A Policy Window for Children has Opened: Are We Ready?

Population Health Sciences

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In his famous book *Agendas, Alternatives, and Public Policies*, John Kingdon defined the policy window as a moment in time when three key elements converge. First, the problem is of sufficient magnitude to drive public opinion. Second, there are viable options for programs or policies to respond to that problem. And third, there is political will to make a change. For children and their parents, we may be in such a policy window.

Magnitude of the Problem: As one examines the key issues of the day for children and families, the issue of "toxic stress" (i.e. excessive and prolonged exposure to stressful experiences) and its effects on children and families consistently rises to the top, and the linkage between toxic stress and health outcomes for children and families is clear. Perinatal studies suggest that the birth of premature and low birth weight babies may be influenced by a mother's lifetime exposure to stress and adverse experiences. A multitude of studies in the broader medical field documents the impact of Adverse Childhood Experiences (ACE) on adult health problems. And, there is now overwhelming evidence of the effects of trauma on the health and well-being of children. The problem is also not trivial: The original ACE study conducted at Kaiser Permanente in the 1990's estimated that nearly two-thirds of the 17,000 adult respondents reported at least one ACE, and one in five experienced three or more traumatic events during childhood.

Policy Options: Several decades of work has resulted in the development of new approaches to treating trauma in children. In addition, there are studies that document the intergenerational benefit of treating maternal depression as a means to improving the healthy development of children. Evidence-based treatments for youth have not only been tested in randomized trials, but we are also seeing programs like the Triple P parenting intervention, as well as Parent Child Interaction Therapy (PCIT) for young children with behavioral problems, being rolled out at scale in the community with results that impact thousands of children within child welfare and beyond.

At the same time, programs like these are greatly under-resourced, and in many instances non-existent in publicly funded behavioral health systems. In this context, we should not be surprised by the over-prescribing of controversial prescription medications for young people, particularly for disruptive or aggressive behavior. Often these drugs, such as antipsychotics, are prescribed as "off label" medications, for which efficacy data are lacking in children and for which safety concerns are numerous. By 2008, 50% of youth in foster care who were prescribed psychotropic medications received an antipsychotic as part of their treatment regimen. This is a sobering and visceral number that evokes tremendous concern about a mental health system with limited capacity for treatment options beyond medication. Let me be clear: medications are an important component of treatment for youth with behavioral health disorders, but it would be hard to argue against the reality that we have over-leveraged the use of medications, as we have neglected the harder work of creating and scaling up sustainable alternative non-pharmacologic models of behavioral health treatment that are evidence-based for

children and their parents.

Political Will: For several years, the federal Administration on Children, Youth and Families (ACYF) has been leading an effort to develop the capacity in publicly funded systems to adopt evidence-based programs that focus on trauma and provide a strong alternative to the off-label use of medication that has become so common in publicly funded systems. Just in the last few months, the President's budget proposed $750 million for Medicaid demonstration projects over the next five years with child welfare systems to reverse the trends we have seen. And, in the context of mental health parity and Medicaid expansion under the Affordable Care Act in most states, we have an opportunity to ensure that previously uninsured parents receive services for their own untreated mental health issues, with benefit not only for themselves but also for their children. The highly visible Oregon Medicaid expansion study has already taught us that the greatest gains for newly covered adults in Oregon have been their new coverage for mental health issues.

So, are we ready?

There are a number of encouraging signs that the political will may be there to make change, but we should not take any of these developments for granted. Policy windows can close as quickly as they open. The White House proposal is just that, a proposal, and still subject to approval by Congress. The definition of essential health benefits under Medicaid expansion to young adults has been ceded to the states, who will need local advocates and researchers to make the case for the value of, and evidence for, services focused on untreated trauma and toxic stress. As they do so, we will also need to give them the data they need to demonstrate that an investment in capacity building for the right services is not an open-ended appropriation. Rather this investment will be more than offset by reductions in the number of children involved in the child welfare system, its intergenerational value to both children and parents, and its ability to lower the costs and consequences of maternal depression and other adult mental health issues. Additionally, these types of investmests have the potential to reduce child behavioral problems (and costs), improve academic outcomes, and reduce the need for hospitalizations and residential treatment placements, among other benefits.

The time to make the case for these investments is now. Here's hoping that we take advantage of it.

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