Grand Challenges for Social Work

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Policy Recommendations for Meeting the Grand Challenge to Ensure Healthy Development for All Youth

Behavioral health problems and mental illness in childhood and adolescence take a heavy toll over a lifetime, with significant impacts on rates of economic independence, morbidity, and mortality.[1] For decades, public policies have focused on treating these problems only after they have been identified—at a high and ongoing cost to young people, families, communities, and the nation—but evidence now suggests that many such problems can be prevented.[2] The Grand Challenge to Ensure Healthy Development for All Youth includes two initiatives: *Unleashing the Power of Prevention* and *Preventing Schizophrenia and Severe Mental Illness*. Unleashing the Power of Prevention seeks to reduce by 20% the incidence and prevalence of behavioral health problems among young people under age 24 over the next decade. It also seeks to reduce racial and socioeconomic disparities in behavioral health problems by 20%. The goal of the Preventing Schizophrenia and Severe Mental Illness initiative is to promote a shift to early intervention targeting individuals at greatest risk for developing psychotic disorders. This brief presents policy recommendations aimed at meeting the goals of both initiatives.

Recommendation 1:
Ensure that 10% of All Public Funds Spent on Young People Support Effective Prevention Programs

In the United States, treatment and lost productivity attributed to behavioral health problems are estimated to cost $247 billion per year.[3] Behavioral health problems reflect and perpetuate social inequities, varying dramatically by gender, race, ethnicity, citizenship, sexual orientation, and class. Current funding for payment systems, resource-allocation mechanisms, and public programs supporting young people must be restructured to increase the percentage of public expenditures for tested, effective prevention programs. Public-private collaborations, such as social impact bonds,[4] wellness trusts,[5] and community benefit expenditures, should be considered as strategies to increase funding for prevention efforts for young people.[6]

Recommendation 2:
Increase Local and State Capacity to Support the High-Quality Implementation of Effective Preventive Interventions

Measurable progress in promoting healthy youth development and preventing behavioral-health problems will require interdisciplinary and cross-sector collaboration across the vertically organized local and state agencies that currently provide health, education, social, protection, and justice services for young people. Most local and state systems lack the interdepartmental structures necessary to overcome the vertical delivery of prevention services. New policies and organizational structures are needed to foster cross-sector implementation of effective prevention programs. Some states have created executive-level children's cabinets to develop, implement, and oversee cross-cutting prevention initiatives.[7] Other states have partnered with universities to enhance infrastructure and technical-assistance capacity through intermediary organizations that help agencies and communities implement and monitor preventive interventions.[8] Collaborative and interdepartmental backbone structures and intermediary organizations should be examined and, when appropriate, replicated.

Recommendation 3:
Develop Community-Level Systems to Monitor Risk, Protection, and Behavioral-Health Outcomes

Existing epidemiological monitoring systems primarily collect county- or city-level data on behavioral health problems, and the data are often system specific. Assessment of prevention needs requires sub-city-level data on the prevalence of risk and protective factors and on behavioral health outcomes.[9] Comprehensive community-prevention monitoring systems would produce epidemiological data that are relevant for communities but can be aggregated for monitoring behavioral health outcomes at state and national levels.[10] Recent policy changes require collection, monitoring, and integration of medical and behavioral-health records. To be most effective for prevention planning, these data should be integrated with sub-city-level information on risk, protection, and behavioral-health outcomes.

Recommendation 4:
Provide Tested, Effective, Family-Focused, Preventive Interventions Without Cost to Patients or Families Through Primary Health-Care Providers

Family-focused preventive interventions can improve the well-being of children and promote cognitive, affective, and behavioral health in young people.[11] However, due to stigma associated with participation, concerns about the expertise of the organizations providing parenting advice, and the absence of sustainable funding, parenting programs are not reaching enough families. Under provisions of the *Affordable Care Act*,[12] family-focused programs for preventing behavioral health problems could be available through primary health care and could be covered by Medicaid at state discretion as well as by private insurers. Strategies to build congressional support for family-focused preventive interventions include the following: (a) encourage the federal Centers for Medicare and Medicaid Services to explore payment mechanisms for effective family-focused preventive interventions; (b) direct the U.S. Health Resources and Services Administration to study parenting programs and include them in future pediatric preventive-care recommendations; and (c) fund a pilot initiative for tests of parenting programs in primary care and ensure that findings from such evaluations are published and communicated to officials with the Health Resources and Services Administration and the U.S. Preventive Services Task Force.

American Academy of Social Work & Social Welfare

Recommendation 5:
Reduce the Duration of Untreated Mental Illness in Young People

Selective and indicated prevention approaches are needed to promote optimal services for youth who show early signs of emerging mental illness. Such approaches should aim both to prevent onset of disorders and also to facilitate access to care for those who already have a diagnosable mental or behavioral-health condition. There is currently a 2-year gap between the onset of problems like schizophrenia and first entry into treatment;[13] the delay in treatment is associated with a broad array of negative clinical and functional outcomes across the life course.[14] This problem can be addressed through policies to promote the following: (a) universal preventive interventions that raise awareness of mental and behavioral-health needs, thereby reducing the threshold of entry into treatment for youth; (b) selective and indicated interventions, particularly community-based psychosocial interventions, for youth at elevated risk for specific classes of mental health outcomes; and (c) training for community mental-health workers, including training in the proper use of nonstigmatizing screening assessments.

Recommendation 6:
Train and Enable a Workforce for Effective Prevention Practice

A well-trained workforce comprised of social workers, nurses, physicians, psychologists, teachers, and others is needed to coordinate and deliver effective prevention programs. Creating such a workforce requires changing policies that shape training, licensure, and funding in the behavioral-health, child-welfare, education, and health sectors. Preservice training should provide hands-on opportunities for practicing prevention skills. Continuing education and certificate programs should help practitioners build prevention expertise. Initiatives such as the Behavioral Health Workforce Education and Training Program should continue funding instruction for all disciplines that provide prevention services. State licensure boards must refine licensure standards or develop new licensing mechanisms that recognize professional practice and mastery in preventive interventions. Finally, reimbursement codes and billing procedures for preventive services delivered by social workers should be developed and implemented.[15]

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End Notes

1. Hale and Viner (2012).
2. Jenson and Bender (2014).
3. National Research Council and Institute of Medicine (2009).
4. Washington State Institute for Public Policy (2010).
5. Lambrew (2007).
6. Cincinnati Children's Hospital Medical Center (2011).
7. Rhoades, Bumbarger, and Moore (2012).
8. Bumbarger and Campbell (2012).
9. Catalano et al. (2012).
10. Mrazek, Biglan, and Hawkins (2004).
11. Leslie et al. (in press).
12. Patient Protection and Affordable Care Act (2010).
13. Marshall et al. (2005).
14. Melle et al. (2004).
15. Hyde (2013).

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