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Seizing the Opportunity: HealthySteps and the Case for Population-Level Infant and Early Childhood Mental Health in Pediatric Care

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Commentary

Decades of research have established, with remarkable clarity, that stability and care provided during a child's earliest years have lasting impact on their health, development, and well-being [1]. Across the lifespan, the consequences of a baby's early relational trauma—or responsive care—shape the architecture of their developing brain. When there is trauma or neglect, toxic stress in infancy alters the stress-response system in ways that, without amelioration, can persist for decades. Caregiver mental health, secure attachment, and social determinants of health are not peripheral concerns for pediatric care, but central to it. And yet, the Infant and Early Childhood Mental Health (IECMH) field continues to serve families primarily through a specialty care model that, by design, reaches only those who have already crossed the threshold into identified need.

The original chapter, *Population Health Opportunities in Pediatrics to Support Infant and Early Childhood Mental Health Promotion and Prevention: The HealthySteps Model*, published in the WAIMH Handbook of Infant and Early Childhood Mental Health (2024), made a compelling case that a specialist-only approach is insufficient, and that pediatric primary care offers a uniquely powerful platform for shifting IECMH from the margins to the mainstream. This commentary extends that argument in three directions: why the population health case is not merely pragmatic but ethical; what the alignment between HealthySteps (HS) Specialist and IECMHC competency frameworks tells us about the future of workforce development; and how the structural financing gap continues to undermine preventive IECMH despite the existence of effective, scalable models.

The Need for a Population Health Approach

The U.S. national average for developmental screening among children ages 9 to 35 months sits at just 37% [2], and even when providers identify concerns, referral systems are burdened by long waitlists, cost barriers, and a shortage of culturally attuned IECMH providers [3,4]. This functional breakdown is also an equity failure. Systemic racism, intergenerational poverty, and unequal access to care affect families. Babies and toddlers from Black, Indigenous, and low-income families face compounded risks including preterm birth, food and housing instability, and exposure to community violence at significantly higher rates than their white and higher-income counterparts [5,6]. A specialty care model for IECMH that requires families to find a referral and navigate a waitlist before receiving services leaves behind the families needing support the most.

HealthySteps adds a new team member to the primary care team, with an IECMH focus, to address this gap through a risk-stratified, population health approach that reaches families through universal services while intentionally offering the most intensive support to those with the greatest needs. One HS Specialist can serve up to 2,000 children annually [7]. This is not just a program efficiency metric, it is evidence that an IECMH-informed presence in primary care—such as HealthySteps services that reach over half a million children nationwide—function exponentially for many, rather than as an add-on for a small percentage of children who receive IECMH care through a specialty model.

The well-child visit schedule, approximately fifteen visits before kindergarten and seven in the first year alone [8], creates the recurring, non-stigmatized contact needed for effective population health. Families who may not typically seek out a mental health referral will generally still bring their baby to the doctor, a place where a trusted relationship serves as foundational to the delivery of IECMH services in addition to standard health care [9]. That some mothers report being more likely to complete a depression screening at their child's pediatric office than with their own provider highlights that the pediatric visit has become a more accessible point of contact for maternal mental health than primary care [10]. Winnicott's observation that there is no such thing as a baby in isolation [11] is an argument for making well-child visits the place where relational care begins.

The international comparisons raised in the original chapter are worth noting. Countries such as Norway and Finland are described as having achieved near-universal reach for preventive developmental care by integrating it into publicly funded, accessible health systems from birth. While the U.S. policy context differs significantly, we maintain that these models demonstrate that treating IECMH-informed care as a universal standard rather than a specialty service is clearly achievable. The question is not whether to expand IECMH to the population level, but how.

The Competency Crosswalk: What It Tells Us about Workforce Development

A significant contribution of the original chapter is its side-by-side analysis of the HS Specialist Competencies [12] and the Infant and Early Childhood Mental Health Consultation (IECMHC) Competencies [13]. On the surface, these two frameworks serve different roles in distinct settings. The IECMHC Competencies were designed primarily for consultants working in early care and education, home visiting, and child welfare, not for clinicians embedded in pediatric practices. The HS Specialist Competencies, by contrast, were built specifically for the primary care context, with its unique rhythms of well-child visits, medical team dynamics, and brief but repeated family contact.

And yet the crosswalk , the mapping of where the two frameworks align, reveals something important: these frameworks share both surface-level vocabulary and deep structural commitments—centering Diversity, Equity, Inclusion, Accessibility and Belonging (DEIAB) [14] as foundational rather than supplemental, treating reflective practice not as a technique but as a professional orientation, and insisting on relationship-based practice as the mechanism through which meaningful change occurs. This alignment suggests the IECMH field, across its many settings, is arriving at a shared understanding of what it takes to do this work well. And it raises a practical question: if the competency frameworks align, should the professional development and credentialing infrastructure align as well?

Currently, HS Specialists are not required to hold IECMH endorsement through the Alliance for the Advancement of Infant Mental Health, though some do . IECMH consultants working in early care and education settings may have limited exposure to pediatric primary care workflows, medical team culture, or the specific challenges of working within a fifteen-minute well-child visit. The crosswalk suggests that a more integrated approach to training and credentialing, one that recognizes the shared knowledge base while honoring distinct practice contexts, could strengthen both pathways.

The HS model offers a template worth examining more broadly. The HS Specialist Competencies were developed collaboratively, with direct input from HS Specialists—across urban, suburban, and rural settings, from disciplines as varied as social work, psychology, and early childhood education, and from communities that reflect the families they serve [12]. They were written not as a ceiling but as a living framework for professional growth. The HS National Office created professional development programming directly around these Competencies, including an all-staff onboarding process that extends the IECMH lens beyond the HS Specialist to the entire practice team.

A single skilled clinician embedded in a practice may work within a medical culture that does not yet share their IECMH orientation. Despite widespread recognition that mental and emotional concerns in childhood have risen to an unprecedented high, there continues to be a sense of hesitancy in approaching mental and emotional development in pediatrics [15]. However, when pediatric providers, nurses, and front desk staff all receive grounding in early brain development, attachment theory, adverse childhood experiences, and trauma-informed care, the HS Specialist becomes less an outlier and more an amplifier, welcomed as a member of the care team. Practice transformation continues to grow over time through shared patient care between the HS Specialist and pediatric providers. Through this collaborative work, providers may begin to notice light pink flags (the earliest possible warning signs of distress—rather than waiting for red flags), welcome complex family conversations, and see the caregiver-child dyad as the unit of care [16].

The early childhood field would benefit from a more systematic effort to identify additional competency and infrastructure models across integrated behavioral health in pediatrics and identify where alignment with established IECMH frameworks can reduce redundancy, improve quality, and support workforce retention.

Bridging Workforce Gaps in IECMH: Scaling through Innovation and Sustainability

The IECMH field faces critical capacity challenges, driven by a severe shortage of endorsed providers that limits access to specialized care and strains existing system infrastructure [17,18]. This crisis is compounded by a lengthy, resource-intensive endorsement path requiring extensive specialized training, supervision, and clinical experience that remains out of reach for many candidates [19]. Furthermore, endorsed professionals are unevenly distributed geographically, leaving rural and underserved areas with severe shortages. National data shows that while most U.S. counties lack child and adolescent psychiatric services entirely, the subset of professionals trained specifically for infants and toddlers is even smaller [20,21]. Many states lack the infrastructure for specialized, evidence-based training, leaving local workforces dependent on temporary federal grants or technical assistance to build programs from scratch [22]. Compounding these barriers, the workforce faces a critical lack of cultural and linguistic alignment between providers and the diverse communities they serve, a gap exacerbated by training pathways that often fail to incorporate diversity-informed, equity-focused frameworks [19]. This severe supply-demand misalignment ultimately deepens systemic inequities and leaves families without vital quality care [17,23].

Compounding this crisis, the broader workforce pipeline remains underdeveloped. Many front-line professionals—such as educators and community health workers—lack access to IECMH-specific professional development, leaving them unprepared to integrate this lens into their daily practice. This issue is rooted in traditional higher education pathways, which rarely include specialized IECMH coursework, leading to a severe shortage of graduate-level clinicians equipped to diagnose and support young children and their families [17]. This systemic training gap creates a narrow perception of IECMH expertise as something limited strictly to endorsed specialists, rather than a broad spectrum of necessary, field-wide competencies.

Another pressing challenge is the lack of sustainable funding mechanisms to support IECMH services [19]. Preventive IECMH practices, such as dyadic care and universal screenings, are often underfunded and undervalued in existing reimbursement models that focus more on paying for diagnoses [23]. Providers frequently struggle to secure payment for these specialized services, making it difficult to sustain their work or invest in ongoing workforce development [18]. In addition to workforce development, scaling IECMH services will depend on systemic changes to funding streams and state Medicaid policies [18,23].

Solutions: A Focus on IECMH-Informed Professional Development and Sustainability

The HS National Office is responding to this challenge by helping create a new profession of IECMH providers to serve in primary care pediatric settings, and to open sustainability pathways to support this work. The response includes a continuum of training and professional development resources rooted in the HS Specialist Competencies. Initially intended exclusively for the HS network, these resources have the potential to reach aligned programs more broadly—efforts to make this possible are being explored. For example, the HS National Office could make our training and professional development resources available for purchase by aligned pediatric programs. Additionally, sustainability pathways have been created to support the financial stability of this work, and whenever possible, these pathways are model agnostic, i.e., not only for the HealthySteps model, but intended to support the field more broadly [24].

Professional Development

The continuum of resources is designed to support HS Specialists over time and across career stages and disciplines. It assumes that HS Specialists approach this work with varying backgrounds and levels of education and experience, will develop competence gradually, prioritize their own learning, and grow through reflection, supervision, and applied practice. Because this learning is dependent on reflective supervision, an additional layer of support was added for those supervising HS Specialists , which is described below. Resources include asynchronous content-focused eLearnings, synchronous virtual learning events, learning collaboratives, and professional development resource tools.

The initial training for HS Specialists (and their supervisors) is a blend of asynchronous and live offerings that include foundational knowledge of IECMH concepts (such as infant brain development, attachment theory, and toxic stress) in addition to a framework for working with families in the primary care setting. Guiding principles include mindfulness, reflection, and parallel process. Learners are encouraged to consider the perspectives of all parties in the exam room (baby, caregiver, and providers) and to consider the caregiver-child relationship as the patient.

The training also offers a more concrete, "what to do in the room with families" training which consists of twelve eLearning modules aligned with the pediatric well-child visit schedule (newborn through 36 months). Each module identifies the most developmentally and relationally salient areas at that visit, including: typical development; building

the relationship with families; video observation practice; anticipatory guidance; caregiver context, including mental health and social determinants of health; and recommended screenings and observations.

In collaboration with the Erikson Institute, the HS National Office has customized their core Facilitating Attuned Interactions (FAN) training specifically for HS. FAN for HS training is a team-based, interactive learning experience focused on building attuned relationships where caregivers feel connected and understood [25]. It invites HS Specialist-Supervisor teams to center attunement in all interactions (with both families and colleagues) which strengthens reflective practice and emphasizes the understanding of misalignment, rupture, and repair in relationships. Training includes live sessions and a 6-month mentoring period.

Additional, ongoing, self-directed professional growth resources are designed to provide direction without prescription, and support individual choice, discernment, and pacing.

- The HealthySteps Reflection Tool for Professional Growth and Development [26] supports the application of the HS Specialist Competencies [12] by providing a framework for discussion of commonly occurring clinical vignettes. This tool is grounded in a quote from Jeree Pawl, PhD, founding board member of ZERO TO THREE, "How you are is as important as what you do," which has become a guiding principle. It reinforces that professional growth is iterative and relational. The Reflection Tool emphasizes reflective practice, parallel process (how HS Specialists are supported affects how families are supported), emotional regulation, and the integration of DEIAB principles into daily practice. It is a collaborative learning resource—not an assessment or performance management tool—and is designed to support growth through reflection rather than compliance or correction.

- The HealthySteps Professional Development (PD) Resource Library [27], organized by HS Specialist Competency areas includes links to a range of articles, websites, eLearning courses, and other training materials spanning topics related to infant mental health and early childhood development.

While not exhaustive, this overview of some of the network's training and professional development resources illustrates both the content and approach to learning. The HS National Office remains committed to expanding these resources to meet the needs of both the HS network and the broader IECMH workforce.

Sustainability

Any discussion about population-level IECMH must continue to grapple with a question raised in the original chapter: Why, given the evidence, the need, and the available models, does preventive IECMH remain so difficult to fund and sustain?

Financing for behavioral healthcare in the United States is largely based on medical necessity. Services are reimbursable when they address an identified condition, diagnose a disorder, or treat a symptom, rather than reimbursing for preventive services. This quandary creates a paradox within the IECMH field where the interventions most likely to prevent costly mental health, developmental, and relational problems later in life are the ones least likely to be reimbursed.

Since the original chapter, numerous states have committed to paying for prevention in the integrated IECMH field. Across at least seven states, significant Medicaid investments have changed the payment paradigm to finally pay for IECMH prevention. They have done this largely through three different pathways, according to their goals and infrastructure: opening new billing codes, allowing flexibility in how existing codes are used (i.e., for prevention), and exploring the use of alternative payment models, paying more , for the enhanced quality of team-based care focused on prevention.

As an example of opening new billing codes, in 2023, New York State Medicaid recognized reimbursement for Community Health Worker (CHW) services [28], thereby increasing the available workforce and allowing CHWs to assist with addressing social determinants of health, enhancing care coordination, and supporting health equity through sustainable funding and policy efforts. Washington State offers another CHW example where Centers for Medicare and Medicaid Services (CMS) had approved reimbursement of CHW services under Medicaid, but implementation faced challenges due to billing requirements [29]. Changes were made, including removal of the in-person requirement allowing billable activities without the patient present [29]. A key factor for sustainability is pairing innovation with implementation aligned with the reality of how services are actually delivered.

California changed medical necessity to allow for payment for prevention [30]. Within the Family Mental Health Benefit, there is now payment when a patient of any age presents with persistent mental health symptoms in the absence of a mental health disorder (i.e., doesn't yet reach diagnostic threshold), and/or when rendered to pregnant and postpartum women of any age, who are at risk of perinatal depression, provided they present with at least one of the approved risk factors.

Finally, in recognition of the higher quality of services provided, the HS National Office facilitated Medicaid policy changes in several states, including Maryland, Arkansas, and New Jersey. These provide an enhanced visit rate or per-member-per-month (PMPM) payment to primary care providers for universal evidence- and team-based enhanced

primary care services for young children that address key prevention and early intervention goals. This streamlined approach supports employment of both licensed and non-licensed behavioral and mental health providers to provide services, paying an enhanced rate for the higher quality of care provided.

Through a significant focus on workforce development and sustainability partnership with field level initiatives, the integrated IECMH field (necessary to bring true population health outcomes to our most vulnerable) is advancing. Current policy context requires steadfast defense of open sustainability pathways alongside continued promotion of the importance of integrated IECMH work.

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