

VIEWPOINT

Parenting as Primary Prevention

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Social-emotional and behavioral dysfunction contributes substantially to adverse health outcomes such as obesity, asthma, and cardiovascular disease; poor quality of life; and exponentially increasing health care costs. These conditions often have roots in childhood, when opportunities exist for primary and secondary prevention and early intervention. However, these opportunities are seldom realized for many reasons, including limited attention to behavioral and/or mental health concerns during pediatric and family medicine training programs and the low priority of *prevention* in the organization and financing of health care in the United States.

Pediatric primary care practices have taken on the responsibility to be the medical home for children from birth through young adulthood. These settings offer a consistent, trusted, and supportive context in which parents and children are welcomed and encouraged to raise a wide range of concerns and to access a variety of preventive and treatment approaches. Almost all children in the United States have a primary care medical home and see a physician frequently during their first few years—for monitoring health, growth, and development, and for providing parental guidance.

The 2010 Patient Protection and Affordable Care Act (PPACA) promotes patient-centered medical homes that incorporate mental health services for adults and children.¹ The health supervision guidelines of *Bright Futures*, published by the American Academy of Pediatrics, are incorporated into the PPACA, thus theoretically making a broad range of behavioral and mental health preventive services available to almost all of America's children. Just as immunizations are provided on a recommended schedule in primary care to prevent infectious diseases, we believe that primary care settings also present a remarkable opportunity for primary prevention of many childhood and adult physical and mental health morbidities. In addition, a national momentum supporting routine and repeated developmental and behavioral surveillance and screening as a central responsibility of pediatric medical homes² has created an opportunity for secondary prevention by addressing risks for behavioral health problems before they become severe.

Almost all parents do the best they can to nurture and care for their children, but many are limited by their own educational, mental health, economic, social, and/or family circumstances. Education and support for parents to learn and practice important skills of parenting have the potential to promote supportive behaviors, parenting confidence, and their children's well-being. From a primary prevention standpoint, by learning the principles of child development and strengthening their skills for interacting with and guiding their child's social-emotional development, parents can learn strategies that promote cognitive and language develop-

ment, emotion regulation, and attention skills in their children. Parents with personal risk factors such as depression or substance abuse may also be identified and linked to services available in the community or in adult medical homes.

Programs that promote strong skills for parents of young children, such as the Family Check-Up program, Triple P (Positive Parenting Program), Incredible Years, and Parent-Child Interaction Therapy, have been shown to improve parenting skills and children's disruptive behaviors. Typically these programs have been centered in mental health settings and thus presuppose identification of the child's behavior as "pathological" or representing "at-risk" parenting to justify access. Parents report hesitation in accepting such referrals because of the stigma attached to their children's behavior and their own effectiveness. Participation in these programs is also detached from ongoing health care relationships or support, and payment mechanisms limit participation.

There are many benefits of locating such programs instead in the primary care context: (1) They become part of the universal preventive "well-child" services that are accepted for all children. (2) Access does not depend on identification of a child or parental deficit or problem, and parents are thus detached from implicit critique. (3) Prevention occurs within the longitudinal continuum of a trusted relationship with the health care system. (4) Programs can be made available to all parents who recognize challenges in their own or their children's behaviors (primary prevention), or by referral based on screening for the well-being of children and family members (secondary prevention). (5) Payment mechanisms can be made consistent with public and private insurance arrangements. (6) Perhaps most important, primary health care is the only current opportunity to provide prevention education and intervention for *all* children and their parents, beginning at birth and continuing through young adulthood. The Healthy Steps model, in its original form and various modifications,³ has pioneered the value of support and assistance for new parents in primary care.

Several evidence-based parenting education programs have been integrated into primary care contexts with fidelity, and their effectiveness in improving parent strategies and decreasing problem behaviors has been demonstrated.⁴ Providing parent-focused programs such as these in primary care pediatric contexts presents considerable feasibility challenges, and requires changes in expectations, staffing patterns, and billing procedures. Emerging interest in creating pediatric primary care practices that provide both traditional health care and behavioral health expertise (*collaborative* or *integrated* care models) positions pediatric primary care to address child behavioral

health by promoting parents' ability to provide maximally nurturing environments,⁵ though funding for such models has been a challenge.

We propose multiple avenues to achieve the incorporation of family-focused health promotion and prevention efforts in pediatric primary care settings: (1) *Bright Futures* guidelines should explicitly support the development of teams including child behavior/mental health/child development specialists, working collaboratively with pediatricians, to provide behavioral health promotion as well as treatment for parents and children. (2) Evaluation of parenting strengths should be included in Medicaid Early and Periodic Screening Diagnostic and Treatment (EPSDT) guidelines. (3) Training in parenting education should be required by the American College of Graduate Medical Education and its Residency Committees in pediatrics and family medicine, and content regarding parenting skills and risk factors should be included on the American Board of Pediatrics and American Board of Family Medicine examinations. These requirements would lead to greater promotion of teaching parenting skills as an integral component of training programs. (4) The National Institutes of Health and private foundations should support

systematic research to discover the best methods for primary child health care clinicians to assist parents in providing healthy and nurturing environments for their children that take into account the sociodemographic and cultural diversity of US families, and to identify genomic bases for vulnerability and resilience of children to adverse experiences.⁶ (5) Feasible process and outcome measurements should be developed to document improvements in children's behavioral and cognitive functioning and thus justify payment for family-focused prevention efforts in primary care.

The health and success of our nation depends on early childhood experiences. The significance and depth of that truism is underscored by extensive science about the interplay between neurological and psychological development, and the profound effects of adverse childhood experiences on overall health throughout the life course.⁷ In turn, early childhood experiences depend on the capacity of adults (parents above all) to protect, nurture, guide, and educate their children. We believe that pediatric and family medical homes can assist parents in this task. Pediatric primary care clinicians have the privilege and the responsibility to help parents be the best parents they can be.

ARTICLE INFORMATION

Published Online: May 16, 2016.

doi:10.1001/jamapediatrics.2016.0225.

Conflict of Interest Disclosures: None reported.

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