

Health Care Reform as a Vehicle for Promoting Children's Mental and Behavioral Health

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May 5, 2015

**The author is a participant in the activities of the IOM-NRC's Forum on Promoting Children's Cognitive, Affective, and Behavioral Health.*

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Most mental health conditions emerge in childhood and adolescence (Kessler and Wang, 2008; IOM and NRC, 2009), and many develop in the context of the same risk factors as physical disease (Mistry et al., 2012; Shonkoff et al., 2009). Similarly, many behavioral health patterns that result in health conditions and health care expenditures in adulthood emerge early (Center on the Developing Child at Harvard University, 2010; Halfon et al., 2014; Shonkoff et al., 2009). Targeted public investment in children’s mental and behavioral health can result in savings in the areas of education, special education, juvenile justice, child welfare, and health care, as well as enhanced educational attainment, work productivity, and health into adulthood (Society for Research in Child Development, 2009; Society for Child and Family Policy and Practice, 2013; Steverman and Shern, 2014). It can also promote the formation of healthy families in the next generation. Evidence-based programs and services could have a very broad impact if policies ensured access for families and communities.

However, children’s mental and behavioral health³ is not confined to a single area of public policy; rather, it is a broad public health issue and inextricably linked to policies related to health, education, and safety. In most cases, public policy attends to problems, which is not a good fit for fostering healthy development in childhood. It is important, then, to consider how policy priorities and funding streams can promote children’s mental and behavioral health in areas such as child care, early education, child welfare, disasters, juvenile justice, violence prevention, and health care reform.

The Institute of Medicine (IOM) and National Research Council (NRC) established the Forum on Promoting Children’s Cognitive, Affective, and Behavioral Health (C-CAB) to engage diverse leaders from academia, government, professional organizations, and philanthropy to advance evidence-based prevention and intervention, as well as implementation science, within the various settings in which children are served. Where possible, the forum takes a two-generation perspective, recognizing that many of the evidence-based approaches to health promotion, prevention and intervention with children involve their parents and caregivers.

The Patient Protection and Affordable Care Act (ACA) builds on the Mental Health Parity and Addiction Equity Act in advancing coverage for mental health and substance abuse services.

¹ The author is a participant in the activities of the IOM-NRC Forum on Promoting Children’s Cognitive, Affective, and Behavioral Health.

² Suggested citation: McCabe, M.A. 2015. *Health care reform as a vehicle for promoting children’s mental and behavioral health*. Discussion Paper, Institute of Medicine, Washington, DC. <http://nam.edu/wp-content/uploads/2015/06/children-healthreformpaper>.

³ Children’s “mental health” lacks a uniform definition across sectors and stakeholders. Within this report it is defined as inclusive of mental, emotional, and behavioral health, consistent with the 2009 National Research Council and Institute of Medicine report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. However, the phrase “behavioral health” is added here because it carries specific connotations for health behaviors, substance abuse, and lifestyle factors that deserve emphasis for the purposes of this paper.

However, the ACA has also stimulated attention to mental health promotion, prevention, and access to evidence-based care. These principles could not be more important than during childhood, when the foundation is laid for lifelong health and well-being (Center on the Developing Child at Harvard University, 2010; Shonkoff et al., 2009).

Opportunities and gaps exist in health care reform to promote children's cognitive, affective, and behavioral health. Leaders in federal agencies and other national organizations are intricately involved with health care reform.

This paper offers the following perspectives to inform policy discussions:

- Emphases within the ACA for prevention and coordination of care enable more family focus, or the two-generation framework (Aspen Institute and the National Association for State Health Policy, 2014). This is perhaps most evident in programs such as Maternal, Infant, and Early Childhood Home Visiting. However, important gaps remain that threaten the reach of evidence-based, family-focused health care and ultimately, healthy development. For example, the current Medicaid landscape finds some children being insured while their parents are not. And yet the best way to help children is to help their parents.
- The integration of behavioral health into primary care (in terms of services, providers, and payment) is still evolving in pediatric/family practice settings, community-based health centers, and school-based health centers. There are untapped opportunities to deliver behavioral health services, particularly for vulnerable populations, in school-based health centers. The ACA did not fund operations in these centers, but they should be considered a key element of community-based health care.
- Health care funding, as well as funding for research related to behavioral health and health care, is still adult-centric. It will be helpful to educate the adult health communities about the life course perspective, or promoting healthy child development for lifelong health (Halfon and Hochstein, 2002). The life course perspective has critical implications for research, practice, and policy.
- There are exciting opportunities for linkages across health and education, primary care and schools, and health care and community programs. There are emerging opportunities for blended funding streams (e.g., state innovation models) to accommodate the reality that an intervention in one silo affects outcomes in another. It should be possible to link social services, social determinants of health, and health care delivery, which would allow us to understand how investments in social services affect health outcomes, how investments in health and behavioral health affect school readiness, school outcomes, and so on. It will be important to align terminology across sectors to facilitate progress in integration.
- Screening for developmental and behavioral health conditions in childhood is being improved, which in turn could improve access to care. However, there are pressing needs for translation and validation for specific populations of children.
- Access to care has been the policy emphasis in the ACA. However, there are still important gaps in providers and in the availability of evidence-based practices and programs. This is particularly true for the most vulnerable children; for example, many providers do not accept Medicaid.

A few additional points are worth emphasizing:

- Primary care is a rapidly evolving area of opportunity; funding needs to keep pace with opportunities. In particular, behavioral health can become more fully integrated into well-child visits, extending beyond the solid recommendations of Bright Futures guidelines (American Academy of Pediatrics, 2015) to innovative ways to promote child mental and behavioral health. Similarly, it will be important to promote prenatal development and healthy parenting, and attend to parental depression, in the primary care setting. To fully capitalize on these opportunities, issues of professional time and work flow will require attention.
- The most rapid progress in integration across sectors serving children and families is at the state level, particularly where there is flexibility in how funds can be tailored for local needs.
- Current practices obscure the return on investment for evidence-based programs that promote children's mental and behavioral health and prevent costly problems for those at risk. For example, the Congressional Budget Office does not presently score prevention programs in terms of savings, only costs. In addition, timelines for return on investments are often determined by budget/funding cycles rather than expectations regarding outcomes. Continued attention to short-term indicators of savings is warranted. However, timelines for return on investments with children and families also need to account for development and such evolving targets as future health and mental/behavioral health, educational attainment, and work productivity.
- The conversations across broad groups of stakeholders (including not only health care providers and policymakers but also business leaders) are changing to include population health, community health, wellness, and healthy development. Continuing health care reform, and funding evidence-based prevention programs, could advance population health.
- It is still common practice to focus attention on those children and families who utilize the most health services, rather than focus on those who need the most. Long-term change in population health will require attention to the most vulnerable children and families.
- There remain critical workforce issues across health care professions and among community health care workers and organizers, including the need to attend to diversity.

There are also highly specific opportunities for advancing progress. For example, some of the programs for which strong evidence exists could be appropriate for review by the U.S. Preventive Services Task Force, the U.S. Community Services Task Force, or the Patient-Centered Outcomes Research Institute (PCORI), and could be considered for goals in Healthy People 2030. Where evidence is insufficient or limited to specific settings, funding the needed research should be a priority.

For health care reform to advance population health, we need to advance opportunities to promote children's mental and behavioral health. This will require continued incremental change, integration, and partnerships.

REFERENCES

- American Academy of Pediatrics. 2015. *Bright Futures guidelines*.
<https://brightfutures.aap.org/about/Pages/About.aspx> (accessed April 27, 2015).
- Aspen Institute and the National Association for State Health Policy. 2014. *The Affordable Care Act: Affording two-generation approaches to health*. Washington, DC: The Aspen Institute.
- Center on the Developing Child at Harvard University. 2010. *The foundations of lifelong health are built in early childhood*. http://developingchild.harvard.edu/resources/reports_and_working_papers/foundations-of-lifelong-health/ (accessed April 30, 2015).
- Halfon, N., and M. Hochstein. 2002. Life course health development: An integrated framework for developing health, policy, and research. *Milbank Quarterly* 80,433-79.
doi: 10.1111/1468-0009.00019.
- Halfon, N., P. H. Wise, and C. B. Forrest. 2014. The changing nature of children's health and development: New challenges require major policy solutions. *Health Affairs* 33,2116-2124. doi: 10.1377/hlthaff.2014.0944.
- IOM (Institute of Medicine) and NRC (National Research Council). 2009. *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academies Press.
- Kessler, R. C. and P. S. Wang. 2008. The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health* 29,115-129.
doi: 10.1146/annurev.pubhealth.29.020907.090847.
- Mistry, K. B., C. S. Minkovitz, A. W. Riley, S. B. Johnson, H. A. Grason, L. C. Dubay, and B. Guyer. 2012. A new framework for childhood health promotion: The role of policies and programs in building capacity and foundations of early childhood health. *American Journal of Public Health* 102,1688-1696. doi:10.2105/AJPH.2012.300687.
- Society for Research in Child Development. 2009. Report of *Healthy development: A summit on young children's mental health: Partnering with communication scientists, collaborating across disciplines and leveraging impact to promote children's mental health*. Washington, DC: Society for Research in Child Development.
- Society for Child and Family Policy and Practice. 2013. Report of *Healthy development summit II: Changing frames and expanding partnerships to promote children's mental health and social/emotional well-being*. Washington, DC: Society for Child and Family Policy and Practice.
- Shonkoff, J. P., W. T. Boyce, and B. S. McEwen. 2009. Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *JAMA* 301, 2252-2259. doi:10.1001/jama.2009.754.
- Steverman, S. and D. Shern. 2014. *Preventing mental, emotional, and behavioral disorders: Financing and implementation strategies*. Alexandria, VA: Mental Health America.