an individual with specialized training (Endorsement preferred) and direct experience working with infants, young children, and their caregivers. IECMH administration leadership staff are essential to advancing agency-wide efforts — including strategic planning, outreach, engagement, service delivery, community coordination, reflective supervision, workforce development, and partnership development. This administrative decision-maker also plays a critical role for outreach and partnering with external community partners to ensure efficient coordination and referral processes outside of the CCBHC. The leader may have met the requirements for Endorsement by the state association for infant mental health as a clinical, research, or policy mentor.

Key Strategy: Formalize Designated Collaborating Organization (DCO) contracts with established IECMH providers to support service delivery.

CCBHCs can expand their IECMH capacity by contracting with organizations with established clinical expertise in serving infants and young children and their caregivers. By formalizing DCO contracts with home visiting programs, early intervention agencies, and community IECMH clinicians, for instance, CCBHCs may more quickly build their capacity to deliver care than they would if attempting to create internal capacity alone. This strategy may be particularly effective for CCBHCs in the initial stages of development or for those serving wide geographic areas or populations requiring highly specialized services.

Program Requirement 2: Availability and Accessibility of Services

A child's mental health is directly connected to the mental and overall well-being of their caregivers. Families benefit when services are coordinated and logistical barriers are reduced. The CCBHC criteria emphasize this coordinated approach, which promotes emotional stability in caregivers and enhances their ability to serve as responsive, healing partners in their children's development.

Key Strategy: Coordinate with existing organizations to expand access to IECMH services.

In addition to contracting with DCOs, CCBHCs can expand access to IECMH services by providing care in community settings and outside the clinic. They may also consider co-locating services with primary health care providers, developing mental health consultation programs for child care providers, and partnering with home-visiting teams. These strategies reflect a systems-level approach grounded in IECMH and family-centered care.

Key Strategy: Develop IECMH capacity in crisis management services.

CCBHC administration can equip crisis response team members with knowledge about infant and early childhood development and enhance intervention skills to help mitigate the trauma experienced by infants and toddlers who witness or hear a family crisis. Additionally, CCBHCs can develop procedures for screening babies and toddlers during crisis encounters to assess the need for IECMH follow-up services.

CCBHC administrators can also share the CCBHC protocols and interventions with system partners — such as hotlines, warm lines, emergency departments, child care providers, schools, child welfare, and law enforcement — while establishing interagency coordination and communication agreements that support child safety and reduce trauma. These crisis response protocols can be refined based on feedback from families.

To further strengthen the early childhood system's capacity to support families in distress, CCBHCs could provide behavioral health crisis training to other infant and early childhood providers, including pediatricians, child welfare staff, and childcare providers.

Note: See Program Requirement 4 for sub-strategies for serving infants and young children during family crisis.

Key Strategy: Leverage telehealth platforms to make IECMH services more accessible.

Telehealth has the potential to increase access to IECMH services for families in remote or underserved areas. However, state regulations vary regarding who is authorized to provide telehealth services (e.g., physicians, social workers, or other licensed mental health providers) and how these services may be delivered (e.g., audio alone, audio with video, or text). Some IECMH treatment and home visiting models include specific guidance for delivering telehealth services while maintaining model fidelity. As a result, staff providing remote services may require additional training. Clear agency protocols for telehealth delivery and supervision are essential to ensure quality. To support a patient- and family-centered approach, technical assistance must be available to individuals and families using telehealth services.

Program Requirement 3: Care Coordination

CCBHC care coordination partnerships are particularly important as the P-5 families they serve often juggle multiple needs and navigate across various systems including pediatric primary care, early childhood education, child welfare, Part C /early intervention, nutrition services, and housing, and between child services and adult mental health supports and services.

Key Strategy: Build partnerships with other health care providers.

Care coordination during the P–5 period centers on the interconnected needs of infants and young children and their caregivers, with the goal of supporting developmental milestones, IECMH, caregiver capacity, and meaningful connections to early learning environments. CCBHCs can collaborate with community-based family and pediatric health care providers (e.g., Federally Qualified Health Care Centers, Community Health Centers, and Rural Clinics) by establishing written agreements or protocols for referrals and follow-up communication to ensure coordinated care. From the prenatal period through school entry, families interact with multiple systems, including a minimum of 14 well-child visits, WIC enrollment through age 2 and community-based childcare. Each of these service providers can and should be part of the care coordination efforts led by the CCBHC.

Key Strategy: Build partnerships with other community organizations.

A CCBHC can develop relationships with a range of community services that support infants and young children. Agreements or contracts may already be established among members of the community early childhood system about referral processes, data collection and use of shared consent forms that meet HIPAA standards, confidentiality, and privacy requirements specific to the care of minors. General and clarified understanding between service providers (e.g., FQHCs, pediatricians, nurse practitioners, child welfare staff, etc.) will expedite partner communication during crises and provide an infrastructure for providing high quality care when working with a specific family.

Over the past 15 years, states and communities have been developing infant and early childhood coordinated systems under the leadership of health, education, or childcare departments, with associated advisory councils. Collaborative staffing, referral agreements, and workforce development strategies provide critical pathways toward coordinated care, expanded access, and long-term systems transformation. CCBHCs may seek support from the larger, state infant and early childhood system. Early childhood advisory councils can provide technical assistance, funding pathways, policy guidance, and workforce development supports that accelerate local implementation. Connecting with the state or local council can provide valuable resources and support the CCBHCs efforts to serve the 0-5 age group and their families.

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State systems can also support:

- Shared training platforms and resources for IECMH competencies, reflective supervision, and cross-sector collaboration
- Access to endorsed professionals and consultation networks that strengthen clinical fidelity
- Data infrastructure to track outcomes, identify gaps, and inform continuous improvement
- Policy alignment that ensures local practices reflect state standards, Medicaid billing guidance, and infant and early childhood priorities

Key Strategy: Build a multidisciplinary team to direct, coordinate, and manage care.

Multidisciplinary teams are intentionally designed to reflect the full range of each family's engagement with the community support system. These teams may include early learning providers, substance use treatment providers, pediatricians, adult mental health providers, IECMH specialists, inpatient facilities, home visiting programs, Part C early intervention, and peer counselors. Successful care teams are built through proactive, intentional discussions that establish shared goals, roles, and priorities. Ongoing communication among all team members is essential to ensure coordinated, flexible, and responsive support that truly benefits the family. From an IECMH perspective, family-centered care during the P–5 period begins by honoring caregivers' voices — valuing their lived experience, family values, culture, values, and unique insight into a child's developmental journey. Effective care coordination embraces collaborative decision-making, where families actively shape treatment goals and planning. By affirming caregivers' strengths and centering their voices in care planning, teams create a supportive network that reduces parental stress, builds resilience, and honors caregivers' essential role in nurturing their child's growth.

Key Strategy: Prepare care coordinators to support the needs of the child-caregiver relationship during major life events or transitions.

Infancy and early childhood are naturally marked by many transitions, and any type can place added stress on family interactions. Major life events may be especially stressful (even traumatic) for infants or young children due to their lack of stability, limited understanding, disruptions to daily routines, or the temporary or permanent loss of emotional support from trusted caregivers. During any intake for child or adult services, staff can intentionally and routinely ask what major life events have occurred recently and how those have been experienced by any infants or young children in the family.

Stressful transitions may include:

- Parental unpredictability due to substance use
- Sudden changes in housing due to eviction, placement with a relative, or foster home
- Prolonged parental absence due to military deployment
- Parents return home from inpatient/residential treatment or incarceration
- Family reunification following involvement with child welfare or juvenile court
- A parent inflicting emotional or physical injury on the other parent
- Multiple and/or sudden changes in primary caregivers, including child care providers

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Critical information to gather during intake, screening, assessment, and treatment planning: the baby's mode of coping with stress (e.g., tears, withdrawal); the individual caregiver's response or lack of response to the child's behaviors; and the family's historical coping methods to such stressful events. Care coordinators can act as trusted guides, connecting families to supports that mitigate stress, promote stability, and build relational capacity. This is critical in IECMH, where caregiver well-being directly impacts infant and young child well-being. Care coordinators help create a more integrated support network by proactively addressing social determinants of health and ensuring continuity across behavioral health, medical, and early learning systems. A well-structured referral network empowers care coordinators to move beyond crisis intervention into preventive, relationship-based care — meeting families where they are and fostering meaningful connections through everyday support.

Key Strategy: Adapt consent and information-sharing procedures that honor the caregivers' roles in the P-5 child's life.

Families benefit from clear, detailed discussions about the purpose and benefits of coordinating care with other providers. CCBHCs can develop internal privacy and consent clinical procedures that consider the child's age and the role of the parent(s) and caregivers in giving consent for treatment. Providers may have to negotiate disagreements between parents regarding consent. Additionally, CCBHCs can establish IECMH-specific procedures for obtaining consent to share information with external partners (e.g., screening results and treatment progress with pediatric health care, Early Intervention, or childcare providers).

Program Requirement 4: Scope of Services

The mental health and well-being of caregivers is critical to the well-being and development of infants and very young children. CCBHCs are uniquely positioned to directly provide or contract for the delivery of IECMH-aligned services and support for the whole family. Ensuring the CCBHC service array includes both adult and child IECMH-focused care is transformative to the family experience of receiving behavioral health care.

Core Program 1: Crisis Services

Note: *Program Requirement #2 regarding policy and procedure preparation for serving a child whose family is in crisis.*

Key Strategy: Promote infant and child well-being through timely interventions during crisis events.

Sub-strategy 1: Train the crisis team to recognize infants and young children's response to traumatic events and develop methods to provide safety and emotional support for infants and young children, even while responding to an adult in crisis. The clinic's routine staff development sessions can include IECMH research and strategies as a component of CCBHC annual professional development sessions. It is critical to note that an unusually quiet or seemingly "good" baby may actually be in more distress than a crying toddler and require timely and developmentally appropriate responses.

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Sub-strategy 2: Establish a list of community resources developed by the interdisciplinary staff and approved by the clinical administrator. This list should be available to families with infants and young children to meet immediate needs. Staff will need to update the list routinely for accuracy.

Sub-strategy 3: Assemble a kit containing items that may soothe an infant or young child (e.g., tissues, blanket, pacifier, soft stuffed animal, age-appropriate snacks) or provide age-appropriate activities (e.g., coloring book, crayons, blocks, picture books).

Sub-strategy 4: Develop a protocol to follow up with each family within 24-72 hours after a crisis event, with particular attention to the infant or young child's emotions and behaviors. Across all stages of crisis service delivery (prevention, response and post-event), the young child's needs can be addressed by the CCBHC staff directly, by referral to community partners, or through services provided by a DCO.

Sub-strategy 5: Include a care plan for the patient's infant or young child (such as designating an alternative caregiver) when developing a mental health crisis response plan with an adult patient.

Core Program 2: Screening, Assessment, and Diagnosis

Key Strategy: Adopt age-appropriate, validated screening and assessment tools

Sub-strategy 1: Identify screening and assessment tools specific to the P-5 population and routinely train staff on utilization. Whenever possible, consider using the same tools as community partners, as this can promote consistency and collaboration. See Appendix A for links to detailed information about appropriate age tools.

Sub-strategy 2: Develop referral relationships with pediatric health care providers to ensure that infants and young children in need of full assessment have timely access to high quality services. Pediatric health care providers are expected to routinely screen infants and young children during well-child visits, yet the National Survey of Children's Health (NSCH) showed that the 2022-2023 national average rate of developmental screenings for children aged 9-35 months was 35.6%. One commonly cited barrier was the lack of available providers to conduct comprehensive follow-up assessments after initial screenings.

Sub-strategy 3: Establish DCO agreements with other agencies or private providers for screening and assessment services, particularly when they have specialized expertise or are designated by the state as assessment providers. For children ages 0-5, timely referrals, in-depth assessments, and treatment planning are especially urgent due to their rapid developmental changes, an urgency not as pronounced in adult populations. Note [DC:0–5™](#) [Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood](#) is the only age-appropriate mental health nosology for infants and young children birth through five years old.

Sub-strategy 4: Develop formal or informal referral agreements with health care providers (including obstetrician-gynecologists) who screen adult caregivers for depression, anxiety, and substance use. New parents are at increased risk for mental health challenges during the first 12 months following birth.

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Sub-strategy 5: Strengthen referral partnerships and formalize data sharing with providers administering infant and early childhood screenings and assessments (e.g., health care providers, Part C Early Intervention providers, and home visiting programs).

Sub-strategy 6: Modify clinical space to ensure that families with infants and young children feel welcomed and safe. Including books, toys, art supplies, child-friendly decor and furniture, sensory-based items, and children's wall art can support clinical observations by encouraging natural interactions within the family. Many of the costs for modifications or maintaining welcoming spaces can be incorporated into the CCBHCs rate development.

Sub-strategy 7: Explore the use of telehealth sessions for screening and assessment, particularly if the CCBHC is located in a state that has approved 5-6 assessment sessions (best practice) prior to diagnosis or allows for sessions solely with the caregiver before diagnosis is determined. CCBHC staff will need routine training on how to use telehealth when screening and assessing young children (0-5).

Sub-strategy 8: Train their staff on [DC:0–5](#) and utilize DC:0–5 in diagnosis, treatment planning, and monitoring of outcomes. The CCBHC should determine if the state has approved or requires DC:0–5 for Medicaid and other insurance billing codes, and whether a crosswalk to DSM-5 or ICD-10 codes is available.

Sub-strategy 9: Gather more than the minimum required information during the CCBHCs initial evaluation of adult clients to explore their caregiving responsibilities and relationships with young children. While these topics will be examined in greater depth during the comprehensive evaluation, early identification is essential to ensure the safety of any children in the home and to understand the patient's life's stressors.

Core Program 3: Person-Centered and Family-Centered Treatment Planning

Key Strategy: Center family voice in treatment planning.

Sub-strategy 1: Ensure the family's voice is a central component of IECMH- informing goals, guiding strategies, and shaping interventions that align with their values and daily rhythms. Broader support networks, including early learning providers, home visitors, and medical providers, should be engaged as partners, promoting consistency and wraparound support across environments.

Sub-strategy 2: Provide recommendations for child and family treatment goals and interventions. Caregivers may be offered a range of evidence-based models focused on health promotion, prevention, and treatment, depending on the services available through the CCBHC or its DCOs. Caregivers are supported in making informed choices about the services they receive.

Sub-strategy 3: Train and supervise CCBHC staff to use negotiation or motivational interviewing skills to manage disagreements among caregivers, ensuring that the child's needs remain the top priority.

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Sub-strategy 4: Provide emotional and practical guidance through peer support services for adults and families as they begin receiving care. This real-time support can increase follow-through and decrease drop-off. Family peer support helps caregivers feel empowered rather than overwhelmed.

Sub-strategy 5: Allow caregivers to define whom they consider “family” and determine who will be included in the child’s treatment plan. Caregivers can also serve as members of the interdisciplinary team for the young child’s treatment. All caregivers should be informed of the child’s alternative care plan in the event of a family crisis or emergency.

Core Program 4: Outpatient Mental Health and Substance Use Services

Key Strategy: Provide evidence-based and/or evidence-informed clinical treatment.

Sub-strategy 1: Identify which evidence-based/evidence-informed models are currently in use in your state through the community needs assessment and discussions with the local early childhood coalition.

Sub-strategy 2: Dyadic treatment is essential for infants and young children as their emotional development is inseparable from their relationships with caregivers. A CCBHC may consider expanding community capacity of a model that has established referral networks or offering a different model to diversify available treatment options.

Sub-strategy 3: Train and certify staff on evidence-based and evidence-informed models, a process which can take 18-24 months and can be costly. Many states have invested in developing in-state model trainers. The national office of a model or the state early childhood coordinating body can assist a local CCBHC in identifying available trainers and scheduling sessions. See Appendix B for detailed information on each model’s purpose and implementation process.

Sub-strategy 4: Align IECMH services with adult treatment services to reduce silos and ensure families receive developmentally appropriate, trauma-informed support from coordinated teams. Integrating IECMH infrastructure within adult-serving systems strengthens crisis response, improves relational continuity, and empowers providers to respond compassionately to intergenerational needs through comprehensive, family-centered care. For example, some [states](#) offer specialized substance abuse treatment services for pregnant and/or parenting women that support the parent-child relationship.

Sub-strategy 5: Expand the “minimum set of evidence-based practices required of CCBHCs” to include parent support, health promotion, and evidence-based treatment models — as well as evidence-informed approaches — tailored to the [early childhood population](#) and their families.

Sub-strategy 6: Check on state regulations regarding dyadic treatment and educate clinical staff accordingly. Some states require that the parent and infant or young child are always seen together, even though some evidence-based models allow for parent-only sessions.

Sub-strategy 7: Support CCBHC staff in maintaining regular communication with the family’s health care providers and interdisciplinary team to ensure coordinated, high-quality care.

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Core Program 5: Primary Care Screening and Monitoring

Key Strategy: Use a shared child development framework and parent education messages.

Sub-strategy 1: Adopt *Bright Futures Guidelines for Health Supervision of Children and Adolescents* as a framework for infant and early child development and train staff to use it when collaborating with primary care providers and caregivers. CCBHCs can encourage medical providers to share the Bright Futures anticipatory guidance messages during well-child visits and during OB-GYN visits from the prenatal period through the post-partum period.

Sub-strategy 2: Monitor the family's access to primary care services and promote a healthy lifestyle throughout the intervention process with routine check-ins.

Core Program 6: Targeted Case Management Services

Key Strategy: Provide infant and early childhood mental health consultation (IECMHC) to build early childhood system capacity.

Sub-strategy 1: Provide reflective guidance, training, and case consultation to CCBHC staff, supervisors, administrators, and community professionals who work directly with infants, young children, and their families, as a means of supporting effective targeted case management and high-quality services.

Sub-strategy 2: Provide IECMH in non-clinical early childhood settings such as childcare centers, early education programs, home visiting models, referral warmlines and service coordination entities (e.g., United Way, 211, FindHelp, Help Me Grow), parent support groups, and family shelters. This indirect service model builds the capacity of caregivers and educators to support emotional development, strengthen parent-child interactions, and foster environments that promote mental wellness from P-5. IECMH as a strategy has also been proven to reduce staff and professional burnout and increase retention rates.

Core Program 7: Psychiatric Rehabilitation Services

Key Strategy: Develop caregiver skills for functioning in the community.

Sub-strategy 1: Integrate goals for building the caregiver's emotional regulation and routine stability to enhance their ability to consistently provide a safe and nurturing home environment for their child.

Sub-strategy 2: Train CCBHC staff on a parent education model or establish a contract with a DCO to deliver parent education.

Sub-strategy 3: Provide group-based non-clinical interventions (e.g., Circle of Security Parenting, Triple P) to promote peer connection, reduce stigma and increase parental knowledge about development and offer emotional support.

Sub-strategy 4: Deliver group-based models through telehealth to improve accessibility and engagement.

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Core Program 8: Peer Supports and Family/Caregiver Supports

Key Strategy: Develop capacity for additional individual and group-based, non-clinical intervention.

Sub-strategy 1: Expand training opportunities for non-clinical professionals such as infant and early childhood educators, home visitors, and community health workers to enhance their capacity to identify early signs of mental health concerns and support families in navigating appropriate services (e.g., in child welfare, courts, and housing). These front-line professionals often hold trusted relationships with families and serve as vital conduits for early intervention. To fulfill this role effectively, non-clinical staff need to be equipped with specialized training (and ongoing support such as Reflective Supervision/Consultation) in IECMH frameworks, developmentally sensitive assessment tools and relationally grounded intervention strategies. These skills help address critical service gaps and promote more integrated, collaborative-care models.

Sub-strategy 2: Strengthen partnerships with other mental health providers to create seamless referral pathways and coordinated care systems. This collaboration enables all professionals to more effectively support young children and their families, particularly in underserved or resource-constrained communities.

How Can the CCBHC Partner to Enhance the Early Childhood System

Babies and toddlers make up the largest group entering foster care. CCBHCs are well-positioned to strengthen the system by embedding peer support staff and Parent Partners throughout the continuum of care. Peers represent a unique and expert workforce — individuals with lived experience navigating mental health challenges, substance use, child welfare involvement and more. Peer support for families can include mentoring, resource navigation, support groups, training, coaching on how to navigate complex systems, advocacy and outreach. Additionally, parent partners — *also known as parent mentors, parent support partners or parent allies* — can provide tailored support services as “individuals who have lived experience navigating the child welfare system as a parent, understand how the child welfare system works, have no open cases, and demonstrate personal and family stability.”

Source: The Critical Role of Parent Partner Programs: Policy and Practice Considerations (2025), Safe Babies, A Program of ZERO TO THREE.

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Core Program 9: Community Care for Uniformed Service Members and Veterans

Key Strategy: Provide evidence-based and evidence-informed parent support services.

Sub-strategy 1: Connect with the family support staff at the local Veteran Administration (VA) Center and local military stations to learn about the family support services available to the veterans and their families.

Sub-strategy 2: Establish formal or informal referral networks with the VA and military installations. Note that smaller or rural bases may lack the resources to provide a full array of parent-support services.

Sub-strategy 3: Coordinate infant and early childhood screenings and assessments (e.g., those provided by health care providers, Part C Early Intervention Services, home visiting programs), parent education programs, and specialized child treatment services with the services provided to the veteran through military resources.

Sub-strategy 4: Partner with infant, child, and adult health care providers (including OB-GYNs) who screen adult military personnel, their families, and veterans for depression, anxiety, and substance use to ensure appropriate services are provided.

Sub-strategy 5: Develop de-identified data-sharing agreements with providers serving uniformed service members and veterans to support coordinated service planning. The U.S. Department of Health and Human Services has provided guidance on creating de-identified data.

Program Requirement 5: Quality and Other Reporting

As a part of the data collection and reporting process, CCBHCs can develop data-sharing agreements with DCO contractors such as IECMH providers and early childhood programs. Programs utilizing evidence-based models are often required to capture child/family outcome data and this information may be helpful for CCBHCs to assess the effectiveness of the services provided. In addition, CCBHCs may consider updating their Electronic Health Record (EHR) systems to gather data on the P-5 population. This could include demographic information, screening and assessment data, diagnosis and treatment information, service utilization and access, care coordination, and child and family outcomes. Disaggregated data can support the identification of families most in need of services.

Data tracking also supports Continuous Quality Improvement (CQI) efforts that can enhance quality service delivery. When collecting data for the early childhood population ages P-5, it is important whenever possible to categorize by subsets of prenatal, 0-3 and 4-5 years. Different interventions and community resources are used for each of these age groups, making this level of detail essential for accurate planning and evaluation.

Tracking family outcomes and implementation efforts allows programs to refine practice and ensure services meet developmental and relational needs. CCBHCs may consider gathering information from parents/ caregivers about the services provided. This information can help demonstrate the impact of IECMH programs, support workforce investment, and inform decisions about service expansion.

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Examples of outcome measures CCBHCs may consider include:

- Bureau of Primary Care — Early Childhood Development grant measures:
 - Number of children aged 0-5 who receive recommended developmental screenings.
 - Number of children and their families assisted with accessing appropriate follow-up services within 30 days of a developmental screening identifying an area of concern. (Source: Fiscal Year 2023 Early Childhood Development, HRSA-23-028, Bureau of Primary Health Care)
- HRSA: MCHB - Transforming Pediatrics for Early Childhood (TPEC) Program-Performance Measurement & Evaluation Plan Guidance:
 - Number and percentage of P-5 families (disaggregated by race/ethnicity and income level) receiving early developmental health and family well-being promotion and prevention services.
 - Number and percentage of P-5 families (disaggregated by race/ethnicity and income level) receiving screening and surveillance for developmental, family, and environmental concerns or risks.
 - Number and percentage of P-5 families (disaggregated by race/ethnicity and income level) receiving care coordination and linkage.
 - Number and percentage of P-5 families (disaggregated by race/ethnicity and income level) receiving targeted consultation or brief intervention.
 - Number of pediatric practice staff receiving training or TA to deliver high-quality ECD services, by role.
 - Proportion of identified policy, financing, or workforce barriers resolved or with measurable improvement. Source: [Transforming Pediatrics for Early Childhood \(TPEC\) | HRSA](#)

Key Strategy: Establish shared data agreements with cross-sector partners.

Sharing data across health, mental health, early education, and child welfare sectors supports coordinated care and integrated service delivery. CCBHCs can consider establishing data sharing agreements with IECMH providers, early childhood programs, such as home visiting and early intervention. DCOs could also provide data on the P-5 population served, including: (1) characteristics of the infants, young children, and families receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of children/families receiving services.

Key Strategy: Use qualitative data (such as caregiver narratives) to enrich metrics.

CCBHCs are encouraged to include “measurement-based care (MBC)” as a part of their data collection efforts. This may include gathering caregiver/parent-reported information to inform clinical care and shared decision-making. This type of qualitative data enriches quantitative metrics by highlighting emotional growth, strengthening protective capacities, and evolving caregiver-child dynamics. These insights humanize the data, elevating the voices of infants and families to drive meaningful and responsive systems of change.

Key Strategy: Collect data through screening tools and structured assessments.

CCBHCs can gather data from selected screening and assessment tools, along with information on infant, child, and family outcomes, as well as dyadic functioning. These tools (see Appendix A) reflect developmental and social-emotional indicators, such as the child's behavior, responses, and actions. They can also capture caregiver growth and family-reported improvements, including a better understanding of the child's needs and increased access to protective factors.

Program Requirement 6: Organizational Authority, Governance, and Accreditation

To reinforce the impact and sustainability of IECMH strategies, governance boards can pursue strategic partnerships with local, regional, and statewide entities that offer expertise in infant and early childhood systems, maternal and child health, family advocacy, and trauma-informed care. These partners may include university-affiliated research centers, child welfare advisory groups, state associations of infant mental health and maternal health initiatives that engage directly with families and communities.

Additionally, by partnering with organizations that prioritize family voice, governance boards can include families with infants and young children and more effectively center the perspectives of those with lived experience, particularly families who have engaged with multiple systems such as behavioral health, child welfare, and early intervention.

Appendix A: Screening and Assessment Tools

[AAP Screen Finder](#)

The Screening Tool Finder can help identify tools to screen or assess child development, perinatal depression, social drivers of health, and more.

[Getting Started Guide: Implementing a Screening Process](#)

This guide is a fillable worksheet designed to help pediatric practice teams develop a screening workflow tailored to their practice and the families they serve.

[Bright Futures Guidelines for Health Supervision of Children and Adolescents](#)

Developed by the AAP, the Guidelines provide evidence-based screenings and growth milestones for each pediatric well-child visit from birth through young adulthood. The book also includes the Edinburgh Postnatal Depression Scale — a 10-question self-report tool designed to identify parents at risk for depression and anxiety during the perinatal year.

[DC:0—5TM Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood](#)

DC:0—5 is a diagnostic classification system for infants and young children, birth through 5 years old. It was created to provide developmentally specific diagnostic criteria and information about mental health disorders in infants and young children.

Appendix B: Selecting IECMH Parent Education, Home Visiting and Treatment Models

Program models may be referred to as “evidence-based” or “evidence-informed.” The “evidence-based” rating indicates that repeated scientific research studies have documented desired outcomes with a specific client/patient population. The gold standard of these studies is the randomized controlled trial.

“Evidence-informed” models have not been tested in such a rigorous manner, however, and may be more deeply informed by community and cultural practices. In addition to one or two studies, the evidence forming the basis for the model may include observational studies in the field, project outcome evaluations and adaptations to serve a different population than the research study.

When selecting an evidence-based or evidence-informed model, it is important to assess whether the goal, target population and delivery method of the intervention align with the clinic’s goals, delivery capacity and populations served.

Note that different clearinghouses may rate the same program model differently due to nonalignment of their specific review criteria. Additionally, ratings can change over time as new research becomes available.

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Below are examples highlighting differences in how various model versions or delivery methods are rated:

- *Triple P* has levels 1-5 and different delivery methods which result in different ratings for evidence.
- *Safe Care* has a variation of ratings depending on the goals of the intervention. Thus, home visiting for prevention of child abuse and neglect is rated “supported” while home visiting for support of child well-being is rated as “promising.”

Clearinghouses have active links to model descriptions, requirements, training, and research.

Title IV-E Clearinghouse

“The Title IV-E Prevention Services Clearinghouse was established by the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS) to conduct an objective and transparent review of research on programs and services intended to provide enhanced support to children and families and prevent foster care placements... The Clearinghouse has reviewed 210 programs and services; 95 of those have been rated as promising, supported or well-supported.” (downloaded from landing page: 7/23/2025)

California Evidence-Based Clearinghouse

The CEBC has adopted the Institute of Medicine’s definition for evidence-based practice, building on a foundation of scientific research while honoring the clinical experience of child welfare practitioners and being fully cognizant of the values of the families we serve.

Evidence-Based Home Visiting

“HomVEE relies on a set of criteria specified by the U.S. Department of Health and Human Services for evidence of effectiveness, the “HHS criteria.” These criteria require that favorable findings for a home-visiting model be replicated in one or more of HomVEE’s eight outcome domains. A home-visiting model must meet these criteria to earn a “HomVEE evidence-based designation.” In the 2024 annual report, Mathematica noted that 72 models had been reviewed and 27 were determined to be evidence-based meeting eight criteria.

NCCP PRiSM

PRiSM offers an online, searchable collection of research-informed IECMH policies and scaled initiatives, along with summaries of research on key IECMH strategies (e.g., IECMH screening, consultation, dyadic treatment). Resources include surveys of IECMH state policies and webinars on Part C interventions that support social-emotional and mental health needs, as well as IECMH strategies used in home visiting programs.

Appendix C: Resources

Expanding Infant and Early Childhood Mental Health Supports and Services: A Planning Tool for States and Communities

- [Expanding Infant and Early Childhood Mental Health Supports and Services: A Planning Tool for States and Communities](#)

IECMH Consultation Crosswalk

- [IECMH Consultation Crosswalk](#)

IECMH Briefing Series

- [The Basics of Infant and Early Childhood Mental Health: A Briefing Paper](#)
- [Infant and Early Childhood Mental Health Consultation: A Briefing Paper](#)
- [Infant and Early Childhood Mental Health Competencies: A Briefing Paper](#)
- [DC:0—5™: A Briefing Paper on Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood](#)
- [DC:0—5™ Crosswalk: A Briefing Paper](#)

Infant and Early Childhood Mental Health Consultation Cost Calculator

- [Infant and Early Childhood Mental Health Consultation Cost Calculator](#)

The Baby Brain Map

- [The Baby Brain Map](#)

IECMH Workforce Solutions

- [IECMH Workforce Solutions](#)

Infant and Early Childhood Mental Health (IECMH) Key Terms and Definitions

- [Infant and Early Childhood Mental Health \(IECMH\) Key Terms and Definitions](#)

Cost-Effectiveness of Infant and Early Childhood Mental Health Treatment

- [Cost-Effectiveness of Infant and Early Childhood Mental Health Treatment](#)

Cost-Effectiveness of Prevention Approaches to Support Infant and Early Childhood Mental Health

- [Cost Effectiveness of Prevention Approaches to Support Infant and Early Childhood Mental Health](#)