FIRST 5 CENTER FOR CHILDREN'S POLICY

BRIEF
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Parent Mental Health Concerns and the Impact on Young Children:

How California Can Support Whole-Family Wellness Through Two Generation Interventions Like Home Visiting and Dyadic Care

In the first years of a child's life, responsive relationships with parents are essential to healthy child development. When an adult responds to a child's cues, neural connections are built and reinforced in the child's brain. These "serve and return" interactions strengthen the bond between a primary caregiver and a child, shape brain architecture, and support healthy child development.[1]

Many factors can interrupt this important parent-child bonding, including parental mental health concerns like depression and anxiety.[2] With household stress intensely heightened by COVID-19, family mental health has been adversely affected, in turn impacting the emotional health of young children. These impacts will be felt long after the pandemic, and families will need ongoing additional support.

Even before the pandemic, perinatal mental health conditions were fairly common among new parents. One in five birthing people in California experience symptoms of perinatal depression or anxiety.[3] Furthermore, a quarter of pregnant people having their first baby experienced two or more hardships in their own childhood, increasing risk for mental health difficulties in the perinatal period and other lasting impacts on family wellbeing.[4, 5]

Culturally relevant interventions that meet the mental and physical health needs of the birthing parent and support the parent-child relationship are critical for whole family wellness, especially during times of increased stress. This brief describes the impacts of parent emotional health concerns on infants and toddlers, the programs that can support new parents, and recommendations on how the State can increase access.

The Impacts of Parent Emotional Health Concerns on Infants and Toddlers

Healthy early childhood development is heavily dependent on the continuous presence of a responsive, nurturing caregiver who recognizes and predictably responds to a child's needs. When this critical parent-child bonding and interaction is compromised by situations in the home or by parental mental health concerns, a child's mental health can be impacted too.

Significant postpartum symptoms of depression, anxiety, or other mental health conditions can potentially interrupt this bonding and expose a child to stress.[6] Physiologic responses to stress can affect infants' social-emotional development, putting them at risk for impaired social interaction and delays in language, cognitive, and social-emotional development. If the parent continues to experience symptoms without support, the child's developmental issues can persist and be less responsive to intervention over time. Parental depression in infancy also is predictive of cortisol levels in preschoolers, and these changes in levels are linked with anxiety, social wariness, and withdrawal.[7]

Having a parent who has significant mental health concerns is considered an Adverse Childhood Experience (ACE) because of the stress it can cause children. ACEs are specific types of adversity, including physical and emotional abuse, neglect, and household dysfunction, which have been studied and shown to affect later health outcomes. Experiencing multiple ACEs, as well as external factors like racism and community violence, can cause toxic stress in children with long-lasting impacts on health and wellbeing.[8]

Parents with ACEs are more likely to have children who experience ACEs, creating an intergenerational cycle of trauma.[9] Furthermore, parents' own experiences of childhood adversity can increase risk for negative perinatal outcomes. Parent ACEs are associated with difficulties breastfeeding, insecure attachment, and poor social emotional functioning.[10]

The COVID-19 pandemic has had widespread impacts on mental health, but low-income households with young children have been acutely affected. Financial hardship and challenges meeting basic needs have increased; 11% of California parents started using social safety net resources who did not access them before.[11] This household stress can cause stress in young children and families will need additional financial and social support to buffer any potential long-term impacts even after the virus is controlled.[12]

PREVALENCE AND DETECTION OF PERINATAL MENTAL HEALTH CONCERNS

Perinatal mood and anxiety disorders (PMADs) are the most prevalent complication of pregnancy and childbirth. Perinatal mental health concerns can affect all new parents, however they are more common among individuals experiencing multiple stressors, such as racism, low income, or having experienced adverse events during their own childhood. The prevalence rate can be as high as 50% for those living in poverty.[13] Racial disparities also exist in the prevalence of depressive symptoms. Black birthing people experience prenatal or postpartum depression at almost twice the rate of white birthing people.[14]

Many perinatal mental health concerns go undetected. The 2016 Listening to Mothers in California Survey found that only one in five individuals who reported symptoms of prenatal anxiety or depression received counseling or treatment.[15] Racial disparities also exist in the receipt of care: although depressive symptoms are most common among Black and Latino birthing people, their access of mental health care is lower than white birthing people's.[16]

Partners may also experience mental health concerns after the birth of a baby. Estimates of postpartum partner depression nationally varies from 2% to as high as 25%. This rate can increase to 50% when the birthing parent experiences postpartum depression.[17]

In addition to the human toll, the societal costs of untreated perinatal mood and anxiety disorders in California is estimated to be $2.4 billion per year, largely borne by employers and health care payers. [18]

Interventions to Support the Parent-Child Dyad

Identification and treatment of parent mental health concerns in pediatric and family service settings is a pathway to foster or repair parent-child attachment. Pharmacologic and psychotherapeutic interventions to support mental health are effective in reducing symptoms, but may not impact parenting behaviors, especially if symptoms interfere with attachment at critical stages of child development.[19] Although the primary caregiver can be screened for postpartum depression and referred to supports for mental health concerns during a child's health care visit, this may not commonly happen in practice, and parents may not want to access a separate mental health referral. Additional pediatric-focused efforts could be bolstered to further meet whole-family needs. Two-generation approaches like dyadic care and home visiting are also recommended by the Centers for Disease Control (CDC) as key strategies for preventing ACEs in early childhood.[20]

DYADIC CARE

Dyadic care refers to serving both the parent and child together as a dyad. Several models of dyadic care have been developed to support parents and children together, targeting family wellbeing as a mechanism to support healthy child development and mental health. Dyadic care that takes place within pediatric settings can help identify depression, provide referrals to services, and coach the parent-child relationship. The primary care provider is supported by a family specialist, creating a team-based approach to meeting family needs including addressing mental health and social support concerns. Pediatric mental health professionals are available to address developmental and behavioral health concerns as soon as they are identified, bypassing the many obstacles families face when referred to offsite behavioral health services.

Dyadic care has been found to improve outcomes for parents and children by strengthening parent-child relational health and overall family wellbeing in addition to mitigating the impact of adverse early experiences. Preventive dyadic behavioral health models are particularly important in this time of family stress, isolation, and income insecurity due to COVID-19.

The prevalence of dyadic care only is modest in California to date because there is no sustainable, broadly-available funding source. Clinics have not been able to draw down Medi-Cal financing to support these models in their practices for a few reasons:

- Dyadic model staff who support the primary care provider often do not have the level of credentialed training required to be a licensed Medi-Cal provider, and so they are unable to be reimbursed for services rendered.
- Behavioral health services, except for family therapy provided by specific types of licensed providers, are often only been reimbursable by Medi-Cal when a child experiences a diagnosable impairment, leaving out young children who often do not have severe enough symptoms to warrant a diagnosis.
- Federally qualified health centers are restricted on how they can bill for physical and behavioral health services rendered to a patient on the same day.[21]

EXAMPLES OF DYADIC CARE MODELS

HealthySteps: A child development expert and behavioral health clinician (HealthySteps Specialist) joins the pediatric primary care team to ensure universal screening, and provide interventions, referrals, and follow-up to the whole family. Studies show parents with depressive symptoms in the program are more likely to discuss their symptoms and report fewer symptoms. In addition, medical providers with HealthySteps in their practice are more likely to discuss postpartum depression with parents.[22] HealthySteps is a tiered model with supports for parental depression at every tier, based on needs and risk identified during the consultation.[23] The Children's Health Center at the UCSF/Zuckerberg San Francisco General Hospital and Trauma Center implements the HealthySteps program, which has helped them achieve a 90% postpartum screening rate for all eligible patients through their six months well-child visit.[24]

DULCE: The DULCE (**D**evelopmental **U**nderstanding and **L**egal **C**ollaboration for **E**veryone) Interdisciplinary Team comprises a Family Specialist, a medical provider, a legal partner, an early childhood systems representative, and a mental health representative. Family specialists attend each well-child visit for the child's first six months of life to provide families with support. The program promotes child development by focusing on parenting skills, conducting universal social determinants of health and mental health screening, providing information about healthy development, and connecting families to legal and community resources.[25] By providing concrete supports for newborns and their families, DULCE can help reduce parental stress and protect against child neglect and abuse.

HOME VISITING

Home visiting programs can also play an important role in supporting primary caregiver mental health and the bond between a parent and child. There are many models of home visiting, but most connect new and expectant parents with a designated support person, such as a nurse or early childhood specialist, who meets with them in their home or another preferred location. Services often include various screenings, including screening for depression, case management, and family support or counseling.[26] Home visitors also provide a wide array of referrals for families, including to mental health services for parents who screen positive or presented with depressive symptoms. Home visiting programs maintain partnerships with local agencies, working closely with behavioral health programs and other community partners.[27]

Home visiting is associated with many improved outcomes for families including positive parenting practices, improved parent and child health, reductions in child maltreatment, and improved child development.[28] In addition, home visiting can help alleviate the intergenerational transmission of trauma by helping parents build positive and healthy attachments with their children.[29]

Home visiting programs are implemented in 51 of 58 counties in California and operate through various funding streams including CalWORKs, federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) dollars, state general funds, and First 5 Proposition 10 dollars.[30] Despite home visiting's presence across the state, many families who would benefit from home visiting do not yet have access. In the 2018–19 state fiscal year, 41,800 children received federally and locally funded home visits, compared to the estimated 145,800 children ages 0 to 2 who would most likely benefit from such services.[31]

FAMILY WELLNESS SUPPORTED BY HOME VISITING DURING THE PANDEMIC

I recently had my second child, and have been lucky enough to have had the same (home visiting) nurse with both of my babies. I have no family local so to feel the true and genuine support from her has gone so far for me. During these scary, daunting and unchartered times of a pandemic all the nurses have stepped their game up. They have learned how to do Zoom telehealth meetings, created an online breastfeeding support group that I joined, and continue to try and think of ways that they can assist new moms. This has given me comfort in a time when I, as well as the rest of our community, have felt so isolated. It has been so nice to have the contact and support of the nurse right now to put my mind at ease about multiple issues, including breast-feeding and new baby questions.

— Molly, Santa Barbara County

Discussion and Recommendations

California has made strides to support parent emotional health in the last few years. In January 2019, Dr. Nadine Burke Harris, a national voice elevating the issues around ACEs and toxic stress, was appointed as California's first-ever Surgeon General. Effective January 2020, DHCS began paying Medi-Cal providers for conducting ACE screenings for children and adults and the Office of the Surgeon General and DHCS is leading an initiative to give Medi-Cal providers support in screening for ACEs, called ACEs Aware.

Additionally, there have been a series of policy changes that provide support for families experiencing perinatal mental health concerns. For example, Medi-Cal now allows members without a mental health diagnosis to receive individual and/or group counseling sessions if they have certain depressive, socioeconomic, and mental health related risk factors.[32] Laws have also been passed to require screening for perinatal mental health conditions in Medi-Cal and require mental health training at hospitals for all clinical staff who work with pregnant and postpartum birthing people.[33, 34]

Despite these strides, many families go without support. Interventions like home visiting and dyadic care are effective in improving family wellbeing, addressing family mental health concerns, and supporting healthy child development, but only a small number of California families have access.

In order to better support families who are experiencing mental health concerns, the State should:

1. **Use flexibility in the Medicaid program to finance home visiting and dyadic care through Medi-Cal to scale implementation.** There is strong evidence that family strengthening services, like home visiting and dyadic care, improve outcomes for families facing adversity. Federal guidance has made clear that Medicaid may be used to finance core components of home visiting and California has not taken full advantage of this opportunity. Furthermore, now that family therapy is a covered Medi-Cal benefit for children, there is an immediate opportunity for the State to fully reimburse evidence-based dyadic care models in Medi-Cal. **Investment in these programs can also save money in the long term, by ensuring prevention and early intervention for families before concerns become more expensive to treat.**

2. **Ensure Medi-Cal providers, clinics, and managed care plans receive specific technical assistance so that new Medi-Cal billing opportunities are translated into improved services and outcomes for families.** Pediatric practices will need support building dyadic models and other innovative pediatric practices into their standard of care and receiving reimbursement for these services. The State should fund and partner with efforts to train providers throughout and thereby maximize the utility of Medi-Cal policies.

3. **Provide continuous Medi-Cal coverage for all birthing people 12 months postpartum, and children in their first five years of life.** Having reliable and continuous health care coverage is critical for accessing mental health supports. California already provides 12 months postpartum Medi-Cal coverage for individuals diagnosed with a mental health condition. **Additionally, the State should accept the new Medicaid state option available through the American Rescue Plan Act of 2021, extending Medicaid postpartum coverage to 12 months for all birthing people to ensure they can receive care when concerns arise.**[35] Children with Medi-Cal insurance currently have continuous coverage for their first year of life. However, in the critical years of development that follow, many churn on and off of coverage because of administrative hurdles even though most stay eligible. **Therefore, the legislature should also accept a 2021-2022 budget proposal to expand continuous Medi-Cal coverage for children until their fifth birthday.**

The first few years of a child's life is a vulnerable time for families, but also presents an opportunity to interrupt intergenerational cycles of trauma and foster healthy parenting and coping strategies. Today, there are fewer built-in supports for families than in the past; many live far from family members, are single parents, and are struggling to access affordable healthcare and childcare. The COVID-19 pandemic has further exacerbated these challenges and increased fear, anxiety, and feelings of isolation. California must take additional steps to support family mental health and expand access to home visiting and dyadic care, two evidence-based programs that can have substantial positive impacts and support whole-family wellness.

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