CoCM Care Pathways for Early Childhood Mental Health

Authors:

- Jill Donelan, Psy.D.
  - VP of Clinical Implementation, Mirah
- Jian Joyner, LSW
  - Chief Program & Development Officer, Zero Overdose
- Lisa Powell, Ph.D.
  - Growth Manager, HealthySteps National Office/ZERO TO THREE
- Cody Hostutler, Ph.D.
  - Clinical Director of Behavioral Health Integration, Nationwide Children's Hospital
  - Associate Professor, Department of Pediatrics, The Ohio State University
- Katie Steele, PhD
  - Director of Research and Learning, Meadows Mental Health Policy Institute
- Mary Beth Callie, PhD
  - Director of Integrated & Whole Person Care, Callie Pediatrics, Tucson, Arizona
- Mary Ann Woodruff, MD, FAAP
  - Medical Director of Care Transformation, Pediatrics Northwest, Tacoma, WA
- Anthony Sossong, MD, MS
  - Psychiatrist, Division of Child & Adolescent Psychiatry, Department of Psychiatry, Massachusetts General Hospital
  - Instructor in Psychiatry, Harvard Medical School
  - Chief Medical Officer, Concert Health
- Rachel Tenenbaum, Ph.D.
  - Collaborative Care Lead and Clinical Supervisor, Fort Health
- Lori Durand, LCSW
  - Clinical Manager, Healthy Young Minds Collaborative Care Program, Sutter Health Pediatrics, San Francisco Bay Area, California
- Amie F. Bettencourt, Ph.D.
  - Associate Professor, Johns Hopkins University School of Medicine

Contributors:

- Virna Little, PsyD, LCSWr, Co-Founder Concert Health
- Clare McNutt, PA-C, MSHS, Senior Vice President for Health Systems Integration, Meadows Mental Health Policy Institute
- Michelle Durham, MD, MPH, Deputy CMO, Meadows Mental Health Policy Institute
- Roshni Koli, MD, Chief Medical Officer, Meadows Mental Health Policy Institute

Please direct all correspondence to Jill Donelan, Psy.D – . jill.donelan@mirah.com

Version 1: September 2026

Table of Contents: CoCM Care Pathways for Early Childhood Mental Health

Introduction: CoCM Care Pathways for Early Childhood Mental Health 3
- Rationale 3
- Purpose and Scope 4
- Guiding Principles 5
- CoCM Adaptations for Pediatrics and Early Childhood: 5
- Federal and State Policy Alignment: 6
- Opportunities and Next Steps: 8

Structure & Flow of the Early Childhood CoCM Care Pathway (Ages 0 to 6) 9
- STEP 1: Initial Screening 9
- STEP 2: Diagnosis and Clinical Formulation 10
- STEP 3: Evidence-Based Intervention 12
- STEP 4: Ongoing Evaluation and Symptom Monitoring 13

Early Childhood CoCM Care Pathway (ages 0-5 years) 15

Appendix I: Guiding Principles for Early Childhood Collaborative Care 19

Appendix II: References 23
- Infant & Early Childhood Mental Health (IECMH) & Developmental Foundations 23
- Collaborative Care Model & System-Level Implementation 26
- Tools for Universal Screening, Differential Diagnosis and Progress Monitoring 31

Introduction: CoCM Care Pathways for Early Childhood Mental Health

Rationale

The CoCM Care Pathways for Early Childhood is intended to provide an evidence-informed, actionable framework for providers to implement the Collaborative Care Model (CoCM) for children ages 0 to 5 years old. CoCM has been successfully implemented to systematically expand effective behavioral health capacity for adults (e.g., Huffman et al., 2014; Thota et al., 2012), adolescents (e.g. Asarnow, et al., 2015; Lawrence-Sidebottom, et al., 2025; Richardson et al., 2014), and school-aged children (e.g., Kolko et al., 2014; Parkhurst, et al., 2022, 2023; Walter et al., 2023). While this evidence base is well established, no published trials to date have tested CoCM specifically with children ages 0-5.

This pathway is offered as a structured extension of the evidence-based CoCM model into a new developmental period. Rather than building from first principles, this approach is grounded in specific tools, frameworks and interventions that are evidence-based, facilitating rapid piloting, testing and refinement.

Identification and implementation of effective, scalable solutions for early childhood mental health is imperative due to a high prevalence of social emotional concerns in children ages 0 to 5 (Gee & Cohodes, 2021; National Academies of Sciences Engineering & Medicine, 2019), combined with persistent limitations in access to behavioral health services for young children (Gleason et al., 2017; Margolis et al., 2022). Because the period from birth to age 5 represents a critical window of rapid brain development, timely solutions to fill this gap are even more essential (Gleason & Finelli, 2025; National Academies of Sciences Engineering & Medicine, 2019). CoCM is a promising model to fill this gap due to its structured, evidence-informed framework and sustainable reimbursement mechanism (Tobin-Tyler et al., 2017; ZERO TO THREE, 2025).

Clinically, CoCM incorporates foundational elements (AIMS Center, 2023) that align with best practices in infant and early childhood mental health (American Academy of Child and Adolescent Psychiatry, 2012). This pathway operationalizes each of these elements with specific, named tools and frameworks, detailed in the Pathway and Structure Flow below:

- **Team-based care** (e.g., Nayak et al., 2023; Zero to Three, 2024), structured around the PCP, Behavioral Health Care Manager (BHCM), and Psychiatric Consultant. Caregivers[1] are an essential member of the care team (Wissow et al, 2021).
- **Integration into pediatric settings** where young children already require frequent visits. A “no wrong door” universal screening and developmental monitoring approach across all clinical touchpoints improves identification of children with social emotional needs and risk factors (Ader et al, 2015; e.g., Horen et al., 2024; Margolis et al., 2022)
- **Brief evidence-based intervention** (e.g. Kolko et al., 2014; Margolis, et. al., 2022; Weersing, et al., 2017), delivered through a defined tier of interventions built for brief, primary care delivery (e.g., the Chicago Parent Program Individualized for Families, Family Check-Up 4 Health, FAST-E, HealthySteps Tier 2-3), distinct from specialty-level interventions used when a higher level of care is warranted.
- **Systematic psychiatric or developmental consultation** (e.g., Horen et al., 2024; Kolko et al., 2014; Margolis et al., 2022; Nayak et al., 2023; Weersing et al., 2017; ZERO TO THREE, 2024), structured around a defined case review process that includes child symptoms, dyadic assessment, physical/medical factors, and systemic/environmental factors.

[1] The term “caregiver” is used inclusively to refer to all types of familial and non-familial caregivers for young children including parents, legal guardians, and other caretakers closely involved in the care of the child.

- **Measurement-Based Care** (MBC; Arruda et al., 2023; Jensen-Doss et al., 2020; Margolis, et al, 2022; Moore et al., 2024; Weitzman, et. al., 2025), using validated social-emotional screening and monitoring tools (e.g., BPSC/PPSC) and an explicit treatment-to-target framework – including Reliable Change Indices when published, and alternative decision rules (e.g., ≥50% score reduction, crossing clinical threshold) where they are not.

Operationally, CoCM billing codes provide a flexible framework for addressing behavioral health needs within the primary care setting. This sustainability is particularly important in early childhood behavioral health, where chronic underfunding and limited reimbursement mechanisms have compounded longstanding workforce shortages and barriers to accessing specialized services (e.g., Hodgkinson, et al., 2017; Zhu et al., 2025). CoCM's reimbursement structure has demonstrated financial sustainability (Chang et al., 2023; Simon et al., 2009; Unützer et al., 2008; Wong et al., 2026), though this kind of evidence typically emerges only after a model has been longitudinally implemented. Financial sustainability is generally established over a longer horizon than clinical feasibility or improvements in patient outcomes, which can be assessed within a single pilot. Comparable outcomes and cost data specific to children 0-5 do not yet exist, and financial feasibility will vary by state depending on Medicaid policy, billing flexibility, and reimbursement rates (see CoCM Coverage by State for a full state-by-state breakdown). As with adult and pediatric CoCM, financial sustainability data for early childhood implementation should be expected to follow clinical feasibility findings, not accompany them from the outset. The policy trends summarized later suggest a growing number of states are removing structural barriers that would support early childhood CoCM specifically.

Individuals enrolled in CoCM benefit from specialized expertise without requiring external referrals (Kolko et al., 2014; Yonek et al., 2020). CoCM services can be delivered in-person or via telehealth, increasing access to care for families while enhancing implementation across diverse practice settings(Carlo et al., 2021, 2024). Collaborative Care Management billing codes (CPT codes 99492–99494) provide a direct mechanism for reimbursement of key clinical intervention and population-based care activities, including care coordination, systematic patient outreach, registry tracking, and collaboration among behavioral health and pediatric primary care providers.

Purpose and Scope

This pathway builds directly on the structural and clinical adaptations already established for pediatric CoCM (see CoCM Adaptations for Pediatrics and Early Childhood, below), extending that same continuum of adaptation to its youngest end. Rather than asking whether CoCM works for early childhood, the pathway addresses a narrower and more answerable question: how can the existing CoCM structure (team-based care, brief interventions, systematic case review, and measurement-informed care) be configured to fit the developmental, relational, and family context of children ages 0-5, using interventions and clinical frameworks that already have their own evidence base in other early childhood service settings.

Consistent with CoCM's core structure, the child remains the identified patient throughout – carrying the active diagnosis in the medical record (via DC:0-5, crosswalked to ICD-10) and anchoring the registry and outcome tracking. The caregiver and caregiving relationship are not a second enrollee, but a required, formally structured input at every stage of the Pathway, from screening to clinical formulation through intervention selection and the dyadic assessment compiled for each systematic case review. As in pediatric CoCM more broadly (see Adaptation 1 below), the younger the child, the more central this input becomes to the treatment plan – but the model's core structure, one identified patient supported by systematic caregiver-informed assessment, remains intact.

CoCM itself is evidence-based and financially sustainable, and many of its core clinical components —caregiver-centered care, brief intervention, psychiatric consultation and systematic case review —are already standard practice in pediatric CoCM. This Pathway proposes one way of configuring CoCM for early childhood, grounded in interventions and principles already evidence-based in other early childhood care models, as a foundation for piloting, testing, and refinement rather than a finalized protocol.

Guiding Principles

The following guiding principles articulate the assumptions and clinical orientation underlying application of CoCM in early childhood and were used to inform the development of this Pathway. The principles reflect developmental science, pediatric clinical practice, and the realities of health system implementation, and are intended to guide implementation of CoCM for young children and their families:

I. Caregiver involvement and relational context are essential components of early childhood behavioral health care, and caregivers serve as the primary voice in shared decision-making.
II. Comprehensive, developmentally informed clinical formulation—encompassing symptom patterns, developmental context, caregiving relationships, and cultural factors—should guide early childhood CoCM.
III. Initiation of CoCM services should prioritize timely intervention over definitive differential diagnosis.
IV. Flexibility in the intensity and timing of care is necessary to meet the developmental and family needs of children from birth to 5 years old.
V. Effective CoCM for children from birth to 5 years old requires thoughtful cross-system coordination, with care plans tailored to each child and family's individual needs.
VI. Psychiatric consultation and systematic case review should emphasize the psychiatric consultant's developmental and clinical expertise.

CoCM Adaptations for Pediatrics and Early Childhood:

While CoCM is extensively validated in adult populations, the model has consistently required population-specific adaptations as it has been extended to new clinical contexts – including perinatal and maternal mental health, oncology, and other specialty populations with distinct clinical presentations, care settings, and support needs. Pediatric populations are no exception. Applying CoCM to children presents unique considerations due to the necessity of caregiver involvement and the differing presentations of child psychopathology, and implementing CoCM in pediatric populations requires structural and clinical adaptations to meet the unique developmental needs of children (American Psychiatric Association, 2021; Asarnow et al., 2005). As with other specialty adaptations, the degree of change required exists on a continuum – for pediatrics, that continuum is anchored to the child's developmental level, with younger children requiring more significant adaptations than older children. This pathway extends that same continuum to its youngest end.

Specific adaptations for CoCM in Pediatrics, which have already been established and proven effective for school-aged and adolescent children (eg: Substance Abuse and Mental Health Services Administration, 2025), should also be considered – and in several cases become more central – for children from birth through five years old:

1. **Mandatory Family and Caregiver Integration** – Pediatric CoCM relies on a family-centric approach. Caregivers must be actively integrated into the treatment process, and engagement sessions

must actively involve caregivers to establish treatment goals, as parental distress and family conflict directly impact child outcomes. In early childhood, this involvement is not merely supportive but often constitutes the primary treatment target: the caregiving relationship, caregiver mental health, and caregiver capacity are frequently the mechanism through which change occurs, particularly for children under 3 years old. As is true throughout pediatric CoCM, the younger the child, the more central caregiver involvement becomes to the treatment plan itself – formalized in this Pathway through required dyadic assessment and caregiver-report measures at every stage.

2. **Prioritizing Brief Behavioral Interventions** – While adult CoCM often utilizes psychotropic medications as a primary treatment pathway, pediatric adaptations heavily favor behavioral interventions as the first line of care. BHCMs must be trained to deliver brief, modular behavioral interventions, such as behavioral parent training. For early childhood specifically, this pathway distinguishes between interventions with an independent evidence base for brief primary care delivery (e.g., FAST-E, HealthySteps Tier 2-3) and specialty-level interventions (e.g., full-course Child-Parent Psychotherapy, PCIT-Emotion Development) reserved for children requiring a higher level of care or referral to specialty settings. This tiering allows the pathway to draw on interventions already evidence-based for the setting and dose in which they are being used, rather than assuming specialty-level protocols transfer directly into brief primary care delivery.

3. **Adapting Screening and Registry Tools –** Pediatric CoCM requires age-specific screening tools and expanded diagnostic tracking within the clinical registry. This pathway specifies validated, developmentally appropriate measures across social-emotional functioning, developmental and autism screening, caregiver wellbeing, and trauma/social determinants of health (detailed in Step 1 of the Pathway), selected for reliability, validity, and cross-cultural and multi-language validation. Progress tracking relies on data from multiple informants; care managers collect routine assessments from parents, and occasionally teachers or childcare providers, rather than relying solely on patient self-report.

4. **Expansion of Care Coordination** – A unique feature of pediatric CoCM is the necessity of coordinating with external child-serving systems, most notably schools, child care providers, and – for children with developmental or autism-related concerns – Early Intervention and preschool special education services. Care managers play a vital role in facilitating referrals to community-based psychosocial support and specialty pediatric psychiatry when a child requires specialized services or a higher level of care.

5. **Specialized Training for the Clinical Team** – The core CoCM team—the PCP, the BHCM, and the Psychiatric Consultant—requires specialized training and expertise in pediatric behavioral health, including fluency with developmentally appropriate diagnostic frameworks such as the DC:0-5 and its associated multi-axial case formulation (LaVille Thoren & Vista-Wayne, 2021; ZERO TO THREE, 2017). Evidence-based frameworks for training and credentialing in early childhood mental health provide comprehensive examples of the breadth and depth of knowledge and skills needed for working with very young children (e.g., Alliance for the Advancement of Infant Mental Health, 2021; Georgetown University Center for Child and Human Development, n.d.; ILAIMH, 2025).

Federal and State Policy Alignment:

Current state and federal policies are increasingly aligning to support timely, universally accessible behavioral health interventions for young children (e.g., Centers for Medicare and Medicaid Services ,

2026; Bipartisan Policy Center, 2025; National Academy for State Health Policy, 2023, 2026; Smith et al., 2023). These policies underscore the critical need for timely behavioral health interventions for young children, and further support the feasibility of implementing CoCM for children in the first 5 years of life. The table below highlights some of the policy levers that may be particularly impactful in expanding access to CoCM for young children.

As noted above, financial feasibility for early childhood CoCM will vary considerably by state; the trends below illustrate the direction of that variation rather than a uniform national baseline. Further work is needed to understand which policy levers meaningfully impact the social emotional wellbeing of children across various populations and settings.

Policy Levers	**Details**
Decreasing barriers to universal screening	States are streamlining care by allowing providers to bill for multiple developmental and behavioral assessments on the same day, as seen in Connecticut and Washington. Other states, including Delaware and North Carolina, require universal reimbursement for annual wellness visits or tie screening rates directly to financial incentives for managed care organizations
Expanding diagnostic allowances to include Z-codes and risk factors	To ensure timely care without requiring a formal mental health diagnosis, states including California, Colorado, and North Carolina allow providers to bill using Z-codes or physical health codes. Additionally, Arkansas mandates the use of developmentally-tailored diagnostic frameworks like the DC:0-5 to establish medical necessity accurately.
Recognizing caregiver diagnosis as a threshold for child services	Acknowledging the critical parent-child dynamic, California and New York allow preventative services to be billed under a child's Medicaid ID based solely on a caregiver's positive mental health screening. Massachusetts and Nevada also permit children to access early family therapy sessions prior to any formal mental health diagnosis.
Aligning the ecosystem of clinical services	States are integrating clinical care with social determinants of health through innovative Medicaid waivers and quality metrics, as demonstrated by North Carolina and Oregon. Access points are also expanding by funding centralized navigation systems like *Help Me Grow* in Washington and allowing CoCM billing in Illinois school-based clinics.
Redefining "treatment-to-target" for young children	Recognizing that clinical success in early childhood extends beyond symptom reduction, Connecticut and Massachusetts mandate outcome metrics that evaluate family functioning and relational stability. Washington explicitly ties "medical necessity"

	to these functional domains, validating developmental progress as a legitimate treatment target.
Broadening the scope of reimbursable psychiatric consultation	Some states that provide specific guidance for the CoCM model—including North Carolina, New York, and Michigan—are explicitly expanding the psychiatric consultant's role beyond pharmacological oversight. Coverage policies now dictate that psychiatric consultants actively advise on comprehensive psychosocial treatments, review clinical registries, and assist with differential diagnoses.
Evidence-based workforce development	To build and retain a highly qualified infant and early-childhood behavioral health workforce, 44 states have worked with ZERO TO THREE to implement Infant and Early Childhood (IECMH) workforce development initiatives. Michigan, Colorado, and New Mexico fund Reflective Supervision/Consultation (RSC) within their Medicaid structures. These policies subsidize specialized diagnostic training and ensure practitioners receive vital, ongoing supervision from credentialed experts.

Opportunities and Next Steps:

This pathway is a starting point, and its use in practice will surface real opportunities to strengthen the evidence base for early childhood COCM. Two areas stand out as natural next steps for the field:

Building measurement infrastructure for registry-driven care. The screening and monitoring tools specified in this pathway are well validated for their intended purposes – screening, periodic assessment, and outcome tracking. With the uptake of early childhood CoCM, an important next step will be to evaluate how these tools or others perform under the frequent, short-interval re-administration that registry-driven systematic case review depends on – building toward the same kind of measurement infrastructure that supports MBC in adult and school-age CoCM.

Strengthening workforce capacity. The specialized expertise required of the psychiatric consultant and clinical team in this pathway – including fluency with the DC:0-5 and developmentally informed case formulation – represents a more specialized workforce pool than general pediatric behavioral health. Continued investment in training pathways, supervision, and consultation structures (as several states are already funding) will help ensure the model can scale sustainably alongside growing demand. Specific attention to development of a diverse workforce, reflective of the diversity of the communities served, is essential.

As with any model that introduces systematic screening and caregiver-informed data collection into a child's medical record, thoughtful attention to implementation – including how findings are used, shared, and acted upon – will be an important part of piloting and refining this pathway responsibly.

Structure & Flow of the Early Childhood CoCM Care Pathway (Ages 0 to 6)

STEP 1: Initial Screening

Screening tools serve a dual purpose: they flag children who may benefit from further evaluation and provide a baseline for tracking change over time. Best practice includes not just universal screening, but universal developmental surveillance, the monitoring of social emotional development over time, to identify young children with social emotional needs

Screening for behavioral health concerns should occur across all clinical touchpoints, regardless of visit type or presenting concern. The best screening tool is the one that gets used, and a “no wrong door” approach ensures that young children and their families in need receive support in a timely manner. Results of standardized screening and monitoring tools are considered in combination with the provider’s behavioral observation, caregiver reports, and clinical judgment. Even when specific concerns are not directly identified through the screening questions, a robust screening process, including discussion of the results with the caregiver, can facilitate important conversations and improve identification of relevant concerns.

Behavioral health screening is a relational process that supports and is supported by engagement and collaboration with the caregiver, rather than a rigid checklist. Screening therefore becomes not just a tool to identify potential concerns, but an opportunity to develop a shared understanding of the child’s needs and a collaborative care plan.

In cases where young children are referred to CoCM without completion of a standardized social-emotional rating scale, this can be completed by the Behavioral Health Care Manager (BHCM) as part of the initial assessment and clinical formulation.

Factors to consider when selecting screening measures include:

- Validated age range and developmental-appropriateness
- Psychometric reliability and validity
- Cultural and language needs of the population served
- Licensing requirements and administrative costs
- Integration into the electronic medical record

Each measure included in this care pathway generally demonstrates robust reliability and validity for young children, has been validated in cross-cultural samples in the United States, and is validated in multiple languages. Some of the measures included in this pathway, however, do require a license and/or may incur administrative costs. Full references for each tool are included in Appendix IV.

Social-Emotional Screening Tools:

- Baby Pediatric Symptom Checklist (BPSC, Sheldrick et al., 2013; Sheldrick, Henn, & Briggs-Gowan, 2023)
- Preschool Pediatric Symptom Checklist (PPSC, Sheldrick et al., 2012)
- Pediatric Symptom Checklist- 17 (PSC-17, Gardner et al., 1999; Murphy et al., 2016)
- Pediatric Symptom Checklist- 35 (PSC-35, Jellinek et al., 1988; Jellinek et al., 1999)
- Survey of Wellbeing of Young Children (SWYC, Perrin et al., 2016, TEAM UP Center, n.d.)[2]

[2]The BPSC or PPSC, depending on the child’s age, and the POSI, are included in the SWYC assessment battery.

- Brief Early Childhood Screening Assessment (Brief ECSA, Fallucco et al., 2017)
- Strengths and Difficulties Questionnaire (SDQ, Croft, Stride, Maughan, & Rowe, 2015)
- Brief Infant-Toddler Social Emotional Assessment (BITSEA, Briggs-Gowan, Carter, Irwin, Wachtel, & Cicchetti, 2004)
- Ages & Stages Questionnaire: Social-Emotional (ASQ:SE; Squires, Bricker, Heo, & Twombly, 2001)
- Child Adjustment and Parenting Efficacy Scale- Developmental Disability (CAPES-DD, Emser, Mazzucchelli, Christiansen, & Sanders, 2016)
- Devereux Early Childhood Assessment-Clinical (DECA-C, LeBuffe & Naglieri, 2003)
- Eyberg Child Behavior Inventory (ECBI, Eyberg & Pincus, 1999)

Developmental & Autism Screening Tools:

- Ages & Stages Questionnaire (ASQ; Squires, Bricker, & Potter, 1997)
- Parents Evaluation of Developmental Status (PEDS, Glascoe, 1997)
- Survey of Wellbeing of Young Children (SWYC)
- Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R, Robins, Fein, Barton, & Green, 2001; Robins et al., 2014)
- Parent's Observations of Social Interactions (POSI, Smith, Sheldrick, & Perrin, 2013)[1]
- Rapid Interactive Screening Test for Autism in Toddlers (RITA-T, Choueiri & Wagner, 2015)
- Screening Tool for Autism in Toddlers and Young Children (STAT™, Stone, Coonrod, & Ousley, 2000)

Caregiver screening:

- Patient Health Questionnaire- 9 (PHQ-9, Yawn et al., 2009)
- Edinburgh Postnatal Depression Scale (EDPS, Cox, Holden, & Sagovsky, 1987; Cox, Chapman, Murray, & Jones, 1996)
- Parental Stress Scale (PSS, Berry & Jones, 1995; Zelman & Ferro, 2018)
- Caregiver Strain Questionnaire (CGSQ, Brannan, Heflinger, & Bickman, 1997; Hileman et al., 2016)
- Parenting Stress Index (PSI, Abidin, 1995; Haskett et al., 2006)

Trauma & Social Determinants of Health:

- Child Trauma Screen (CTS, Lang & Connell, 2017; Lang & Connell, 2018).
- Health Leads (Health Leads, 2016; Fiori et al., 2021).
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE, National Association of Community Health Centers & Association of Asian Pacific Community Health Organizations, 2022; Weir et al., 2020).
- Safe Environment for Every Kid (SEEK PSQ, Dubowitz, Feigelman, Lane, & Kim, 2009; Dubowitz, Lane, Semiatin, & Magder, 2012; Eismann et al., 2019).
- WE CARE Survey (Garg et al., 2007; Garg et al., 2015; Zielinski, Paradis, Herendeen, & Barbel, 2017).
- Young Child PTSD Checklist (YCPC, Perrin et al., 2016; Danzi, Knowles, & Kelly, 2024).

Additional Measures for Diagnosis and Assessment

- Children's Sleep Habits Questionnaire (CSHQ, Owens et al., 2000)

STEP 2: Diagnosis and Clinical Formulation

CoCM requires that an active behavioral health diagnosis is included in the medical record. This diagnosis functions as justification for medical necessity of care as well as guiding appropriate care plans. It is relevant to

note, however, that diagnostic certainty is typically not necessary to guide behavioral health services at this level of care. In fact, within the context of CoCM, diagnosis can be refined and updated as a result of the assessment process and in collaboration with the consulting psychiatrist.

This approach in the treatment of young children, definitive differential diagnosis is useful to the extent that it guides treatment. Therefore, the goal of this step may be best conceptualized as the development of a working diagnosis and clinical formulation, sufficient to inform an evidence-based intervention plan.

Notably, there are severe limitations of extending downward the diagnostic criteria used for adults (Egger & Emde, 2011; Gleason et al., 2017). Therefore, developmentally-appropriate formulation framework and assessment tools are necessary in order to accurately describe behavioral health disorders in young children. The DC:0-5 offers both, providing a comprehensive set of diagnoses for children in this age group as well as a comprehensive multi-axial framework for case conceptualization in young children.A crosswalk for mapping these diagnoses to ICD-10 codes is available, enabling providers to bill for their services (Zero to Three, 2025).

It is relevant to note that while universal screening does not always directly assess traumatic exposure or response, trauma may present in any number of symptoms in this age group (internalizing, externalizing, developmental delays). It is therefore recommended that trauma be considered as a differential diagnosis for all children identified as having mental health needs (National Child Traumatic Stress Network, 2010).

Children with significant concerns for autism and developmental disabilities may require more comprehensive evaluation for accurate diagnosis and access to appropriate services. Coordination of services with Individuals with Disabilities Education ACT (IDEA) Part C services (commonly referred to as Zero to Three, Early Intervention or First Steps) and/or Early Childhood Special Education (ECSE) services (IDEA Part B), depending on the child's age, is recommended.

Recommendations for diagnosis and clinical formulation:

- It is recommended that the diagnosis and clinical formulation be guided by measurement results as well as:
    - Observation of the child
    - Observation of the caregiver-child dyad
    - Caregiver reports (including teachers/daycare providers if applicable)
    - Available records (medical, educational, etc.)
    - DC: 0-5 provides a developmentally appropriate diagnostic framework including a crosswalk with ICD-10 diagnostic codes
- Consistent with the framework proposed in the DC:0-5, a comprehensive, developmentally-appropriate clinical formulation for early childhood social and emotional concerns should include consideration of:
    - The child's development across all domains (language, cognitive, social/emotional, physical)
    - Medical/physical factors
    - Caregiving relationship(s) (e.g., goodness of fit) and Caregiver wellbeing (e.g., caregiver mental health and caregiver strain)
    - Cultural, Social and environmental context including risk factors (Social Determinants of Health, traumatic exposures) and strengths (resiliency factors, resources)
- Diagnosis codes are presented in a tiered structure in the table below to distinguish between generally uncontested behavioral health diagnosis codes.
    - Diagnosis codes listed in the pathways are not intended to be comprehensive, refer to the ICD-10 for a full listing of applicable diagnostic codes and criteria.
    - Z codes describing social and environmental factors influencing health and well-being are frequently applicable for this age group.
    - R codes focused on specific symptoms, signs and abnormal results can also be useful descriptive diagnoses for young children.
    - There may be state- or payer-specific billing restrictions related to the use of Z-codes and R-codes for CoCM.

STEP 3: Evidence-Based Intervention

Evidence-based interventions within early childhood CoCM are most often dyadic in nature, with caregivers serving as active participants in treatment rather than solely as informants. These interventions recognize the central role of caregiver-child relationships in early development and encompass a range of clinical approaches. Preventive and parenting skills interventions include programs such as Triple P and The Incredible Years; skill-based and behavioral treatments include approaches such as Parent-Child Interaction Therapy (PCIT), Applied Behavior Analysis (ABA), and Parent Management Training (PMT); reflective and relational approaches include interventions such as Promoting First Relationships and Circle of Security Parenting (COS-P); and modular approaches, such as Families and Schools Together-Early Childhood (FAST-E), provide flexible frameworks that can be adapted to meet diverse clinical needs.

Some evidence-based interventions for young children are suitable for the brief, episodic nature of CoCM within pediatric primary care settings, and others may be more appropriate within speciality care settings. Coordination of care across multiple service settings or referral to alternative treatment settings may be warranted. Also included in the evidence-based interventions are group-based models, which can either be delivered in group format outside of CoCM or may be adapted for use with individual caregivers and families within the model.

Selection of interventions for individual children and families should be guided by the child's presenting concerns, developmental stage, functional needs, and family context, rather than being contingent upon the establishment of a finalized diagnosis. This approach reflects the developmental and relational nature of early childhood behavioral health, in which intervention selection is often based on identified needs, caregiver-child dynamics and functional impairment rather than diagnostic criteria alone.

Brief Evidence-Based Interventions suitable for Primary Care/CoCM

- Chicago Parent Program Individualized for Families (CPPi): (Bettencourt et al., 2026; Gross et al., 2026).
- Family Check-Up 4 Health (FCU4Health): (Berkel et al., 2020).
- First Approach Skills Training - Early Childhood (FAST-E): (Blossom et al., 2024).
- Hand in Hand Parenting (adapted): (Wipfler, 2006; Wipfler & Schore, 2016).
- Healthy Steps (Tier 2-3): (Caughy, Miller, Genevro, Huang, & Nautiyal, 2003; Caughy, Huang, Miller, & Genevro, 2004; Minkovitz et al., 2007; Briggs et al., 2014).
- Parent Management Training (PMT): (Kazdin, 2005).
- Parent-Child Interaction Therapy (PCIT) - adapted: (Eyberg & Robinson, 1982).
- Parents as Teachers: (Wagner & Clayton, 1999; Jespersen, Morris, Hubbs-Tait, & Washburn, 2021).
- Promoting First Relationships: (Spieker, Oxford, Kelly, Nelson, & Fleming, 2012).
- Supportive Parenting for Anxious Childhood Emotions (SPACE): (Lebowitz, Marin, Martino, Omer, & Silverman, 2020; Lebowitz, 2024).

Group-Based Interventions

- Chicago Parent Program (CPP): (Gross et al., 2003; Gross et al., 2009; Breitenstein et al., 2012; Gross et al., 2019; Bettencourt et al., 2022; McGrane Minton et al., 2024).
- Circle of Security - Parenting (COS-P): (Hoffman, Marvin, Cooper, & Powell, 2006).
- Incredible Years: (Webster-Stratton, 1981; Webster-Stratton, Reid, & Hammond, 2001; Webster-Stratton & Bywater, 2019).
- Triple P (Positive Parenting Program): (Sanders, Berk, Campbell, & Stallman, 2014; Prinz, 2019; Sanders, 2023).

Supplemental / Specialty Evidence-Based Interventions

- Applied Behavioral Analysis (ABA): (Lovaas, 1987; Dawson et al., 2010; Bacotti, Peters, & Vollmer, 2022).
- Attachment and Bio-Behavioral Catchup (ABC): (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008; Schein, Roben, Costello, & Dozier, 2022).
- Child First: (Lowell, Carter, Godoy, Paulicin, & Briggs-Gowan, 2011).
- Child-Parent Psychotherapy (CPP): (Lieberman, Weston, & Pawl, 1991; Lieberman, Van Horn, & Ippen, 2005).
- Occupational Therapy / Sensory-Integration Therapy: (Piller et al., 2024; Silva et al., 2025).
- Parent-Child Interaction Therapy (PCIT): (Eyberg & Robinson, 1982).
- Parent-Child Interaction Therapy - Emotion Development (PCIT-ED): (Luby, Barch, Whalen, Tillman, & Belden, 2012; Luby, Rogers, Tillman, & Barch, 2018; Wood, Self-Brown, et al., 2020).
- Parents as Teachers: (Wagner & Clayton, 1999; Jespersen, Morris, Hubbs-Tait, & Washburn, 2021).
- Physical Therapy: (Harbourne et al., 2021; Finlay-Jones et al., 2024; Pop, Nicolescu, & Gherle, 2025; Silva et al., 2025).
- Speech Therapy: (Pak et al., 2023; Roberts & Kaiser, 2011; Silva et al., 2025).
- TF-CBT Preschool: (Cohen, Mannarino, & Iyengar, 2011; Scheeringa, Weems, Cohen, Amaya-Jackson, & Zeanah, 2011).

STEP 4: Ongoing Evaluation and Symptom Monitoring

Progress monitoring should use a validated, standardized tool specific to social-emotional symptoms and concerns. In the treatment-to-target framework, the outcome of CoCM is focused on the child's behavioral health symptoms and behaviors. Alternatively, idiographic measures such as the Youth Top Problems (YTP, Weisz et al., 2011; Herren, Garibaldi, Evans, & Weisz, 2018; Wood et al., 2022) or provider-rated measures of patient severity and treatment progress such as the Clinical Global Impressions - Improvement or Clinical Global Impressions -Severity (CGI-I, CGI-S, Guy, 1976; Greenhill et al., 2006) may also be acceptable outcome measures.

Within the treatment-to-target framework, interpreting changes in symptom trajectory requires clear benchmarks. Some common methods to interpret improvement on standardized symptom monitoring scores are described below.

- When available, Reliable Change Indices (RCIs) help determine whether improvement exceeds measurement error. RCI values in the care pathways are derived from the relevant scientific literature.
- When validated tools lack published RCIs, alternative decision rules may include a ≥ 50% reduction from baseline.
- Crossing Clinical Threshold (CCT; movement from a score above the clinical threshold to below),
- Finally, meaningful improvement in school, peer, or family functioning can be considered alongside measurement results.

To maximize the efficacy of systemic case reviews with the psychiatric consultant, the BHCM should compile the following prior to consultation:

- **Child Symptoms and Functioning**
    - Baseline scores from the BPSC/PPSC
    - Notable observations of the child
    - Child symptoms across settings (home, community, school/child care)
    - Impact of symptoms on child's functioning
    - Impact of symptoms on caregiver/family functioning
- **Dyadic Assessment**
    - Observations and assessment of caregiver-child relationship(s)

    - Parental mental health assessment
    - Evaluation of parental stress
- **Physical and Medical Factors**
    - Co-occurring physical/somatic symptoms (e.g., sleep disturbances, failure to thrive, feeding problems)
    - Significant medical diagnoses and treatment
    - Current medications
- **Systemic and Environmental Factors**
    - Social determinants of health (SDOH) and social needs
    - Caregiving environment
    - History of developmental trauma and environmental stressors

Ongoing monitoring of additional factors, including the child's overall developmental trajectory, caregiver mental health symptoms, and caregiver stress, can inform care planning and guide treatment adjustments. For some patients and families, these factors may represent primary targets of CoCM intervention, particularly when reductions in caregiver strain and improvements in caregiver functioning serve as important indicators of treatment progress.

Early Childhood CoCM Care Pathway (ages 0-5 years)

Initial Screening	**"No Wrong Door"** – children may be identified for follow-up and further assessment via universal screening for social-emotional and/or developmental concerns as well as provider observations, caregiver concerns, and/or behavioral observations.				
Symptomatic Cluster	**Autism & Developmental Delays:**	**Internalizing Symptoms**	**Externalizing Symptoms/ Behaviors**	**Specific Behavioral/ Developmental Concern (toileting, sleeping, eating, etc.)**	**Trauma**
Assessment Tools for Differential Diagnosis and Clinical Formulation	MCHAT RITA-T STAT ASQ/ASQ-SE SWYC- POSI	**PPSC**: Internalizing Subscale **SPAS** **SDQ:** Emotional Symptoms Subscale	**PPSC**: Externalizing Subscale and/or Attention Problems Subscale **SDQ**: Conduct Problems and/or Hyperactivity/ Inattention Subscales	CSHQ	Child Trauma Screen Young Child Version (CTS) Young Child PTSD Checklist (YCPC)
	Screen for caregiver mental health (**PHQ** or **EPDS**) Screen for caregiver strain (**PSS** or **PPSC** Parenting Concerns Subscale or Caregiver Strain Scale)				
	Screen for Health-Related Social Needs (**Health Leeds**, **SEEK PSQ**, **WE CARE,** or **PRAPARE**)				
Common Diagnoses (ICD-10)	Adjustment disorder with depressed mood (F43.21) Adjustment disorder with anxiety (F43.22) Adjustment disorder with disturbance of conduct (F43.24) Adjustment disorder with mixed disturbance of emotions and conduct (F43.25) Adjustment disorder with other symptoms (F43.29) Adjustment Disorder, Unspecified (F43.20) Unspecified behavioral and emotional disorder with onset usually occurring in childhood and adolescence (F98.9)				
	Childhood Autism (F84.0) Pervasive Developmental	Separation Anxiety Disorder of Childhood (F93.0) Social Anxiety	Disturbance of Activity and Attention (F90.1) Other Persistent Mood Disorders	Nonorganic Insomnia (F51.0) Night Terrors (F51.4) Nightmares (F51.5)	Reaction to Severe Stress, Unspecified (F43.9) Posttraumatic Stress

	Disorder, Unspecified (F84.9) Global Developmental Delay (F88) Speech and Language Delay, Unspecified (F80.9) Other Disorders of Psychological Development (Sensory Processing Disorder) (F88)	Disorder of Childhood (F93.2) Generalized Anxiety Disorder (F41.1) Selective Mutism (F94.0) Major Depressive Disorder Depressive Episode (F32) Unspecified Mood Disorder (F39)	(Disruptive Mood Dysregulation Disorder) (F34.8)	Overeating Associated with Other Psychological Disturbances (F50.4) Feeding Disorders of Infancy and Early Childhood (F98.2) Other Eating Disorders (F50.8) Nonorganic Encopresis (F98.1) (age 4+) Nonorganic Enuresis (F98.0) (age 5+)	Disorder (F43.10) Other Reactions to Severe Stress (F43.8)
Additional Diagnostic Codes –State-Specific Billing Restrictions may apply	Problems of adjustment to life-cycle transitions (Z60.0) Parent-child relational problem (Z62.820) Other problems related to primary support group, including family circumstances (Z63) Irritability and anger (R45.4) Excessive crying, infant (R68.11) Fussy infant, baby (R68.12)				
	Problems related to education and literacy (Z55) Developmental Concern (R62.50) Delayed Milestones (R62.0) Other symptoms and signs involving general sensations and perceptions (R44.8)	High expressed emotional level within family (Z63.8) inattention (R41.840) Unhappiness (R45.2) Nervousness (R45.0)	High expressed emotional level within family (Z63.8) Inadequate parental supervision and control (Z62.0) inattention and concentration deficit (R41.84) impulsiveness (R45.87) Overactivity (R46.3)	Behavioral insomnia of childhood (Z73.819) Feeding difficulties, unspecified (R63.30) Fecal incontinence (R15) (4+ years) Urinary Incontinence (R32) (5+ years)	Low Income (Z69.6) Homelessness (Z59) Acculturation difficulty (Z60.3) Upbringing away from parents (Z62.29) Problem related to other psychosocial circumstances (Z65) State of emotional shock and stress, unspecified (R45.7)

Symptom Monitoring / Treat-To-Target	**Child Adjustment and Parenting Efficacy Scale-Developmental Disability (CAPES–DD)**-- 50% reduction from baseline on Behavioral Problems or Emotional Problems Subscale or Total Problems Scale	**Preschool Pediatric Symptom Checklist (PPSC)** – Crossing Clinical Threshold or 50% reduction from baseline on total or subscale(s) **Baby Pediatric Symptom Checklist (BPSC)** – Crossing Clinical Threshold or 50% reduction from baseline on total or subscale(s) **Pediatric Symptom Checklist - 35 (PSC-35)**-- RCI: Change of 6 or more points from baseline (Kamin et al., 2015, Murphy et al., 2016) **Strengths & Difficulties Questionnaire (SDQ) –** RCI: Change of 4 or more points on the total Difficulties Score				
	Youth Top Problems (YTP)-- RCI: Change of 0.49 or more points on the caregiver-reported top problems rating **Clinical Global Impressions- Improvement (CGI-I)**-- RCI: Reduction of 2 or more points **Clinical Global Impressions- Severity (CGI-S)** – RCI: Increase of 2 or more points				
Brief Evidence-Based Interventions suitable for Primary Care/CoCM	-Family Check-Up 4 Health (FCU4Health) -Parent Child Interaction Therapy (PCIT) - adapted -Healthy Steps (Tier 2-3)	-FAST- Early Childhood -Family Check-Up 4 Health (FCU4Health) -Supportive Parenting for Anxious Childhood Emotions (SPACE) -Promoting First Relationships -Parents as Teachers -Promoting First Relationships – Hand in Hand Parenting - adapted -Chicago Parent Program Individualized for Families (recent adaptation)	-FAST- Early Childhood -Family Check-Up 4 Health (FCU4Health) -Parent Management Training -Parent Child Interaction Therapy (PCIT) - adapted –Hand in Hand Parenting -adapted -Chicago Parent Program Individualized for Families (recent adaptation) -Family Check-Up	-FAST- Early Childhood -Family Check-Up 4 Health (FCU4Health) -Healthy Steps (Tier 2-3)	-Family Check-Up 4 Health (FCU4Health) -Promoting First Relationships -Child & Family Traumatic Stress Intervention (CF-TSI)

Supplemental Group-Based Interventions		-Circle of Security-Parenting -Chicago Parent Program -Triple P	-Incredible Years -Triple P -Chicago Parent Program		-Circle of Security-Parenting -Chicago Parent Program
Supplemental / Specialty Evidence-Based Interventions	-Applied Behavioral Analysis -Parents as Teachers -Occupational Therapy/Sensory -Integration Therapy -Physical Therapy -Speech Therapy	-Parent Child Interaction Therapy - Emotion Development (PCIT- ED) -Child First	-Parent Child Interaction Therapy (PCIT) -Child First -Occupational Therapy/Sensory -Integration Therapy	-PCIT -Occupational Therapy/Sensory -Integration Therapy -Physical Therapy -Speech Therapy -Child First	-Child-Parent Psychotherapy -ABC -PCIT -TF-CBT Preschool -Child First

Appendix I: Guiding Principles for Early Childhood Collaborative Care

These guiding principles articulate the assumptions and clinical orientation underlying application of the Collaborative Care Model (CoCM) in early childhood. They reflect developmental science, pediatric clinical practice, and the realities of health system implementation, and are intended to guide adaptation of CoCM for young children and their families.

Principle 1. Caregiver involvement and relational context are essential components of early childhood behavioral health care, and caregivers serve as the primary voice in shared decision-making.

Rationale. Relational health is foundational to behavioral health outcomes in early childhood (Buka et al., 2022; Williams, 2023). Caregiver wellbeing has a direct impact on young children's emotional wellness and developmental trajectory (Dumitriu et al., 2023; Schuyler Center for Analysis and Advocacy, 2022). While caregivers experiencing severe stress or conditions like parental depression can be a source of risk for young children's development (Cree et al., 2018; Van der Waerden et al, 2015), responsive and supportive caregiving practices also play a key role in prevention and promotion of child well-being and development (Gee & Cohodes, 2021, 2023; National Academies of Sciences, Engineering, and Medicine, 2025). Furthermore, fostering caregiver warmth and sensitivity can directly mitigate early risk trajectories, actively protecting against the development of early childhood conduct and behavioral problems (Vanderbilt-Adriance et al., 2015).

Evidence-based interventions for this age group consistently involve caregivers and primary attachment figures as active participants in care (eg: Margolis et al, 2020; McLuckie,et al., 2019; Nayak et al., 2021; Shepard & Dickstein, 2009; Zeanah, 2019), for all types of caregivers including parents of all genders, foster parents and non-related caregivers, and extended family members (Buka et al., 2022; Saroca,& Sargent, 2022) Furthermore, meta-analysis has demonstrated that incorporating parents into the therapeutic process significantly enhances the effectiveness of psychological interventions for youth (Dippel et al., 2022; Fawley-King et al., 2013). Notably, fathers have historically been marginalized and overlooked in pediatric clinical interventions, yet research demonstrates the critical role that fathers play in early childhood development (Cimino et al., 2024; Panter-Brick et al., 2014).

Because children in this age group cannot directly voice their own perspective, caregivers serve as the primary voice in shared decision-making (Margolis et al., 2020). Caregivers should be explicitly invited to share their perspectives, needs and preferences for their child's care including treatment planning, engagement decisions, and coordination with child-serving systems (Hubner et al., 2018; Nayak et al., 2023; Riley et al., 2021). Treatment planning and care navigation may therefore appropriately be directed at the caregiver level, in addition to direct work with the child. Cultural differences in caregiving norms, family structure, and relational expectations must be recognized and incorporated into care planning (Cohen et al., 2023; Sanchez, et al., 2022).

Caregiver engagement, dyadic understanding, and relational framing should therefore be understood as clinically essential elements of formulation, care planning, and effective intervention throughout early childhood CoCM.

Principle 2. Comprehensive, developmentally informed clinical formulation—encompassing symptom patterns, developmental context, caregiving relationships ,and cultural factors—should guide early childhood Collaborative Care.

Rationale. In early childhood, behavioral health concerns are most reliably understood through patterns of symptoms, functional impact, and developmental context rather than through narrow diagnostic categorization (Ogundele, 2018; Wiggins et al., 2021). A comprehensive clinical formulation necessarily incorporates the child's development stage and physical health, the family and caregiving environment, and the broader social and cultural context (Horen et al., 2024). Cultural differences in caregiving practices, family structure, and help-seeking behavior, which are particularly salient given the centrality of caregiving relationships to behavioral health outcomes in this age group, should also be carefully considered (Buka et al, 2022).

While formal psychiatric diagnosis plays an important role in billing, insurance coverage, and system alignment (Zeanah et al., 2016), symptom clusters and clinical presentation are often sufficient to initiate evidence-based intervention (Arruda et al., 2023). Diagnostic specificity is most clinically valuable when it informs treatment selection, supports monitoring of progress, and facilitates coordination across systems (Briggs-Gowan et al., 2013; Egger & Emde, 2011; Zeanah et al., 2016). More definitive diagnoses—such as autism spectrum disorder, global developmental delay, or conditions requiring educational accommodations—may be more appropriately established through specialty evaluation outside the context of CoCM (Habayeb et al., 2023; Hyman et al., 2020).

Accordingly, early childhood CoCM should emphasize developmentally informed formulation over premature diagnostic closure.

Principle 3. Initiation of CoCM services should prioritize timely intervention over definitive differential diagnosis.

Rationale. There is inherent complexity of diagnostic assessment during a developmental period characterized by rapid change, emerging skills, and substantial variability in the timing and expression of developmental milestones. In early childhood, diagnoses must be interpreted within the context of the child's developmental stage, trajectory, caregiving environment, and functional presentation. Diagnostic clarification is often an iterative process, and waiting for a definitive differential diagnosis may be clinically appropriate in some cases when additional developmental information is needed. However, requiring diagnostic certainty before initiating intervention may delay access to supports that address functional impairment, caregiver-child relational disruption, emotional or behavioral symptoms, and developmental concerns that are already evident (Arruda et al., 2023; Zeanah & Zeanah, 2019). Given the presence of critical developmental windows during which timely intervention may influence long-term trajectories, early childhood CoCM should prioritize identification of current needs and initiation of appropriate supports while diagnostic understanding continues to evolve (Wiggins et al., 2021; Zeanah et al., 2019).

The flexibility of the Collaborative Care Model allows treatment to begin based on the presence of a working behavioral health diagnosis rather than a finalized diagnostic determination. In young children, diagnostic labels are best understood as tools to describe the child's current needs and guide intervention planning, rather than as fixed representations of underlying etiology. Selection of evidence-based interventions should be guided by the child's presenting concerns, age, developmental stage, functional needs, caregiver-child relationship, and family context, rather than contingent upon confirmation of a specific diagnosisUse of developmentally appropriate diagnostic frameworks, such as those described in DC:0-5, can support care

planning and identification of appropriate interventions while recognizing the dynamic nature of early childhood development.

Specialized diagnostic evaluations, including formal psychological or neuropsychological assessments for conditions such as autism spectrum disorder, global developmental delay, or diagnoses requiring educational accommodations, may be more appropriately established through specialty services outside the context of CoCM (Habayeb et al., 2023; Hyman et al., 2020). Nonetheless, timely access to services for youth with suspected developmental disabilities remains critical (Hyman et al., 2020). In these circumstances, CoCM may provide valuable interim support through care coordination, caregiver guidance, symptom monitoring, and targeted interventions while families pursue specialty evaluation and diagnostic clarification.

Principle 4. Flexibility in the intensity and timing of care is necessary to meet the developmental and family needs of young children.

Rationale. The appropriate intensity, frequency, and distribution of behavioral health care for young children may vary substantially over time (Kolko & Perrin, 2014). Care often involves significant engagement with caregivers, coordination with collateral providers, and interaction with child-serving systems— all of which may require variable levels of effort across months (Nayak, et al., 2023). Implementation of CoCM with young children should therefore allow for flexible delivery of care that aligns with developmental needs, caregiver availability, and system-level coordination demands, rather than assuming a uniform monthly service intensity (Godoy et al., 2022).

Principle 5. Effective early childhood Collaborative Care requires thoughtful cross-system coordination, with care plans tailored to each child and family's individual needs.

Rationale. Young children interact with multiple systems— including pediatric primary care, early intervention, early education and care, and community services—and effective CoCM requires active coordination across these systems (Child Health and Development Institute, 2023, 2025). Care plans should be tailored to individual patient and family needs and preferences, and should avoid unnecessary duplication of services in initiating care (Nayak et al., 2023).

Children with significant developmental delays or autism spectrum conditions represent one important population for whom cross-system coordination is especially critical (Horen et al., 2024). These children may require specialized developmental services such as Early Intervention or Special Education, and CoCM's tiered, flexible structure positions it to play important complimentary roles: bridging to or from Early Intervention, supporting families when services are unavailable or insufficient, and addressing behavioral, attachment-related, and caregiver concerns in the context of developmental differences (Habayeb et al., 2023; Hyman et al., 2020). This is one example of a population-specific consideration; similar thoughtfulness should be applied to other populations with complex or overlapping service needs as they are identified.

Principle 6. Psychiatric consultation and systematic caseload review in early childhood Collaborative Care should emphasize the consultant's developmental and clinical expertise, and not solely focus on medication management.

Rationale. In traditional CoCM, psychiatric consultation and systematic caseload review often focuses on pharmacologic guidance. However, child and adolescent psychiatrists and other psychiatric consultants bring

expertise that extends well beyond medication management—including diagnostic formulation, developmental assessment, care planning, and family systems consultation—all of which can add substantial value in the care of young children (American Psychiatric Association, 2021; Buka et al., 2022). Involvement of a psychiatric consultant should not be interpreted as implying that medication is indicated or must be considered as part of treatment (Carlo et al., 2021, Meadows Mental Health Policy Institute, 2023;). Rather, experts in child psychiatry can assist care teams and families to balance the risks and benefits of medications, nonpharmacological interventions and “wait and watch” options (Gleason et al., 2017; Shaligram & Walter, 2023).

Therefore, CMS, CHIP and payers must clearly articulate the role and scope of the psychiatric consultant, particularly in the context of children ages 0 to 5, to utilize their full range of skills and expertise to support holistic care for young patients. While this may at times include consideration of pharmacological interventions for young children, this should in no way suggest that prescribing psychotropic medications is the goal of CoCM or the sole role of the psychiatric consultant

Appendix II: References

Infant & Early Childhood Mental Health (IECMH) & Developmental Foundations

Alliance for the Advancement of Infant Mental Health. (2021). Preparing competency-based learning for IECMH endorsement: Training guide and self-assessment. https://www.ct-aimh.org/wp-content/uploads/2023/05/AlliancePreparingCompBasedLearning_2021-FINAL-1.pdf

Buka, S. L., Beers, L. S., Biel, M. G., Counts, N. Z., Hudziak, J., Parade, S. H., Paris, R., Seifer, R., & Drury, S. S. (2022). The family is the patient: Promoting early childhood mental health in pediatric care. *Pediatrics, 149*(Suppl 5), e2021053509L.

Cimino, S., Tafà, M., & Cerniglia, L. (2024). Fathers as Key Figures Shaping the Foundations of Early Childhood Development: An Exploratory Longitudinal Study on Web-Based Intervention. *Journal of Clinical Medicine, 13*(23), 7167.

Cree, R. A., Bitsko, R. H., Robinson, L. R., Holbrook, J. R., Danielson, M. L., Smith, C., Kaminski, J. W., Kenney, M. K., & Peacock, G. (2018). Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States, 2016. *Morbidity and Mortality Weekly Report, 67*(50), 1377–1383.

Dumitriu, D., Lavallée, A., Riggs, J. L., Frosch, C. A., Barker, T. V., Best, D. L., Blasingame, B., Bushar, J., Charlot-Swilley, D., Erickson, E., Finkel, M. A., Fortune, B., Gillen, L., Martinez, M., Ramachandran, U., Sanders, L. M., Willis, D. W., & Shearman, N. (2023). Advancing early relational health: A collaborative exploration of a research agenda. *Frontiers in Pediatrics, 11*, 1259022.

Gee, D. G., & Cohodes, E. M. (2021). Influences of caregiving on development: A sensitive period for biological embedding of predictability and safety cues. *Current Directions in Psychological Science, 30*(5), 376–383.

Gee, D. G., & Cohodes, E. M. (2023). Leveraging the developmental neuroscience of caregiving to promote resilience among youth exposed to adversity. *Development and Psychopathology, 35*(5), 2168–2185.

Gleason M. M. (2017). Partnering With Child-Serving Professional Organizations: The Example of Early Childhood Mental Health Policy. *Journal of the American Academy of Child and Adolescent Psychiatry, 56*(12), 1012–1014. https://doi.org/10.1016/j.jaac.2017.09.434

Gleason, M. M., & Finelli, J. (2025). Introduction to Infant and Early Childhood Mental Health. Child and adolescent psychiatric clinics of North America, 34(2), 143–156. https://doi.org/10.1016/j.chc.2024.07.014Hyman, S. L., Levy, S. E., Myers, S. M., & Council on Children with Disabilities, Section on Developmental and Behavioral Pediatrics. (2020). Identification, evaluation, and management of children with autism spectrum disorder. *Pediatrics, 145*(1), e20193447.

Illinois Association for Infant Mental Health. (2025, December 18). ILAIMH IECMH executive summary. https://ilaimh.org/wp-content/uploads/2026/02/ILAIMH-IECMH-Executive-Summary-12.18.2025.pdf

National Academies of Sciences, Engineering, and Medicine. (2019). Fostering healthy mental, emotional, and behavioral development in children and youth: A national agenda. The National Academies Press. https://www.nationalacademies.org/projects/DBASSE-BCYF-16-06/publication/25201

National Academies of Sciences, Engineering, and Medicine. (2025). Early relational health: Building foundations for child, family, and community well-being. The National Academies Press. https://www.nationalacademies.org/projects/DBASSE-BCYF-23-03/publication/29234

National Child Traumatic Stress Network. (2010). Early childhood trauma. https://www.nctsn.org/resources/early-childhood-trauma

Ogundele, M. O. (2018). Behavioural and emotional disorders in childhood: A brief overview for paediatricians. *World Journal of Clinical Pediatrics, 7*(1), 9–26.

Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K., & Leckman, J. F. (2014). Practitioner review: Engaging fathers-Recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry, 55*(11), 1187–1212.

Sanchez, A. L., Jent, J., Aggarwal, N. K., Chavira, D., Coxe, S., Garcia, D., La Roche, M., & Comer, J. S. (2022). Person-Centered Cultural Assessment Can Improve Child Mental Health Service Engagement and Outcomes. *Journal of Clinical Child and Adolescent Psychology, 51*(1), 1–22. https://doi.org/10.1080/15374416.2021.1981340

Simon G. (2009). Collaborative care for mood disorders. *Current Opinion in Psychiatry, 22*(1), 37–41. https://doi.org/10.1097/YCO.0b013e328313e3f0

Van der Waerden, J., Galéra, C., Larroque, B., Saurel-Cubizolles, M.-J., Sutter-Dallay, A.-L., & Melchior, M. (2015). Maternal depression trajectories and children's behavior at age 5 years. *The Journal of Pediatrics, 166*(6), 1440–1448.e1.

Vanderbilt-Adriance, E., Shaw, D. S., Brennan, L. M., Dishion, T. J., Gardner, F., & Wilson, M. N. (2015). Child, family, and community protective factors in the development of children's early conduct problems. *Family Relations, 64*, 64–79.

Wiggins, J. L., Briggs-Gowan, M. J., Brotman, M. A., Leibenluft, E., & Wakschlag, L. S. (2021). Toward a developmental nosology for disruptive mood dysregulation disorder in early childhood. *Journal of the American Academy of Child & Adolescent Psychiatry, 60*(3), 388–397.

Williams R. C. (2023). From ACEs to early relational health: Implications for clinical practice. *Pediatrics & Child Health, 28*(6), 377–393.

Zeanah, C. H., Jr. (Ed.). (2019). Handbook of infant mental health (4th ed.). Guilford Publications.

Zeanah, C. H., Carter, A. S., Cohen, J., Egger, H. L., Keren, M., Lieberman, A. F., Mulrooney, K., & Osofsky, J. D. (2016). DC:0–5: Diagnostic classification of mental health and developmental disorders of infancy and early childhood. ZERO TO THREE.

Zeanah, C. H., & Zeanah, P. D. (2019). Infant mental health: The clinical science of early experience. In C. H. Zeanah (Ed.), Handbook of infant mental health (4th ed., pp. 5–24). The Guilford Press.

ZERO TO THREE. (2017, November 27). Infant and early childhood mental health competencies: A briefing paper. https://www.zerotothree.org/wp-content/uploads/2017/11/Infant-and-Early-Childhood-Mental-Health-Competencies_-A-Briefing-Paper-2.pdf

ZERO TO THREE. (2025, December 1). *Crosswalk from DC:0-5™ to DSM-5 and ICD-10*. https://www.zerotothree.org/resource/crosswalk-from-dc0-5-to-dsm-5-and-icd-10/

Collaborative Care Model & System-Level Implementation

Ader, J., Stille, C. J., Keller, D., Miller, B. F., Barr, M. S., & Perrin, J. M. (2015). The medical home and integrated behavioral health: advancing the policy agenda. *Pediatrics, 135*(5), 909–917.

AIMS Center. (2023). Pediatric CoCM implementation guide. University of Washington. https://aims.uw.edu/wordpress/wp-content/uploads/2023/06/Pediatric-CoCM-Implementation-Guide_Final-Reduced-Size.pdf

American Academy of Child and Adolescent Psychiatry. (2012). Best principles for integration of child psychiatry into the pediatric health home. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

American Psychiatric Association. (2021). Treating the pediatric population in the collaborative care model. https://www.psychiatry.org/getmedia/0a4609b8-2b12-4df2-b8ab-eca0fa103fe2/APA-Treating-Pediatric-in-the-CoCM-Guide.pdf

Arruda, W., Bélanger, S. A., Cohen, J. S., Hrycko, S., Kawamura, A., Lane, M., Patriquin, M. J., & Korczak, D. J. (2023). Promoting optimal mental health outcomes for children and youth. *Paediatrics & child health, 28*(7), 417–436. https://doi.org/10.1093/pch/pxad032

Asarnow, J. R., Jaycox, L. H., Duan, N., LaBorde, A. P., Rea, M. M., Murray, P., & Wells, K. B. (2005). Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized controlled trial. *JAMA, 293*(3), 311–319.

Asarnow, J. R., Rozenman, M., Wiblin, J., & Zeltzer, L. (2015). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics, 169*(10), 929–937.

Bipartisan Policy Center. (2025, January 7). *Redesigning the health care delivery system to better meet the needs of youth*. https://bipartisanpolicy.org/report/health-care-redesign-youth/

Carlo, A. D., Barnett, B. S., & Unützer, J. (2021). Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. *JAMA psychiatry, 78*(4), 355–356. https://doi.org/10.1001/jamapsychiatry.2020.3216

Carlo, A. D., McNutt, C., & Talebi, H. (2024). Extending the Clinical Impact of Behavioral Health Prescribing Clinicians Using the Collaborative Care Model (CoCM). *Journal of general internal medicine, 39*(8), 1525–1527. https://doi.org/10.1007/s11606-024-08649-2

Centers for Medicare & Medicaid Services. (2026, February). State Medicaid & CHIP Toolkit: Children's Behavioral Health Services and the EPSDT Requirements. U.S. Department of Health and Human Services. https://www.medicaid.gov/federal-policy-guidance/downloads/state-medicaid-chip-bh-epsdt.pdf

Chang, D., Morrison, D. J., Bowen, D. J., Harris, H. M., Dusic, E. J., Velasquez, M. B., & Ratzliff, A. D. H. (2023). Making it to sustainability: Evaluating billing strategies for collaborative care. *Psychiatric Services, 74*(11), 1192–1195.

Child Health and Development Institute. (2023, November). Strengthening the behavioral health workforce for children, youth, and families: A strategic plan for Connecticut. https://www.chdi.org/resource-library/reports/strengthening-the-behavioral-health-workforce-for-children-youth-and-families

Child Health and Development Institute (CHDI). (2025). Issue Brief 93: Strengthening Children's Behavioral Health Systems of Care: The Essential Role of Infrastructure. https://www.chdi.org/resource-library/issue-briefs/strengthening-systems-of-care

Cohen, A. K., Hazelton, T., Bassey, H., Gutierrez-Padilla, M., Novosel, C., Nichols, C. R., & Jain, S. (2023). Improving functioning of children birth to five with emotional and behavioral problems: The role of comprehensive mental health services and supports. *Pediatric Reports,* 15(1), 33–44.

Dippel, N., Szota, K., Cuijpers, P., Christiansen, H., & Brakemeier, E. L. (2022). Family involvement in psychotherapy for depression in children and adolescents: Systematic review and meta-analysis. *Psychology and Psychotherapy, 95*(3), 656–679. https://doi.org/10.1111/papt.12392

Fawley-King, K., Haine-Schlagel, R., Trask, E. V., Zhang, J., & Garland, A. F. (2013). Caregiver participation in community-based mental health services for children receiving outpatient care. *The Journal of Behavioral Health Services & Research, 40*(2), 180–190. https://doi.org/10.1007/s11414-012-9311-1

Georgetown University Center for Child and Human Development. (n.d.). Competencies: Infant/early childhood mental health consultation. https://www.iecmhc.org/documents/IECMHC-competencies.pdf

Gleason, M. M., Goldson, E., Yogman, M. W., Committee on Psychosocial Aspects of Child and Family Health, Section on Developmental and Behavioral Pediatrics, & Section on Early Education and Child Care. (2016). Addressing early childhood emotional and behavioral problems. *Pediatrics, 138*(6), e20163025.

Habayeb, S., Inge, A., Myrick, Y., Hastings, A., Long, M., Hoffman, S. B., Parker, S., Theodorou, P., Soutullo, O., Beers, L., & Godoy, L. (2023). *A Multisystem Approach to Improving Autism Care. Pediatrics, 152*(5), e2022060584. https://doi.org/10.1542/peds.2022-060584

Horen, N. M., Sayles, J., McDermott, K., Sippel-Klug, K., Drake-Croft, J., & Long, T. (2024). Infant and early childhood mental health (IECMH) and early childhood intervention: Intentional integration. International Journal of Environmental *Research and Public Health, 21*(7), 870.

Hubner, L. M., Feldman, H. M., & Huffman, L. C. (2018). Parent communication prompt to increase shared decision-making: A new intervention approach. *Frontiers in Pediatrics, 6*, 60.

Huffman, J. C., Niazi, S. K., Rundell, J. R., Sharpe, M., & Katon, W. J. (2014). Essential articles on collaborative care models for the treatment of psychiatric disorders in medical settings: A publication by the Academy of Psychosomatic Medicine Research and Evidence-Based Practice Committee. *Psychosomatics*, *55*(2), 109–122.

Jensen-Doss, A., Douglas, S., Phillips, D. A., Gencdur, O., Zalman, A., & Gomez, N. E. (2020). Measurement-based care as a practice improvement tool: Clinical and organizational

applications in youth mental health. *Evidence-based practice in Child and Adolescent Mental Health, 5*(3), 233–250. https://doi.org/10.1080/23794925.2020.1784062

Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski, S. (2014). Collaborative care outcomes for pediatric behavioral health problems: A cluster randomized trial. *Pediatrics, 133*(4), e981–e992.

Kolko, D. J., & Perrin, E. (2014). The integration of behavioral health interventions in children's health care: services, science, and suggestions. *Journal of Clinical Child and Adolescent Psychology, 43*(2), 216–228. https://doi.org/10.1080/15374416.2013.862804

Lawrence-Sidebottom, D., McAlister, K., Roots, M., & Huberty, J. (2025). Evaluating the effectiveness of a collaborative care digital mental health intervention on obsessive-compulsive symptoms in adolescents: A retrospective study. *Digital Health, 11*, 20552076251331885. https://doi.org/10.1177/20552076251331885

LaVille Thoren, K., & Vista-Wayne, J. (2021). The collaborative care model: Improving access to children's mental health care. *Journal of Child and Adolescent Psychiatric Nursing, 34*(2), 83–87.

Margolis, K., Briscoe, A., & Tracey, J. (2020, May). Babies don't go to the doctor by themselves: Innovating a dyadic behavioral health payment model to serve the youngest primary care patients and their families. California Children's Trust. https://cachildrenstrust.org/wp-content/uploads/2020/05/Dyadic_final_May2020.pdf

Margolis, K. L., Buchholz, M., Charlot-Swilley, D., Serrano, V., Herbst, R., Meiselman, E., & Talmi, A. (2022). Early childhood integrated behavioral health: A promoter of equity in pediatric care. *Clinical Practice in Pediatric Psychology, 10*(3), 263–272.

Meadows Mental Health Policy Institute. (2023, November). Improving behavioral health care for youth through collaborative care expansion: Final report. https://mmhpi.org/wp-content/uploads/2023/05/Improving-Behavioral-Health-Care-for-Youth_CoCM-Expansion.pdf

McLuckie, A., Landers, A. L., Curran, J. A., Cann, R., Carrese, D. H., Nolan, A., Corrigan, K., & Carrey, N. J. (2019). A scoping review of mental health prevention and intervention initiatives for infants and preschoolers at risk for socio-emotional difficulties. *Systematic reviews, 8*(1), 183. https://doi.org/10.1186/s13643-019-1043-3

Moore, C., Adams, S., Beatty, M., Dharmaraj, B., Desai, A. D., Bartlett, L., Culbert, E., Cohen, E., Stinson, J. N., & Orkin, J. (2024). Caregiver and care team perceptions of online collaborative care planning for CMC. *Pediatrics, 154*(3), e2024065884.

National Academy for State Health Policy (NASHP). (2026). State Medicaid Coverage of Behavioral Health Therapy for Children and Youth. https://nashp.org/state-medicaid-coverage-of-behavioral-health-therapy-for-children-and-youth/

National Academy for State Health Policy (NASHP). (2023). States Enhance Medicaid Payment for Interprofessional Consultation: Opportunities for Maternal and Child Behavioral Health. https://nashp.org/states-enhance-medicaid-payment-for-interprofessional-consultation-opportunities-for-maternal-and-child-behavioral-health/

Nayak, S. S., Scoglio, A. A. J., & Nandi, S. (2023). Implementing integrated early childhood mental health services in primary care: Relationships, vision, and sustainability. *Administration and Policy in Mental Health and Mental Health Services Research, 50*, 763–772.

Nayak, S. S., Tobias, C., & Wolfe, J. (2021). Engaging and supporting young children and their families in early childhood mental health services: The role of the family partner. *Community Mental Health Journal, 58*, 87–98.

Parkhurst, J. T., Ballard, R. R., Lavigne, J. V., Von Mach, T., Romba, C., Perez-Reisler, M., & Walkup, J. T. (2022). Extending collaborative care to independent primary care practices: A chronic care model. *Clinical Practice in Pediatric Psychology, 10*(1), 32–43.

Parkhurst, J. T., Garcia-Goetting, C., Peist, E., Ballard, R., Romba, C., & Lavigne, J. V. (2023). Pediatric collaborative care outcomes in a regional model. *Frontiers in Psychiatry, 14*.

Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014). Collaborative care for adolescents with depression in primary care: a randomized clinical trial. *JAMA, 312*(8), 809–816. https://doi.org/10.1001/jama.2014.9259

Riley, A. R., Walker, B. L., Ramanujam, K., Gaultney, W. M., & Cohen, D. J. (2021). A mixed-method investigation of parent perspectives on early childhood behavioral services in primary care. *The Journal of Behavioral Health Services & Research, 49*(1), 134–148.

Saroca, K., & Sargent, J. (2022). Understanding Families as Essential in Psychiatric Practice. *Focus, 20*(2), 204–209. https://doi.org/10.1176/appi.focus.20210035

Schuyler Center for Analysis and Advocacy. (2022, April). Care for families improves outcomes: The importance of dyadic services [Policy brief]. https://scaany.org/wp-content/uploads/2022/04/Dyadic-Services-Brief.pdf

Shaligram, D., & Walter, H. J. (2023). Utilization and Outcomes of Direct Consultation in a Child Psychiatry Access Program. *Psychiatric services, 74*(1), 100–103. https://doi.org/10.1176/appi.ps.20220093

Shepard, S. A., & Dickstein, S. (2009). Preventive intervention for early childhood behavioral problems: an ecological perspective. *Child and Adolescent Psychiatric Clinics of North America, 18*(3), 687–706. https://doi.org/10.1016/j.chc.2009.03.002

Smith, S., Granja, M. R., Burak, E. W., Johnson, K., & Ferguson, D. (2023). Medicaid Policies to Help Young Children Access Key Infant-Early Childhood Mental Health Services: Results from a 50-state Survey. https://www.nccp.org/publication/medicaid-survey-2023/

Substance Abuse and Mental Health Services Administration. (2025). Integrating behavioral health services within specialty practices serving pediatrics (Publication No. PEP25-06-001). https://library.samhsa.gov/product/integrating-behavioral-health-services-within-specialty-practices-serving-pediatrics/pep25-06-001

Thota, A. B., Sipe, T. A., Byard, G. J., Zometa, C. S., Hahn, R. A., McKnight-Eily, L. R., Croft, J. B., Ghandour, R. M., Kramer, M. L., & Community Preventive Services Task Force. (2012). Collaborative care to improve the management of depressive disorders: A community guide systematic review and meta-analysis. *American Journal of Preventive Medicine*, *42*(5), 525–538.

Tobin-Tyler, E., Hulkower, R. L., & Kaminski, J. W. (2017). Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers. Milbank Memorial Fund. https://www.milbank.org/publications/behavioral-health-integration-in-pediatric-primary-care-considerations-and-opportunities-for-policymakers-planners-and-providers/

Unützer, J., Katon, W. J., Fan, M. Y., Schoenbaum, M. C., Lin, E. H., Penna, D., R. D., & Powers, D. (2008). Long-term cost effects of collaborative care for late-life depression. *The American Journal of Managed Care, 14*(2), 95–100. https://doi.org/10.1001/jama.288.22.2836

Walter, H. J., DeMaso, D. R., & The AACAP Committee on Quality Issues. (2023). Clinical Update: Collaborative Mental Health Care for Children and Adolescents in Pediatric Primary Care. *Journal of the American Academy of Child & Adolescent Psychiatry, 62*(2), 91-119.

Weersing, V. R., Gonzalez, A., Hatch, B., & Lynch, F. L. (2022). Promoting racial/ethnic equity in psychosocial treatment outcomes for child and adolescent anxiety and depression. *Psychiatric Research and Clinical Practice, 4*(3), 80–88. https://doi.org/10.1176/appi.prcp.20210044

Weitzman, C., Guevara, J., Curtin, M., Macias, M., AAP Section on Developmental and Behavioral Pediatrics, AAP Council on Early Childhood, AAP Committee on Psychosocial Aspects of Child and Family Health, & SOCIETY FOR DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS (2025). Promoting Optimal Development: Screening for Mental Health, Emotional, and Behavioral Problems: Clinical Report. *Pediatrics, 156*(3), e2025073172. https://doi.org/10.1542/peds.2025-073172

Wissow, L. S., Platt, R., & Sarvet, B. (2021). Policy Recommendations to Promote Integrated Mental Health Care for Children and Youth. *Academic pediatrics*, 21(3), 401–407.

Wong S, You XX, Borer M. Integrated Care Models: Expanding Mental Health Access and Ensuring Their Financial Sustainability. *JAACAP Connect, 13*(2). doi:10.62414/001c.156188

Yonek, J., Lee, C. M., Harrison, A., Mangurian, C., & Tolou-Shams, M. (2020). Key components of effective pediatric integrated mental health care models: A systematic review. *JAMA Pediatrics, 174*(5), 487–498.

ZERO TO THREE. (2023, April). Financing opportunities to support integrated behavioral health prevention: Potential HealthySteps financing opportunities. https://www.healthysteps.org/

Zhu, J. M., Chung, S., & Giliberti, M. (2025). Integrated behavioral health care in pediatric practices: The dollars don't add up. *Health Affairs Scholar, 3*(4), qxaf046.

Tools for Universal Screening, Differential Diagnosis and Progress Monitoring

Ages & Stages Questionnaire (ASQ)

- Squires, J., Bricker, D., & Potter, L. (1997). Revision of a parent-completed developmental screening tool: Ages and Stages Questionnaires. *Journal of Pediatric Psychology*, 22(3), 313–328.

Ages & Stages Questionnaire: Social-Emotional (ASQ:SE)

- Squires, J., Bricker, D., Heo, K., & Twombly, E. (2001). Identification of social-emotional problems in young children using a parent-completed screening measure. *Early Childhood Research Quarterly*, 16(4), 405-419.

Baby Pediatric Symptom Checklist (BPSC)

- Sheldrick, R. C., et al. (2013). The Baby Pediatric Symptom Checklist: Development and initial validation of a new social/emotional screening instrument for very young children. *Academic Pediatrics*, 13(1), 72-80.
- Sheldrick, R. C., Henn, L. M., & Briggs-Gowan, M. J. (2023). Assessing the validity of the Baby Pediatric Symptom Checklist (BPSC) and Preschool Pediatric Symptom Checklist (PPSC) within diverse primary care networks. *Journal of Developmental & Behavioral Pediatrics, 44*(3), e156–e165

Brief Early Childhood Screening Assessment (Brief ECSA)

- Fallucco, E. M., Wysocki, T., James, L., Kozikowski, C., Williams, A., & Gleason, M. M. (2017). The Brief Early Childhood Screening Assessment: Preliminary Validity in Pediatric Primary Care. *Journal of Developmental & Behavioral Pediatrics*, *38*, 89–98.

Brief Infant-Toddler Social Emotional Assessment (BITSEA)

- Briggs-Gowan, M. J., Carter, A. S., Irwin, J. R., Wachtel, K., & Cicchetti, D. V. (2004). The Brief Infant-Toddler Social and Emotional Assessment: screening for social-emotional problems and delays in competence. *Journal of Pediatric Psychology*, 29(2), 143-155.

Caregiver Strain Questionnaire (CGSQ)

- Brannan, A. M., Heflinger, C. A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the impact on the family of living with a child with serious emotional behavioral problems. *Journal of Emotional and Behavioral Disorders*, 5(4), 212-222.
- Hileman, B. J., et al. (2016). Validation of the Caregiver Strain Questionnaire–Short Form 11 (CGSQ-SF11) for parents of children with early-onset behavioral disorders. *Journal of Child and Family Studies*, 25(8), 2410-2420.

Child Adjustment and Parenting Efficacy Scale- Developmental Disability (CAPES-DD)

- Emser, A. S., Mazzucchelli, T. G., Christiansen, H., & Sanders, M. R. (2016). Child Adjustment and Parenting Efficacy Scale-Developmental Disability (CAPES-DD): First psychometric evaluation of a new child and parenting assessment tool. *Research in Developmental Disabilities*, 53-54, 158-177.

Child Trauma Screen (CTS)

- Lang, J. M., & Connell, C. M. (2017). Development and validation of a brief trauma screening measure for children: The Child Trauma Screen. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(3), 390–398.
- Lang, J. M., & Connell, C. M. (2018). The Child Trauma Screen: A follow-up study of psychometric properties. *Journal of Traumatic Stress*, 31(4), 540-548.
- Danzi, B. A., Knowles, E. A., & Kelly, J. T. (2024). Improving posttraumatic stress disorder assessment in young children: comparing measures and identifying clinically-relevant symptoms in children ages six and under. *Scientific Reports*, *14*.

Children's Sleep Habit Questionnaire (CSHQ)

- Owens, J. A., Spirito, A., & McGuinn, M. (2000). The Children's Sleep Habits Questionnaire (CSHQ): psychometric properties of a survey instrument for school-aged children. Sleep, 23(8), 1043–1051.

Clinical Global Impressions- Improvement (CGI-I) & Clinical Global Impressions- Severity (CGI-S)

- Greenhill, L., Kollins, S., Abikoff, H., McCracken, J., Riddle, M., Swanson, J., McGough, J., Wigal, S., Wigal, T., Vitiello, B., Skrobala, A., Posner, K., Ghuman, J., Cunningham, C., Davies, M., Chuang, S., & Cooper, T. (2006). Efficacy and safety of immediate-release methylphenidate treatment for preschoolers with ADHD. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*, 1284–1293
- Guy, W. (1976). *ECDEU Assessment Manual for Psychopharmacology*. Rockville, MD: U.S. Department of Health, Education, and Welfare.

Devereux Early Childhood Assessment-Clinical (DECA-C)

- LeBuffe, P. A., & Naglieri, J. A. (2003). *Devereux Early Childhood Assessment Clinical Form (DECA-C): A measure of behaviors related to risk and resilience in preschool children*. Kaplan Early Learning Company.

Edinburgh Postnatal Depression Scale

- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150(6), 782-786.
- Cox, J. L., Chapman, G., Murray, D., & Jones, P. (1996). Validation of the Edinburgh Postnatal Depression Scale (EPDS) in non-postnatal women. *Journal of Affective Disorders, 39*(3), 185–189.

Eyeberg Child Behavior Inventory (ECBI)

- Eyberg, S., & Pincus, D. (1999). Eyberg Child Behavior Inventory & Sutter-Eyberg Student Behavior Inventory-Revised: Professional Manual. Odessa, FL: *Psychological Assessment Resources*.

Family Check-Up 4 Health (FCU4Health)

- Berkel, C., Smith, J. D., Bruening, M. M., Jordan, N., Fu, E., Mauricio, A. M., Grimm, K. J., Winslow, E., Ray, K., Bourne, A., & Dishion, T. J. (2020). The Family Check-Up 4 Health: Study protocol of a randomized type II hybrid effectiveness-implementation trial in integrated primary care (the healthy communities 4 healthy students study). *Contemporary Clinical Trials*, 96, 106088.

Health Leeds

- Health Leads. (2016). *The Health Leads Screening Toolkit*. Boston, MA: Health Leads.
- Fiori, K. P., Heller, C. G., Flattau, A., Harris-Hollingsworth, N. R., Parsons, A., Rinke, M. L., Chambers, E., Hodgson, S., Chodon, T., & Racine, A. D. (2021). Scaling-up social needs screening in practice: a retrospective, cross-sectional analysis of data from electronic health records from Bronx county, New York, USA. *BMJ Open*, 11(9), e053633.

M-CHAT

- Robins, D. L., Fein, D., Barton, M. L., & Green, J. A. (2001). The Modified Checklist for Autism in Toddlers: an initial study investigating the early detection of autism and pervasive developmental disorders. *Journal of Autism and Developmental Disorders*, 31(2), 131-144.
- Robins, D. L., et al. (2014). Validation of the Modified Checklist for Autism in Toddlers, Revised with Follow-up (M-CHAT-R/F). *Pediatrics*, 133(1), 37-45.

Parents Evaluation of Developmental Status (PEDS)

- Glascoe, F. P. (1997). Parents' concerns about children's development: prescreening technique or screening test?. *Pediatrics*, 99(4), 522-528.

Parental Stress Scale (PSS)

- Berry, J. O., & Jones, W. H. (1995). The Parental Stress Scale: Initial psychometric evidence. *Journal of Social and Personal Relationships*, 12(3), 463-472.
- Zelman, J. I., & Ferro, M. A. (2018). The parental stress scale: psychometric properties in families of children with or without a chronic health condition. *Family Relations*, 67(2), 240-253.

Parenting Stress Index

- Abidin, R. R. (1995). *Parenting Stress Index (3rd ed.)*. Psychological Assessment Resources.
- Haskett, M. E., et al. (2006). Factor structure and validity of the Parenting Stress Index-Short Form. *Journal of Clinical Child and Adolescent Psychology*, 35(2), 302-312.

PHQ-9

- Yawn, B. P., et al. (2009). Concordance of Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire (PHQ-9) to assess postpartum depression. *Journal of the American Board of Family Medicine*, 22(5), 483-491.

POSI

- Smith, N. J., Sheldrick, R. C., & Perrin, E. C. (2013). An abbreviated screening instrument for autism spectrum disorders. *Infant Mental Health Journal*, 34(2), 149-156.

PRAPARE

- National Association of Community Health Centers & Association of Asian Pacific Community Health Organizations. (2022). *PRAPARE implementation and action toolkit*. PRAPARE. https://prapare.org/prapare-toolkit/
- Weir, R. C., Proser, M., Jester, M., Li, V., Hood-Ronick, C. M., & Gurewich, D. (2020). Collecting social determinants of health data in the clinical setting: Findings from national PRAPARE implementation. *Journal of Health Care for the Poor and Underserved*, *31*(2), 1018–1035. https://doi.org/10.1353/hpu.2020.0075

Pediatric Symptom Checklist- 17 (PSC-17)

- Gardner, W., Murphy, M., Childs, G., Kelleher, K., Pagano, M., Jellinek, M., McInerny, T., Sturner, R., & Wasserman, R. (1999). The PSC-17: A brief pediatric symptom checklist with psychosocial problem subscales: A report from PROS and ASPN. *Ambulatory Child Health*, *5*(3), 225–236.
- Kamin, H. S., McCarthy, A. E., Abel, M. R., Jellinek, M. S., Baer, L., & Murphy, J. M. (2015). Using a Brief Parent-Report Measure to Track Outcomes for Children and Teens with Internalizing Disorders. Child psychiatry and human development, 46(6), 851–862. https://doi.org/10.1007/s10578-014-0525-8
- Murphy, J. M., Bergmann, P., Chiang, C., Sturner, R., Howard, B., Abel, M. R., & Jellinek, M. (2016). The PSC-17: Subscale scores, reliability, and factor structure in a new national sample. *Pediatrics, 138*(3), e20160038.

Pediatric Symptom Checklist- 35 (PSC- 35)

- Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S., & Fenton, T. (1988). Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *The Journal of Pediatrics, 112*(2), 201–209.
- Jellinek, M. S., Murphy, J. M., Little, M., Pagano, M. E., Comer, D. M., & Kelleher, K. J. (1999). Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: A national feasibility study. *Archives of Pediatrics & Adolescent Medicine, 153*(3), 254–260

Preschool Pediatric Symptom Checklist (PPSC)

- Sheldrick, R. C., Henson, B. S., Merchant, S., Neger, E. N., Murphy, J. M., & Perrin, E. C. (2012). The Preschool Pediatric Symptom Checklist (PPSC): Development and initial validation of a new social/emotional screening instrument. *Academic Pediatrics, 12*(5), 456-467. https://doi.org/10.1016/j.acap.2012.06.008

RITA-T

- Choueiri, R., & Wagner, S. (2015). A new interactive screening test for autism spectrum disorders in toddlers. *The Journal of Pediatrics*, 167(2), 460-466.

SEEK PSQ

- Dubowitz H, Feigelman S, Lane W, Kim J. Pediatric primary care to help prevent child maltreatment: the Safe Environment for Every Kid (SEEK) Model. *Pediatrics, 123*(3):858–864
- Dubowitz H, Lane WG, Semiatin JN, Magder LS. The SEEK model of pediatric primary care: can child maltreatment be prevented in a low-risk population? *Acad Pediatr, 12*(4):259–268
- Eismann EA, Theuerling J, Maguire S, Hente EA, Shapiro RA. Integration of the Safe Environment for Every Kid (SEEK) model across primary care settings. *Clin Pediatr, 58*(2):166–176

Spence Preschool Anxiety Scale (SPAS)

- Spence, S. H., Rapee, R., McDonald, C., & Ingram, M. (2001). The structure of anxiety symptoms among preschoolers. *Behaviour Research and Therapy*, 39(11), 1293-1316.

STAT

- Stone, W. L., Coonrod, E. E., & Ousley, O. Y. (2000). Brief report: Screening tool for autism in two-year-olds (STAT): Development and preliminary data. *Journal of Autism and Developmental Disorders*, 30(6), 607-612.

Strengths and Difficulties Questionnaire (SDQ)

- Croft, S., Stride, C., Maughan, B., & Rowe, R. (2015). Validity of the strengths and difficulties questionnaire in preschool-aged children. *Pediatrics*, 135(5), e1210-e1219.

Survey of Wellbeing of Young Children (SWYC)

- Perrin, E. C., et al. (2016). The Survey of Well-being of Young Children (SWYC). *Clinical Pediatrics*, 55(8), 740-754.
- TEAM UP Center. (n.d.). *The SWYC*. https://www.teamupcenter.org/swyc/

WE CARE

- Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. (2015) Addressing social determinants of health at well child care visits: a cluster RCT. *Pediatrics, 135*(2).
- Garg A, Butz AM, Dworkin PH, et al. (2007) Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE Project. *Pediatrics, 120*(3): 547–558
- Zielinski S, Paradis HA, Herendeen P, Barbel P. (2017) The identification of psychosocial risk factors associated with child neglect using the WE-CARE screening tool in a high-risk population. *J Pediatr Health Care, 31*(4): 470–475

Young Child PTSD Checklist (YCPC)

- Perrin, E. C., et al. (2016). The Survey of Well-being of Young Children (SWYC). *Clinical Pediatrics*, 55(8), 740-754.
- Danzi, B. A., Knowles, E. A., & Kelly, J. T. (2024). Improving posttraumatic stress disorder assessment in young children: comparing measures and identifying clinically-relevant symptoms in children ages six and under. *Scientific Reports*, *14*.

Youth Top Problems (YTP)

- Weisz, J. R., et al. (2011). Assessing the effects of treatment in youth: The Top Problems Assessment. *Journal of Consulting and Clinical Psychology*, 79(6), 895-905.
- Herren, J., Garibaldi, P., Evans, S. C., & Weisz, J. R. (2018). *Youth Top Problems Assessment Manual*. Harvard University.
- Wood, J. J., Kuhfeld, M., Sturm, A., Cai, L., Wood, K. S., Cornejo Guevara, M. V., Galán, C. A., Johnson, A. R., Cho, A.-C., & Weisz, J. R. (2022). Personalized autism symptom assessment with the Youth Top Problems Scale: Observational and parent-report formats for clinical trials applications. *Psychological Assessment*, 34(1), 43–57.

Applied Behavioral Analysis (ABA)

- Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 55(1), 3–9.
- Dawson, G., Rogers, S., Munson, J., Smith, M., Winter, J., Greenson, J., Donaldson, A., & Varley, J. (2010). Randomized, controlled trial of an intervention for toddlers with autism: The Early Start Denver Model. *Pediatrics*, *125*(1), e17–e23.
- Bacotti, J. K., Peters, K. P., & Vollmer, T. R. (2022). Parents Are People Too: Implementing Empirically Based Strategies During Daily Interactions. *Behavior Analysis in Practice*, *15*, 986–1000.

Attachment and Bio-Behavioral Catchup (ABC)

- Dozier, M., Peloso, E., Lewis, E., Laurenceau, J. P., & Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Development and Psychopathology*, *20*(3), 845–859.
- Schein, S. S., Roben, C. K. P., Costello, A. H., & Dozier, M. (2022). Assessing Changes in Parent Sensitivity in Telehealth and Hybrid Implementation of Attachment and Biobehavioral Catch-Up During the COVID-19 Pandemic. *Child Maltreatment*, *28*, 24–33.

Chicago Parent Program (CPP)

- Bettencourt, A. F., Stavisky, L., Hoppe, E., Kassa, G. M., Breitenstein, S. M., & Gross, D. (2026). An individualized adaptation of the Chicago Parent Program (CPPi): Feasibility, acceptability, and preliminary efficacy in child mental health settings. Cognitive and Behavioral Practice. Advance online publication. doi.org
- Gross D, Kassa G M, Breitenstein SM., Hoppe E, Stavisky L, Daniels MC, & Bettencourt AF (2026). The Chicago Parent Program. In T. Del Vecchio & M. Terjesen (Eds.), Handbook of Behavioral Parent Training. American Psychological Association. https://www.apa.org/pubs/books/handbook-behavioral-parent-training
- Gross, D., Belcher, H. M. E., Budhathoki, C., Ofonedu, M. E., Dutrow, D., Uveges, M. K., & Slade, E. (2019). Reducing Preschool Behavior Problems in an Urban Mental Health Clinic: A Pragmatic, Non-Inferiority Trial. Journal of the American Academy of Child & Adolescent Psychiatry, 58(6), 572-581.e1. https://doi.org/10.1016/j.jaac.2018.08.013
- Gross, D., Garvey, C., Julion, W., Fogg, L., Tucker, S., & Mokros, H. (2009). Efficacy of the Chicago Parent Program with low-income African American and Latino parents of young children. Prevention Science: *The Official Journal of the Society for Prevention Research, 10*(1), 54–65. https://doi.org/10.1007/s11121-008-0116-7
- McGrane Minton, H., Murray, L., Allan, M. J., Perry, R., Bettencourt, A. F., Gross, D., Strano, L., & Breitenstein, S. M. (2024). Implementation of a Parent Training Program During Community-Based Dissemination (From In-Person to Hybrid): Mixed Methods Evaluation. *JMIR Pediatrics and Parenting, 7*, e55280.

Child First

- Lowell, D. I., Carter, A. S., Godoy, L., Paulicin, B., & Briggs-Gowan, M. J. (2011). A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice.

Child-Parent Psychotherapy (CPP)

- Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development*, 62(1), 199–209.
- Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44(12), 1241–1248.

Circle of Security - Parenting (COS-P)

- Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of Security intervention. *Journal of Consulting and Clinical Psychology*, 74(6), 1017–1026.

First Approach Skills Training -Early Childhood (FAST-E)

- Blossom, J. B., Jungbluth, N., Bolden, C., et al. (2024). "Evaluation of the First Approach Skills Training (FAST) Integrated Pediatric Primary Care Program: Implementation and Clinical Effectiveness". Evidence-Based Practice in Child and Adolescent Mental Health.

Hand in Hand Parenting

- Wipfler, P. (2006). *Listening to children*. Hand in Hand.
- Wipfler, P., & Schore, T. (2016). *Listen: Five simple tools to meet your everyday parenting challenges*. Hand in Hand Parenting.

Healthy Steps

- Caughy, M. O., Huang, K.-Y., Miller, T., & Genevro, J. L. (2004). The effects of the Healthy Steps for Young Children Program: Results from observations of parenting and child development. *Early Childhood Research Quarterly*, 19(4), 611–630. https://doi.org/10.1016/j.ecresq.2004.10.004
- Minkovitz, C. S., Strobino, D., Mistry, K. B., Scharfstein, D. O., Grason, H., Hou, W., Lalongo, N., & Guyer, B. (2007). Healthy Steps for Young Children: Sustained results at 5.5 years. *Pediatrics*, 120(3), e658–e668. https://doi.org/10.1542/peds.2006-1205
- Briggs, R. D., Silver, E. J., Krug, L. M., Mason, Z. S., Schrag, R. D., Chinitz, S., & Racine, A. D. (2014). Healthy Steps as a moderator: the impact of maternal trauma on child social-emotional development. *Clinical Practice in Pediatric Psychology*, 2(2), 166–175. https://doi.org/10.1037/cpp0000060
- Caughy, M. O., Miller, T. L., Genevro, J. L., Huang, K.-Y., & Nautiyal, C. (2003). The effects of Healthy Steps on discipline strategies of parents of young children. J*ournal of Applied Developmental Psychology*, 24(5), 517–534. https://doi.org/10.1016/j.appdev.2003.08.004

Incredible Years

- Webster-Stratton, C. (1981). Modification of mothers' behaviors and attitudes through a videotape modeling group discussion program. *Behavior Therapy*, 12(5), 634–642.
- Webster-Stratton, C., Reid, M. J., & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. *Journal of Clinical Child Psychology*, 30(3), 283–302.
- Webster-Stratton, C., & Bywater, T. (2019). The Incredible Years® series: An internationally evidenced multimodal approach to enhancing child outcomes. *APA handbook of contemporary family psychology: Family therapy and training (Vol. 3).* 343–359.

Occupational Therapy/Sensory -Integration Therapy

- Piller, A., McHugh Conlin, J., Glennon, T. J., Andelin, L., Auld-Wright, K., Teng, K., & Tarver, T. (2024). Systematic review of sensory-based interventions for children and youth (2015-2024). *Frontiers in Pediatrics*, 13, Article 1720179.
- Silva, L., et al. (2025). Efficacy of physiotherapy combined with occupational and speech therapy for children with autism spectrum disorder: A randomized controlled trial. *Frontiers in Pediatrics, 13*, 153214

Parent Management Training (PMT)

- Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. Oxford University Press.

Parent-Child Interaction Therapy (PCIT)

- Eyberg, S. M., & Robinson, E. A. (1982). Parent-child interaction training: Effects on family functioning. *Journal of Clinical Child Psychology, 11*(2), 130–137.

Parent-Child Interaction Therapy - Emotion Development (PCIT- ED)

- Luby, J. L., Rogers, C., Tillman, R., & Barch, D. M. (2018). Development of a novel parent-child interaction therapy emotion development (PCIT-ED) module for preschool depression: A randomized controlled trial. The American Journal of Psychiatry, 175(12), 1192–1203.
- Luby, J. L., Barch, D. M., Whalen, D., Tillman, R., & Belden, A. (2012). A randomized controlled trial of parent-child psychotherapy targeting emotion development for early childhood depression. *American Journal of Psychiatry, 169*(11), 1146–1153.

- Wood, J. N., Self-Brown, S., et al. (2020). "Integrated CARE: Adaptation of Child-Adult Relationship Enhancement for Pediatric Primary Care." *Clinical Pediatrics*, 59(13), 1163–1172.

Parents as Teachers

- Wagner, M. M., & Clayton, S. L. (1999). The Parents as Teachers program: Results from two demonstrations. *The Future of Children*, 9(1), 91–115.
- Jespersen, J. E., Morris, A. S., Hubbs-Tait, L., & Washburn, I. J. (2021). Evaluation of a parent education program emphasizing responsive parenting and mindfulness: An inclusive randomized controlled trial. *Child & Youth Care Forum, 50*(5), 859–883. https://doi.org/10.1007/s10566-021-09597-2

Physical Therapy

- Harbourne, R. T., Westcott McCoy, S., Dusing, S. C., et al. (2021). START-Play Physical Therapy Intervention Impacts Motor and Cognitive Outcomes in Infants With Neuromotor Delays: A Randomized Clinical Trial. *Physical Therapy, 101*(2), pzaa207.
- Pop, S. M., Nicolescu, L., & Gherle, A. V. (2025). Early rehabilitation interventions for global developmental delay: A narrative review. *Experimental and Therapeutic Medicine*, *30*(3), 423.
- Finlay-Jones, A. L., et al. (2024). A systematic review and meta-analysis of the associations between infant motor milestones and subsequent neurodevelopmental conditions. *Neuroscience & Biobehavioral Reviews, 165*, 105822.
- Silva, L., et al. (2025). Efficacy of physiotherapy combined with occupational and speech therapy for children with autism spectrum disorder: A randomized controlled trial. *Frontiers in Pediatrics, 13*, 153214

Promoting First Relationships

- Spieker, S. J., Oxford, M. L., Kelly, J. F., Nelson, E. M., & Fleming, C. B. (2012). Promoting First Relationships: Randomized trial of a relationship-based intervention for toddlers in child welfare. *Child Abuse & Neglect*, 36(10), 738–748.

Speech Therapy

- Silva, L., et al. (2025). Efficacy of physiotherapy combined with occupational and speech therapy for children with autism spectrum disorder: A randomized controlled trial. Frontiers in Pediatrics, 13, 153214
- Pak, N. S., Chow, J. C., Dillehay, K. M., & Kaiser, A. P. (2023). Long-Term Effects of Early Communication Interventions: A Systematic Review and Meta-Analysis. Journal of speech, language, and hearing research : JSLHR, 66(8), 2884–2899. https://doi.org/10.1044/2023_JSLHR-22-00711
- Roberts, M. Y., & Kaiser, A. P. (2011). The effectiveness of parent-implemented language interventions: A meta-analysis. *American Journal of Speech-Language Pathology, 20*(3), 180–199.

Supportive Parenting for Anxious Childhood Emotions (SPACE)

- Lebowitz, E. R., Marin, C., Martino, A., Omer, H., & Silverman, W. K. (2020). Parent-based treatment as efficacious as cognitive-behavioral therapy for childhood anxiety: A randomized noninferiority trial of SPACE. *Journal of the American Academy of Child & Adolescent Psychiatry*, 59(3), 362–372.
- Lebowitz, E. R. (2024). "Parent Training for Childhood Anxiety Disorders in Primary Care and Pediatric Networks." *Journal of Clinical Child & Adolescent Psychology*.

TF-CBT Preschool

- Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Trauma-focused cognitive behavioral therapy for children who have experienced sexual abuse: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(12), 1205–1215.
- Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Zeanah, C. H. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three- through six-year-old children: A randomized clinical trial. *Journal of Child Psychology and Psychiatry*, 52(8), 853–860.

Triple P (Positive Parenting Program)

- Prinz, R. J. (2019). A Population Approach to Parenting Support and Prevention: The Triple P System. *The Future of Children*, *29*, 122–143.
- Sanders, M. R. (2023). The Triple P System of Evidence-Based Parenting Support: Past, Present, and Future Directions. *Clinical Child and Family Psychology Review*, *26*, 880–903.
- Sanders, M. R., Berk, M. N., Campbell, S. J., & Stallman, H. M. (2014). "Training Pediatric Residents to Provide Parent Education: Outcomes of a Primary Care Triple P Intervention." *Academic Pediatrics*, 14(5), 516–523.