# Collaborative primary care for children with behavior disorders

## Children's Mental Health: Disruptive Behavior

Benefit-cost estimates updated December 2023. Literature review updated August 2017.

Current estimates replace old estimates. Numbers will change over time as a result of model inputs and monetization methods.

The WSIPP benefit-cost analysis examines, on an apples-to-apples basis, the monetary value of programs or policies to determine whether the benefits from the program exceed its costs. WSIPP's research approach to identifying evidence-based programs and policies has three main steps. First, we determine "what works" (and what does not work) to improve outcomes using a statistical technique called meta-analysis. Second, we calculate whether the benefits of a program exceed its costs. Third, we estimate the risk of investing in a program by testing the sensitivity of our results. For more detail on our methods, see our Technical Documentation.

Program Description: Collaborative primary care for behavior disorders integrates behavioral health into the primary care setting to treat children and adolescents with oppositional defiance disorder, attention deficit/hyperactivity disorder, or other behavior disorders. In the collaborative care model, a care manager coordinates with a primary care provider and behavioral health care providers to develop and implement measurement-based treatment plans for individual patients. Care managers also provide psychoeducation and brief psychotherapy-based modules, such as cognitive behavioral therapy. Studies in this meta-analysis report on Doctor-Office Collaborative Care (DOCC), a specific collaborative care model. In the included studies, patients received collaborative care for six months. Patients in the comparison group received "enhanced" treatment as usual, which consisted of brief psychoeducation and referrals to usual mental health services.

## Benefit-Cost Summary Statistics Per Participant

### Benefits to:

| | |
|---|---|
| Taxpayers | $459 |
| Participants | $254 |
| Others | $366 |
| Indirect | $23 |
| Total benefits | $1,102 |
| Net program cost | ($323) |
| Benefits minus cost | $779 |

| | |
|---|---|
| Benefit to cost ratio | $3.41 |
| Benefits minus costs | $779 |
| Chance the program will produce benefits greater than the costs | 60% |

The estimates shown are present value, life cycle benefits and costs. All dollars are expressed in the base year chosen for this analysis (2022). The chance the benefits exceed the costs are derived from a Monte Carlo risk analysis. The details on this, as well as the economic discount rates and other relevant parameters are described in our Technical Documentation.

## Meta-Analysis of Program Effects

| Outcomes measured | Treatment age | No. of effect sizes | Treatment N | Adjusted effect sizes and standard errors used in the benefit-cost analysis | | | | | | Unadjusted effect size (random effects model) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | First time ES is estimated | | | Second time ES is estimated | | | | |
| | | | | ES | SE | Age | ES | SE | Age | ES | p-value |
| Attention-deficit/hyperactivity disorder symptoms | 8 | 2 | 201 | -0.149 | 0.141 | 8 | 0.000 | 0.141 | 9 | -0.309 | 0.075 |
| Disruptive behavior disorder symptoms | 8 | 2 | 201 | -0.064 | 0.141 | 8 | -0.035 | 0.086 | 11 | -0.227 | 0.108 |

Meta-analysis is a statistical method to combine the results from separate studies on a program, policy, or topic in order to estimate its effect on an outcome. WSIPP systematically evaluates all credible evaluations we can locate on each topic. The outcomes measured are the types of program impacts that were measured in the research literature (for example, crime or educational attainment). Treatment N represents the total number of individuals or units in the treatment group across the included studies.

An effect size (ES) is a standard metric that summarizes the degree to which a program or policy affects a measured outcome. If the effect size is positive, the outcome increases. If the effect size is negative, the outcome decreases.

Adjusted effect sizes are used to calculate the benefits from our benefit cost model. WSIPP may adjust effect sizes based on methodological characteristics of the study. For example, we may adjust effect sizes when a study has a weak research design or when the program developer is involved in the research. The magnitude of these adjustments varies depending on the topic area.

WSIPP may also adjust the second ES measurement. Research shows the magnitude of some effect sizes decrease over time. For those effect sizes, we estimate outcome-based adjustments which we apply between the first time ES is estimated and the second time ES is estimated. We also report the unadjusted effect size to show the effect sizes before any adjustments have been made. More details about these adjustments can be found in our Technical Documentation.

## Detailed Monetary Benefit Estimates Per Participant

| Affected outcome: | Resulting benefits:[1] | Benefits accrue to: | | | | |
|---|---|---|---|---|---|---|
| | | Taxpayers | Participants | Others[2] | Indirect[3] | Total |
| Disruptive behavior disorder symptoms | Criminal justice system | $13 | $0 | $32 | $7 | $52 |
| Disruptive behavior disorder symptoms | Labor market earnings associated with high school graduation | $91 | $213 | $116 | $0 | $420 |
| Disruptive behavior disorder symptoms | K-12 grade repetition | $3 | $0 | $0 | $1 | $4 |
| Disruptive behavior disorder symptoms | K-12 special education | $149 | $0 | $0 | $74 | $223 |
| Disruptive behavior disorder symptoms | Health care associated with disruptive behavior disorder | $218 | $62 | $225 | $109 | $613 |
| Disruptive behavior disorder symptoms | Costs of higher education | ($14) | ($21) | ($6) | ($7) | ($48) |
| Program cost | Adjustment for deadweight cost of program | $0 | $0 | $0 | ($162) | ($162) |
| Totals | | $459 | $254 | $366 | $23 | $1,102 |

[1]In addition to the outcomes measured in the meta-analysis table, WSIPP measures benefits and costs estimated from other outcomes associated with those reported in the evaluation literature. For example, empirical research demonstrates that high school graduation leads to reduced crime. These associated measures provide a more complete picture of the detailed costs and benefits of the program.

[2]"Others" includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance.

[3]"Indirect benefits" includes estimates of the net changes in the value of a statistical life and net changes in the deadweight costs of taxation.

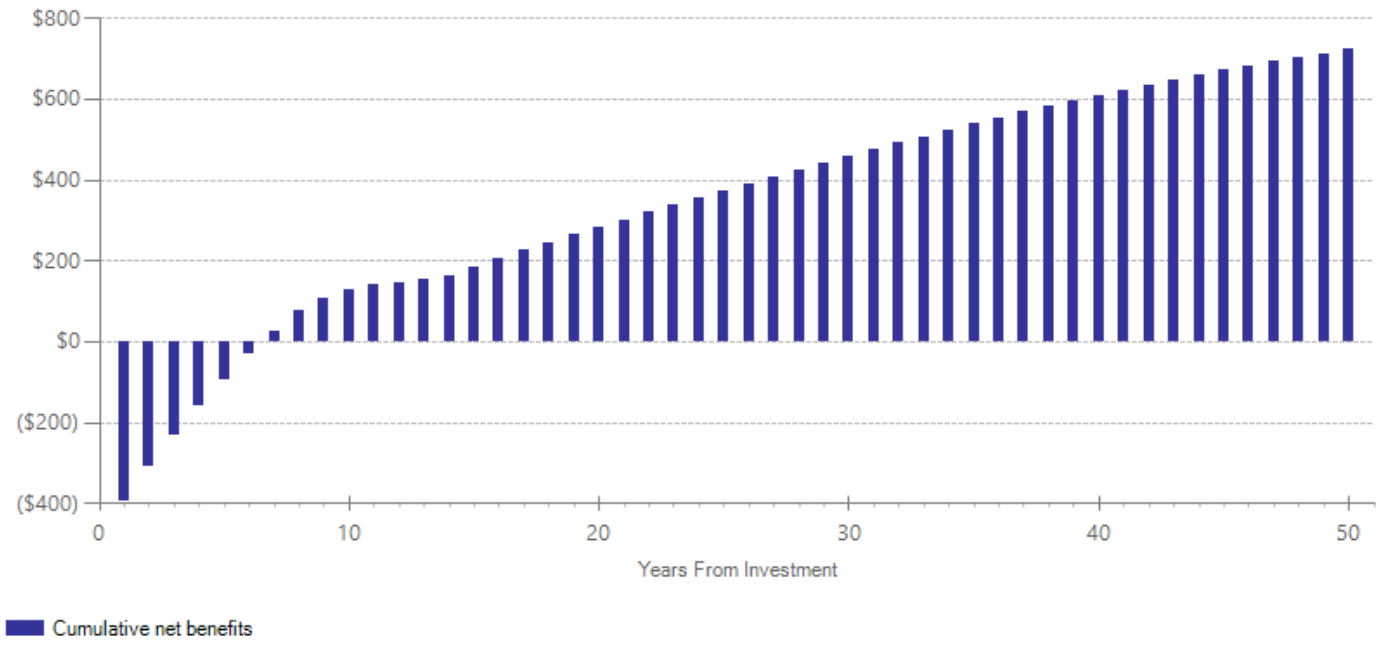
## Detailed Annual Cost Estimates Per Participant

| | Annual cost | Year dollars | Summary | |
|---|---|---|---|---|
| Program costs | $511 | 2010 | Present value of net program costs (in 2022 dollars) | ($323) |
| Comparison costs | $259 | 2010 | Cost range (+ or -) | 15% |

Per-participant cost estimates are based on the average cost per child enrolled in the treatment group and average cost per child enrolled in the comparison group, as reported in Yu et al. (2017). These estimates include the costs of training, outreach, equipment, and provider salaries.

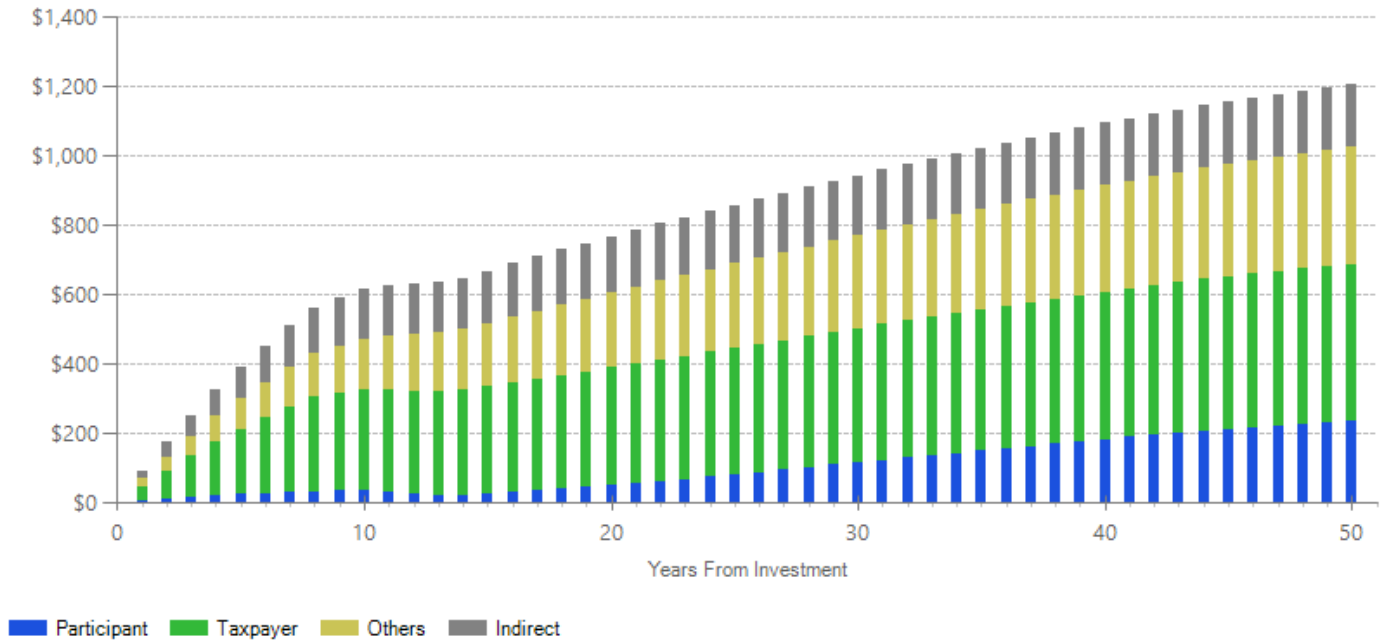
The figures shown are estimates of the costs to implement programs in Washington. The comparison group costs reflect either no treatment or treatment as usual, depending on how effect sizes were calculated in the meta-analysis. The cost range reported above reflects potential variation or uncertainty in the cost estimate; more detail can be found in our Technical Documentation.

## Benefits Minus Costs Over Time (Cumulative Discounted Dollars)



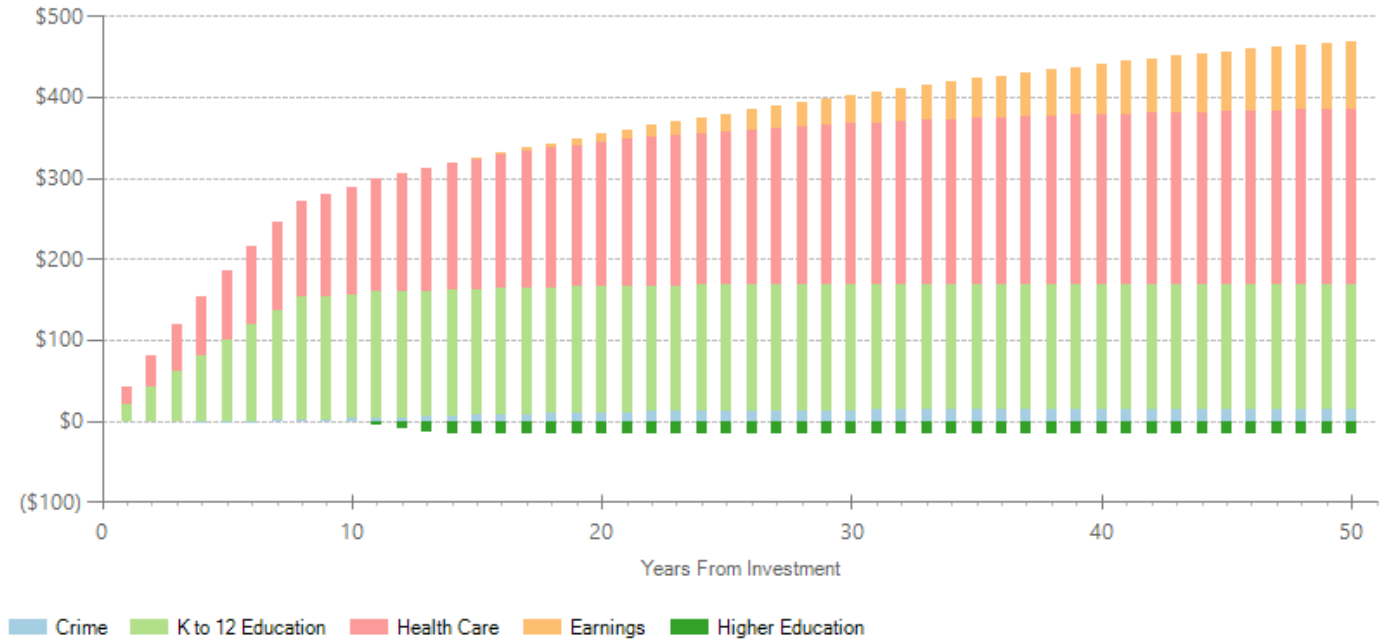

The graph above illustrates the estimated cumulative net benefits per-participant for the first fifty years beyond the initial investment in the program. We present these cash flows in discounted dollars. If the dollars are negative (bars below $0 line), the cumulative benefits do not outweigh the cost of the program up to that point in time. The program breaks even when the dollars reach $0. At this point, the total benefits to participants, taxpayers, and others, are equal to the cost of the program. If the dollars are above $0, the benefits of the program exceed the initial investment.

## Benefits by Perspective Over Time (Cumulative Discounted Dollars)




The graph above illustrates the breakdown of the estimated cumulative benefits (not including program costs) per-participant for the first fifty years beyond the initial investment in the program. These cash flows provide a breakdown of the classification of dollars over time into four perspectives: taxpayer, participant, others, and indirect. “Taxpayers” includes expected savings to government and expected increases in tax revenue. “Participants” includes expected increases in earnings and expenditures for items such as health care and college tuition. “Others” includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance. “Indirect benefits” includes estimates of the changes in the value of a statistical life and changes in the deadweight costs of taxation. If a section of the bar is below the $0 line, the program is creating a negative benefit, meaning a loss of value from that perspective.

## Taxpayer Benefits by Source of Value Over Time (Cumulative Discounted Dollars)




The graph above focuses on the subset of estimated cumulative benefits that accrue to taxpayers. The cash flows are divided into the source of the value.

# Citations Used in the Meta-Analysis

Kolko, D.J., Campo, J., Kilbourne, A.M., Hart, J., Sakolsky, D., & Wisniewski, S. (2014). Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial. *Pediatrics, 133*(4), 981-92.

Kolko, D.J., Campo, J.V., Kilbourne, A.M., & Kelleher, K. (2012). Doctor-office collaborative care for pediatric behavioral problems: a preliminary clinical trial. *Archives of Pediatrics & Adolescent Medicine, 166*(3), 224-31.

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