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Will Health Care Reform Rescue Families in Crisis?

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As part of the annual series on child health in the United States, Torio and colleagues¹ published an update on hospitalizations and emergency room use by children and adolescents with mental disorders. For those working in the field, the results are disturbing but not surprising. From 2006 to 2011, hospitalizations due to mental disorders increased by 50% while hospitalizations for other chronic conditions generally declined or stayed the same. Hospitalizations due to mental disorders for children aged 10 to 14 years increased by 151.0%, and emergency department visits related to mental disorders among children aged 5 to 9 years increased by 88.0%. The largest increase in hospitalizations was for children in the lowest income bracket.

There are some problems with the data sources that raise questions about the precise changes that occurred between 2006 and 2011. For example, one of the data sources, the Healthcare Cost and Utilization Project (HCUP), is based on administrative claims data with its many problems. The Medical Expenditure Panel Survey (MEPS) has relatively small sample sizes per year in each cohort for children with specific problems. The use of 2 specific points in time (2006 and 2011) does not allow for the national variation that occurs year to year in such data sets.

However, none of this alters the basic message: the use of intensive services such as hospitalization and emergency room visits for mental disorders has increased dramatically since 2006. Poor children in particular are disproportionately affected. Increases in suicide, suicide ideation, and self-injury are particularly troubling. These trends are, unfortunately, consistent with the rapid increases in the use of psychiatric drugs for children and adolescents. Such drugs are now the most expensive class of drugs for state Medicaid programs, and the powerful second-generation antipsychotics account for much of this.² In short, clinicians, families, and communities are confronting a growing number of children and adolescents in psychiatric crisis.

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One might wonder whether the true prevalence of children's disorders has increased, thus accounting for the rise in use of intensive services. In fact, this is not the case. Epidemiologic reviews, using standardized psychiatric instruments, do not demonstrate dramatic increases in the number of children and adolescents with psychiatric disorders during this time frame.

Instead, the results from Torio and colleagues suggest that community-based services are failing children, and families are therefore turning to emergency and hospital services to get help. These disturbing trends fly in the face of the aspirations of advocates for community-based services for children and adolescents with mental disorders, and of the investments by the federal and state governments in community-based services. The System of Care grants funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) were developed explicitly to build a network of strong community-based early intervention and treatment services for children and adolescents and to reduce dependency on hospitalizations and emergency rooms as a safety net. This response has clearly been insufficient. Similarly, mental health interventions for use in primary care offices have been called for since 1985. Although training, screening, diagnosis, and advocacy have increased, long-standing improvements in outcomes for children served in primary care settings are still undocumented.⁴ Even less can be said about improvements in mental health services for children and adolescents in juvenile justice, foster care, and special education settings.

What could happen to create a true network of community-based early intervention and treatment services? The Patient Protection and Affordable Care Act (PPACA), on its own, contains little direct legislative salve for children's mental health. Nevertheless, the multiple changes wrought by PPACA in encouraging value-based care and accountability standards have set in motion a series of incentives that could drive improvement. Developing community-based services to reduce risk and promote mental health will now have to be made on the basis of a strong business case. ' But the good news is that expensive psychiatric care such as emergency room services, hospitalization, and use of psychiatric drugs is anathema to value-based purchasers like accountable care organizations, and it threatens the stability of capitated care programs. The opportunity to make a business case for community-based services now exists to a stronger degree than ever before.

These new business entities may actually provide the solutions that academics have long sought: the use of early prevention and intervention services. There are some aspects of mental health that everyone can and should learn (eg, parents, teachers, bus drivers, nurses, receptionists). This kind of knowledge can and should be given away; it should be built into the training of every teacher, made available to all parents upon the birth of their child, and taught in medical school. This includes learning basic social and behavioral learning principles, understanding child development, and learning the effects of trauma. Previously, such services were poorly reimbursed in fee-for-service programs. Value-based systems encouraged by PPACA and market trends will not restrict the use of preventive services; instead, these will be seen as opportunities for achieving cost savings and better outcomes—at least in theory.

This general knowledge base will have to be structured, administered, and embedded in other systems to actually reach—and be effective for—the 13 to 14 million children and families in the United States in need of help. This might entail building parenting classes into WIC programs, Head Start, and all pediatric practices, as well as engaging high-risk schools in ecological interventions, such as the Good Behavior Game.⁷ It might also entail linking, via mobile technology, regional centers with specific expertise around, for example, cognitive behavioral therapy for specific disorders (eg, anxiety, depression, trauma), so that families could receive tailored psychological care when needed, rather than be wait-listed for 6 months or more.

However, creating a network of community-based services will take more than this. It will take a bigger view of how to carve out and structure a set of supports and expertise about mental health that is general, widely disseminable, and highly specific. This will require a collective will to take the longer view—to recognize that investments now in early intervention may not have their societal payoff until decades later. But getting ahead of the curve now will benefit children and families later. Patience and a collective will to use the opportunities afforded by the ascension of a reorganized health care system under PPACA creates the financial incentives for developing a robust network of prevention and community-based services and thus stronger families and children.

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