

Certified Community Behavioral Health Clinics and Infant and Early Childhood Mental Health



ZERO TO THREE
Early connections last a lifetime

Overview and Purpose

What is a CCBHC?

A Certified Community Behavioral Health Clinic (CCBHC) is a specially designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs serve anyone who walks through the door, regardless of their diagnosis and insurance status.

Source: [National Council for Mental Wellbeing](#)

The [CCBHC model](#) has rapidly grown nationwide and is transforming the public behavioral health¹ safety net system. This model, which requires behavioral health clinics to serve the entire lifespan, provides high-quality and timely care through a required set of [nine core services](#) and a modernized reimbursement structure called the [Prospective Payment System \(PPS\)](#).



1. Behavioral health is defined here as the mental health and substance use needs of the population served.

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An infant and early childhood system brings together health (holistically defined and for all members of the family); child welfare, including the dependency court; early care and education, other human services; and family support program partners — as well as community leaders, families, and other partners — to achieve agreed-upon goals for thriving children and families.

While there has been rapid uptake of this model, little attention has been paid to the opportunities for CCBHCs to address the unique needs of infants, toddlers, and their families. Early childhood leaders, professionals, and advocates can participate in state and local design of CCBHCs and help transform access to prevention, early intervention, assessment, diagnosis, and treatment services for families with young children.

This document discusses questions the ZERO TO THREE team has received from state infant and early childhood leaders and advocates about CCBHCs and highlights opportunities for these partners to collaborate.

Key Findings

- Infants, toddlers, and their families should be prioritized in every stage of CCBHC development and ongoing implementation. CCBHCs are well-positioned to serve the whole family unit across the lifespan through an innovative continuum of care.
- Additional systems integration is needed and can be accomplished through intentional partnerships between early childhood systems and CCBHC state and local leadership.
- A reciprocal network of referrals is needed to further integrate infant and early childhood systems with CCBHCs. For example, connecting early childhood system partners (e.g., pediatricians), home visiting, and early care and learning settings with CCBHCs has great potential benefit for families and providers alike.
- As states continue to develop guidelines for CCBHC implementation, there is opportunity for infant and early childhood advocates and leaders to inform the creation of policy language that addresses the unique, urgent mental health and developmental needs of infants and toddlers. State CCBHC policy manuals do not currently reflect these needs.
- Overall, little guidance is available in CCBHC certification criteria on how to partner with child welfare systems. Infants and toddlers at risk for or already involved with child welfare need rapid response with age-appropriate and high-quality care. Policies can be adopted at the state and local level that will create intentional partnerships across CCBHCs and child welfare systems.

Why is it important for infant and early childhood leaders to get involved in CCBHC implementation?

More than 500 CCBHCs are operating in 46 states, Washington, D.C. and Puerto Rico² Federal policy requires them to serve behavioral health needs across all ages, including infants, toddlers, and their families. Infant and early childhood system leaders have an opportunity to inform the CCBHC service array, partnerships and infrastructure decisions needed for CCBHCs to meet [federal certification criteria](#). At the state and local level, infant and early childhood system partners can do the following:

- Share best practices to build out the infant and early childhood mental health (IECMH) continuum of services and identify opportunities for CCBHCs to align their infrastructure and policy with the needs of infants and toddlers. CCBHCs can coordinate with infant and early childhood systems and develop working relationships with early childhood systems leaders who are well-positioned to facilitate introductions and relationship building. This includes partnerships with child welfare agencies as required in the CCBHC model.
- Engage in discussion and planning around how the [nine core services](#) can be adapted and inclusive of services, supports and staffing that meet the needs of infants and toddlers. This includes how to integrate IECMH and other prevention/early intervention services into the CCBHC continuum.
- Advocate to help state leaders and CCBHCs develop understanding of “the why” of IECMH and infant and early childhood services, the key components of infant and early childhood systems, and the needs and gaps that exist in states.

State-level Efforts and Opportunities to Inform Planning and Implementation of CCBHCs

Connecting with State and Local Implementation

The Substance Abuse and Mental Health Services Administration sets the [federal certification criteria for CCBHCs](#), which states must follow to certify clinics. States have also expanded upon these baseline federal policy requirements. A number of states are now certifying clinics based on federal and state criteria, while others are working towards the establishment of a statewide certification process. Thirty-eight states have established or are actively planning for state-level implementation of the CCBHC model. The [National Council for Mental Wellbeing](#), which houses several national technical assistance centers for clinics and states, maintains a publicly available state and site implementation list.

The state-level entities leading this effort are usually the public agencies responsible for behavioral health and/or the state Medicaid authority. Some states have amended their Medicaid state plans to include CCBHCs. *Conversations among early childhood system leaders about strategies for leading and connecting with those at the state and local clinic level would be very beneficial.*

2. National Council for Mental Wellbeing. (2024). Find a CCBHC. <https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-locator/>

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Not every state has a state-level implementation effort; in some places, local clinics that receive federal grant funding are leading the way. CCBHCs are housed in local nonprofit organizations or units of local government tied to the behavioral health authority. ***Given the variation in how CCBHCs are structured within states and the varying phases of implementation, it's important for early childhood allies to understand and connect with local implementation efforts. CCBHC leadership can also reach out to their local and state counterparts in early childhood and child welfare.***

Key Questions

- What are the existing infant and early childhood coordinating bodies at the state and local levels? How can CCBHCs coordinate with these and build upon existing relationships?
- Who is leading CCBHC implementation at the state level? Is there a key leadership team or group managing this? Does the process involve input from early childhood leaders?
- Who are the key leaders at the CCBHC level? Are they having discussions at the state level to move to statewide implementation?
- How are the voices of parents and providers with lived experience contributing to the discussions and planning?
- Has the state developed a CCBHC provider manual?
- What is the process for providing feedback on improvements to the CCBHC certification manual?

Informing the Community Needs Assessment

One of the initial steps to adapting the CCBHC structure to support babies and toddlers is to conduct a community needs assessment (CNA). The CNA is part of the start-up process and the ongoing implementation of the CCBHC model. The CNA informs the CCBHC's understanding of the strengths, needs and gaps in the community among specific populations, as well as infrastructure decisions, including staffing, training, physical space, and development of cost structure. An infant and early childhood perspective is valuable to each of the above-mentioned areas. Given that the CNA process is one of the initial implementation activities that leads to how a CCBHC builds its service array, it is critical to involve early childhood system partners. Input from families with infants and young children should also be prioritized, helping ensure that the CNA process captures their unique needs, the services they would like included, and the ways that access is promoted.

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CCBHCs can also analyze community data on infants and toddlers. Much of this information can be obtained from the periodic needs assessments required for the Title V Maternal and Child Health Services Block Grant; the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; the Preschool Development Grant Birth Through Five program (PDG); and the Early Childhood Comprehensive Systems (ECCS) program.

States can enhance the CNA process and guidelines beyond the federal requirements, regarding such factors as the frequency of reassessment after the initial CNA, which partners within their community to include, and what data to collect and review as part of this analysis.

Infant and early childhood systems leaders can inform state leaders and clinics on programs and partners that would be critical to CCBHC success with infants and toddlers, such as the [Safe Babies approach](#), [HealthySteps](#), [Early Head Start](#), the [Individuals with Disabilities Education Act Parts B and C \(Early Intervention Services\)](#), [IECMH consultation](#), [Bright Futures Guidelines](#), developmental health screening initiatives, and a variety of evidence-based home visiting programs.

Key Questions to Ask About Your State's Implementation

- How frequently are CNAs required? (at least every three years)
- Are there requirements for community partner involvement and key data for the CNA process? Do these requirements reflect the early childhood system and the needs of families with babies and toddlers?
- Is there information in the needs assessments conducted by Title V, MIECHV, ECCS or PDG that could inform the CCBHC CNA?
- What community partnerships are required or recommended for CCBHCs? Do these partnerships reflect the early childhood system and key programs that the state has invested in for infant and early childhood (e.g., Safe Babies, HealthySteps, home visiting, early intervention, etc.)?
- How can the certification manual be updated to reflect IECMH across the continuum? Is there existing language within your state's Medicaid or behavioral health policy where this can be cross-walked?

Informing the Prospective Payment System Rates

One of the hallmarks of the CCBHC model when implemented at the state level is the PPS rate — a clinic-specific, cost-related rate paid to the clinic when a Medicaid beneficiary receives a CCBHC service. The state can choose either a daily or monthly bundled rate. The unique services and supports needed by families with infants and toddlers should be considered when developing the rate-setting process, including the specialized workforce required to provide clinical and non-clinical care for infants and toddlers. These services and supports can be directly provided by the CCBHC or through a contract arrangement (referred to in the CCBHC criteria as a designated collaborating organization [DCO]).

Under either scenario, the CCBHC can build the costs for these services into its rates. For example, if a CCBHC contracts with an IECMH clinician or an IECMH group practice to provide two-generation clinical mental health treatment, the CCBHC can then build that into its proposed cost report.³ Alternatively, the CCBHC can build internal capacity to directly provide IECMH treatment by directly hiring clinical IECMH staff. Either way, costs can be captured in the PPS rates.

The PPS rate may also cover workforce training and professional development to ensure there is skill and knowledge related to infants and toddlers or competence in recommended or required evidence-based practices. The rate may cover professional development costs where the training/education and reflective supervision directly relate to the provision of quality care.

Infant and early childhood systems leaders provide expertise in developing a daily or monthly cost-related payment rate ([see PPS cheat sheet](#)). These rates are negotiated by each clinic with the state in those states with a statewide implementation effort.

Key Questions

- Is there a state-level office coordinating infant and early childhood services for health, early care and education, early intervention, and Medicaid?
- What priorities for prevention, assessment and treatment have been identified in the state?
- Are there established evidence-based treatment models operating in the state that could be considered for DCOs?
- What is the existing local and state structure for making referrals (e.g., United Way, Unite Us, Help Me Grow etc.)?
- Is there an early childhood system-wide approach to assessing for and collecting data on social determinants of health, intimate partner violence, parental depression and substance use?
- Do CCBHCs have a relationship with Association of Infant Mental Health or individual pediatric offices for referrals and follow-up?

3. The CCBHC cost report is a tool used by clinics to detail operational costs. The state reviews cost reports to determine clinic-specific PPS rates.

Developing Provider Certification Manuals

Even though CCBHCs are required to serve people across all age groups, the unique mental health and developmental needs of the very youngest children are not yet widely reflected in state CCBHC policies. ZERO TO THREE's Safe Babies Policy Team conducted a scan of CCBHC provider manuals in states that are actively implementing the model ([see Appendix](#)). Overall, only a few states have language specific to infants and toddlers in their CCBHC provider documentation and implementation manuals, including **Michigan, Minnesota, and Oklahoma**.

As states continue to develop guidelines for CCBHC implementation, there is opportunity for infant and early childhood advocates and leaders to inform the creation of policy language that addresses the unique, urgent mental health and developmental needs of infants and toddlers.

While states must follow federal guidelines around CCBHC certification criteria, they are also permitted to build upon federal policy. For example, state policy manuals can outline requirements for clinical and non-clinical services for specific age groups, specify the type of qualified workforce that delivers services, and suggest or require specific evidence-based practices for certain subgroups.

Partnering with Child Welfare

Nationally, infants and toddlers are overrepresented in child welfare, accounting for one-third of entries to foster care.⁴ High-quality and well-coordinated services and supports for families involved in child welfare should be prioritized based on the urgency of need and the requirement that CCBHCs partner with child welfare. Per the federal [CCBHC Certification Criteria](#):

*"Care coordination requirements shall include partnerships or formal contracts with... other community or regional services, supports, and providers, including schools, child **welfare agencies**, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services."*

However, in the recent review of CCBHC program manuals, ZERO TO THREE found minimal language around these types of partnerships or the recommended services and supports for such families within either state or federal CCBHC policy. Infant and early childhood and child welfare leaders can be instrumental in guiding CCBHC leadership to use data that reflects which children in child welfare are being served, their ages, the services being provided and the outcomes in terms of mental health, early childhood development, and child welfare.

Given the flexibility of the PPS, there is potential to build a truly trauma-responsive system that can support the needs of the whole family in the CCBHC setting. Providing clinical and non-clinical care to child welfare-involved families is complex, and there is potential to ensure that clinic rates reflect the additional efforts necessary to working with these families, including the costs associated with direct care, documentation, training, reflective supervision, and travel.

4. Children's Bureau. (2024 March 13). AFCARS Report #30. U.S. Department of Health and Human Services, Administration for Children and Families. <https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-report-30.pdf>

Partnering with State and Local Infant and Early Childhood Systems

Over the past decade, states and localities have enhanced infant and early childhood systems in the areas of prevention, assessment, diagnosis, and treatment through agency collaboration and public-private partnerships. The infant and early childhood state infrastructure may be led by a governor's cabinet or state government-level coordinator, a state-level designated advisory council, or a multi-disciplinary coordinating group involving planning, referral networks and service, and workforce development. Parallel structures also exist at the regional level, with efforts to enhance the family voice in developing and evaluating infant and early childhood services. If CCBHCs are not yet connected or participating, they could be welcomed as critical partners at the state and local levels.

These infant and early childhood system-building efforts have helped increase access to quality services for families. Improvements have been made to referral networks through agency agreements or the implementation of such models as Help Me Grow, Unite Us, and 211, as well as state-developed phone lines (e.g., 1-800-CHILDREN in Kansas) that are available to both providers and families seeking services. CCBHCs can also partner with existing referral lines. As clinics develop a continuum of services for infants and toddlers, they can collaborate with the entities running statewide referral hotlines to ensure their services are accurately reflected for this age group.

A major effort by the American Academy of Pediatrics (AAP) and the Health Resources and Services Administration is focused on increasing the number of children receiving periodic developmental (physical and mental health) screenings, followed by full assessments and treatment plans as needed. To support this, the Center for Medicare and Medicaid Services has issued new guidance to states on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. AAP's [Bright Futures Guidelines](#) include screening for age-appropriate social-emotional development and outline best practices for each well-child visit.

CCBHCs can help strengthen these efforts by receiving referrals for assessment, diagnosis, treatment planning, and case management from community and state partners, with a renewed focus on infants and toddlers. Additional opportunities exist for CCBHCs to increase access to routine screenings and assessments by connecting with pediatric health homes and other providers that already support families with infants and toddlers. CCBHCs can also accept referrals for families that are identified for potential mental health and substance use care by their pediatricians.

Additional Resources

- [ZERO TO THREE IECMH Financing Policy Project](#)
- [Bright Futures Guidelines \(with well-child visit by stage of development\)](#)
- [CMS 2024 guidance on best practices for adhering to EPSDT requirements](#)
- [ZERO TO THREE IECMH Guiding Principles](#)
- [Foundations of Well-being: Policy Strategies for Integrating Infant and Early Childhood Mental Health into Child Welfare](#)

APPENDIX: Scan of Infant/Toddler Language from State CCBHC Certification Manuals

	Community Needs Assessment	Comprehensive Evaluation /Diagnosis	Services (Treatment, Consultation)	Providers
KANSAS	Certification application groups children ages 0-13 together. No specific information requested within application about very young children (data, staffing, EBPs, etc.)	No language for infants/toddlers.	No language for infants/toddlers. Core EBPs to not appear to include any early-childhood interventions.	No language for infants/toddlers.
MICHIGAN	From CCBHC demonstration handbook: CNA is required every 3 years; recommendation to update annually. There is no specific mention of children in the required components of the CNA. Staffing: Must have child mental health professionals with expertise in trauma. Does not specify IECMH expertise. Training plan requirements and recommendations do not reference child welfare system, early childhood system.	CCBHC manual language: "Persons served with mental illness can have a diagnosis/illness identified to be either a Mild-to-Moderate condition, severe mental illness (SMI) and/ or a serious emotional disturbance (SED) based on assessment. For a diagnosis of SED, please refer to the Technical Requirement for Infants, Toddlers, Children, Youth, and Young Adults with Serious Emotional Disturbance (SED) and Intellectual and/ or Developmental Disabilities (I/DD), which can be found on the MDHHS website at Policies & Practice Guidelines (michigan.gov). CCBHCs will use the Michigan Child and Adolescent Needs and Strengths Tool (MichiCANS) ratings and LOCUS scores to determine which category of mental health severity an individual may be assigned to: Mild-to-Moderate or SED/SMI." Michigan's CCBHC manual references broader Medicaid policy re: definitions and diagnosis of SEDs for the age group; the state policy differentiates Infant and Toddler Serious Emotional Disturbance for birth to 3 years. They include language about the "why" and the "how" of assessment. See pages at link above: pp. 5-9 for ages 0-3 pp. 9-13 for ages 4-5 "Unique criteria must be applied to define SED for the birth through age three population, given: - the magnitude and speed of developmental changes through pregnancy and infancy and early childhood; - the limited capacity of the very young to symptomatically present underlying disturbances; - the extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and > the vulnerability of the very young to relationship and environmental factors."	Michigan requires certain evidence-based practices, and the list includes "Infant Mental Health." See sections 2.C.11.1 and 8.D.6.3.1. The services that fall under infant mental health include home-based services and prevention-direct services, which are described on Michigan's Medicaid website.	In general, to provide infant mental health in Michigan, providers must meet certain criteria. This is not delineated in the CCBHC manual, but it is inferred by way of the reference to the infant mental health EBP. Waivers are available for providers who do not yet meet MI-AIMH endorsement requirements. It appears as though CCBHC staff would need to follow the requirements of the infant mental health EBP in order to bill for services. "Infant Mental Health model is provided by Masters-prepared early childhood mental health professional who must minimally have Endorsement at Level 2 by the Michigan Association of Infant Mental Health; Level 3 is preferred." https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/childrenand-families/eb-pp-offered/ecmh-imh

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	Community Needs Assessment	Comprehensive Evaluation /Diagnosis	Services (Treatment, Consultation)	Providers
MINNESOTA	State has a manual dedicated to needs assessment process and requirements. Data on children are aggregated by ages 0-17. Special population data includes foster care census and state guardianship census. No data required on reasons for removal or breakdown by age groups entering foster care. Section on Model Practices delivered by the CCBHC includes early childhood interventions. Of the 40 open-ended questions in the assessment, there are no specific questions about serving families with infants/toddlers or partnerships with early childhood systems.	CCBHC manual states: “A comprehensive evaluation for children under 5 years old must utilize the current version of the DC: 0–5™ Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three which may consist of up to four separate billable encounters including: • An initial session as a family psychotherapy session without the member present and may include providing treatment to the parents or guardians along with inquiring about the child. Bill the initial session as a family psychotherapy session (90846). If possible, defer billing until completion of assessment with encounter date as date of service. • Three separate sessions follow the initial session; one session must include face-to-face contact with the child. • Bill the three to four completed assessment sessions as a comprehensive evaluation (90791 Q2). • The level of care tool (ECSII) must be incorporated into the comprehensive evaluation for it to be considered complete. • The comprehensive evaluation must be completed before recommending additional CCBHC services. • In the event patient or family participation stops before all sessions are completed, CCBHCs may bill for the sessions completed. • It is allowable for CCBHC providers to gather information for each required assessment component from internal staff, existing documentation or external providers from whom the CCBHC has obtained a release of information and if the documentation is less than one year old.”	No language for infants/toddlers.	No language for infants/toddlers.
MISSOURI	All CNA materials posted on state’s website are National Council for Mental Wellbeing documents outlining approaches to the process.	No language for infants/toddlers,	CCBHC manual recommends PCIT as an EBP.	No language for infants/toddlers.

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	Community Needs Assessment	Comprehensive Evaluation /Diagnosis	Services (Treatment, Consultation)	Providers
NEVADA	Unavailable for review.	References ASQ:SE and Children's Behavioral Checklist as screening/diagnostic tools. "For children, a comprehensive assessment must include: 1. The Children's Uniform Mental Health Assessment (CUMHA) and the Child and Adolescent Service Intensity Instrument (CASII); and 2. Other age-appropriate screening and prevention interventions including, where appropriate, assessment of learning disabilities." The regs reference the CASII, but not the early-childhood counterpart ECSII.	No language for infants/toddlers.	No language for infants/toddlers.
NEW MEXICO	<u>Certification criteria</u> recommends including child welfare agencies and foster care entities as part of the input process; it also references domestic violence programs. No reference to early childhood providers/partners. <u>Data collection tool</u> breaks out 0-5 population data at state and local levels. Substantiated child welfare cases are also included – whole population, not by age. No specification in staffing requirements for early childhood expertise or credentials. Outpatient services for children require evidence-based services that are developmentally appropriate, youth-guided, and family-driven.	No language for infants/toddlers in <u>certification criteria</u> .	No language for infants/toddlers.	Infant mental health specialists are referenced in one checklist item and are lumped in with occupational therapists and other roles. It's an item that references whether the CCBHC is exploring these roles.
NEW YORK	<u>From CCBHC provider manual</u> : Required CNA every 3 years. No specific requirements for data, partnerships, or staff capacity identified in manual. Must demonstrate partnerships for coordinated care, including child welfare agencies; no reference to early childhood providers/partners.	No language for infants/toddlers in provider manual. State does not allow Designated Collaborating Organization (contracting out) arrangements for screening/assessment/diagnosis.	Recommends PCIT or CPP, but not required. State does not allow DCO (contracting out) arrangements for clinical treatment services.	No language for providers with specific expertise on infants/toddlers/IECMH.

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	Community Needs Assessment	Comprehensive Evaluation /Diagnosis	Services (Treatment, Consultation)	Providers
OKLAHOMA	Recommends partnerships with: "Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation Programs"	CCBHC manual has extensive details in a section dedicated to "Infant and Early Childhood Mental Health – Ages 0-5" "The comprehensive assessment for children 0-5 is an in-depth, detailed assessment of the child's emotional, social, behavioral, and developmental functioning. Service components include a diagnostic assessment and/or a functional assessment by [a licensed behavioral health professional (LBHP)] to objectively determine the service intensity needs of children with (or significant risk for) Severe Emotional Disturbance (SED). Methods for completing an assessment include clinical interviewing, observation of the infant/toddler and their caregiver in multiple settings (if possible), use of standardized assessment tools and interactive assessments that are usually recorded and shared with the parent/caregivers as part of the assessment process. The current version of the DC:0–5 manual recommends a minimum of 3-5 sessions for the comprehensive assessment...."	"IECMHC is a prevention-based service that pairs a mental health consultant with families and adults who work with infants and young children in the different settings where they learn and grow, such as childcare, pre-school, and their home. The aim is to build adults' capacity to strengthen and support the healthy social and emotional development of children – early and before intervention is needed. CMHC involves expanding the competence of staff to understand and respond to challenging behaviors, emphasizes the importance of early relationships, promotes positive social and emotional development in young children, and empowers staff to link families with community resources. IECMHC should practice in a trauma-responsive and culturally sensitive manner." Recommended evidence-based practices (EBPs) include parent-child interaction therapy (PCIT), child-parent psychotherapy (CPP), Strengthening Families, and Circle of Security	"LBHP or licensure candidate required for initial and comprehensive assessments. Clinicians conducting comprehensive assessments for children 0-5 must be trained to utilize the DC:0–5 for diagnosis in order to appreciate developmentally appropriate stages and how to differentiate when these same behaviors may indicate a problem that would warrant therapeutic intervention. (Some assessment/screeners have specific qualification; it depends on which screeners are used for each piece whether they are qualified. Providers should follow the published guidelines based on the tool being used."
OREGON	Must be completed every 3 years. Suggested partnerships based on the population served, needs and preferences of people receiving services, and needs identified in the CNA process: "Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs"	No language for infants/toddlers.	No language for infants/toddlers. 2024 memo from state health authority on required EBPs does not include early-childhood interventions.	No language for infants/toddlers.

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	Community Needs Assessment	Comprehensive Evaluation /Diagnosis	Services (Treatment, Consultation)	Providers
RHODE ISLAND	<u>Per the CCBHC provider manual</u>: CNA is required every 3 years. <u>Certification application</u> combines children and adolescents in one age group (0-15).	No language for infants/toddlers.	No language for infants/toddlers. 15 required EBPs; however, no specific interventions for young children are included.	No language for infants/toddlers.
TEXAS	<u>Provider manual</u> states that CNA must be done every 3 years. No references to early childhood in CNA requirements.	No language for infants/toddlers in <u>provider manual</u> .	No language for infants/toddlers.	No language for infants/toddlers.
VERMONT	<u>Draft CNA guide</u> (Sept 2024) includes an indicator for children under 5 in poverty (org completing assessment needs to include). Includes data point on foster care placements and state guardianship; does not require age breakdown for these. No references to early childhood system partners as those who are required or recommended to provide input or participate in the CNA process. https://mentalhealth.vermont.gov/document/draft-vt-ccbhc-cna-guide-sept-2024	Does not appear to have a provider manual developed yet.		

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Safe Babies
A Program of ZERO TO THREE™



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Early connections last a lifetime

The Safe Babies Policy Team provides technical assistance to help inform state policy efforts that strengthen families, particularly those facing significant stressors such as poverty, housing instability, substance use and mental health concerns. Our work includes research, policy tracking, analysis of funding sources, published [tools and resources](#), and individualized training and support related to policy and sustainability. For questions, please reach out to safebabies@zerotothree.org.