DHCFP

Review and Evaluation of Proposed Legislation Entitled: An Act Relative to Children's Mental Health Senate Bill No. 2518

Provided for
The General Court

July 28, 2008

Deval L. Patrick, Governor
Commonwealth of Massachusetts

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, Secretary
Executive Office of
Health and Human Services

Sarah Iselin, Commissioner
Division of
Health Care Finance and Policy

Report Authors

Colleen Barry, PhD, Yale School of Medicine

James P. Highland, PhD, Compass Health Analytics, Inc.

Kate Nordahl, Division of Health Care Finance and Policy

Table of Contents

EXECUTIVE SUMMARY

This report was prepared by the Division of Health Care Finance and Policy (Division) pursuant to the provisions of M.G.L. c. 3, § 38C requiring the Division to evaluate the impact of mandated benefit bills. S. 2518 *An Act Relative to Children's Mental Health* incorporates various goals including seeking to establish a Mental Health Commission for Children, to ensure greater communication among state agencies in providing services to children with behavioral health needs, and to create an office of compliance coordination within the Executive Office of Health and Human Services to ensure compliance with *Rosie D. vs. Romney*. This report addresses only the specific components of S. 2518 related to commercially insured populations.

With regard to private insurance, the bill authorizes coverage consisting of a range of inpatient, intermediate, and outpatient services that permit medically necessary and active and non-custodial treatment for mental disorders in the least restrictive clinically appropriate setting for children and adolescents under 19, including collateral services. Collateral services are described as face-to-face or telephonic consultation of at least 15 minutes in duration by a licensed mental health professional determined to be necessary to make a diagnosis, and to develop and implement a treatment plan. Intermediate services are to be determined by the Division of Insurance in consultation with the Department of Mental Health. In addition, the proposed bill would mandate additional disclosure and reporting requirements for managed behavioral health organizations (MBHO).

To prepare this review and evaluation, the Division conducted interviews with health insurers, providers, and child welfare advocates in the Commonwealth, examined whether billing for collateral services occurred in other private or public insurance contexts, reviewed research evidence on the diagnosis and treatment of mental health disorders in childhood in intermediate level settings, and conducted an analysis of the fiscal impact of the components of S. 2518 related to private insurance.

The Division identified one provision of S. 2518 with potential material cost implications for the relevant population. S. 2518 requires coverage for "collateral services," defined in the legislation as "…face-to-face or telephonic consultation, of at least 15 minutes in duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan."[1]

Coverage for collateral services as generally defined in the proposed bill is not currently mandated or included voluntarily in commercial insurance products, and so this study uses information from other contexts applied to data from the Massachusetts commercial population which was adjusted to estimate the impact.

[1] S. 2518. Section 11.

After reviewing the literature and other available sources of information, the only payer identified currently covering collateral services for children was MassHealth managed care. (MassHealth is the name for the Medicaid program in the Commonwealth.). In order to estimate the impact of mandating collateral services on the commercial population, the ratio of per member collateral services spending to per member children's behavioral health spending in the MassHealth population was applied to the per member spending on children's behavioral health in the commercial population. This estimate was adjusted upward to reflect higher fees in the commercial sector. Low, middle, and high scenarios were computed to address the uncertainty stemming from the application of Medicaid utilization to the commercial population.

Exhibit 1 displays the projected impacts for the years 2008-2012 for three scenarios. Over the five year period, the mid-scenario impact averages approximately $1.5 million per year, which is 5 ½ cents per member per month, or about 0.01% of premium.

Exhibit 1

Estimated Cost Impact of SB2518, An Act Relative to Children's Mental Health, on Fully-Insured Health Care Premiums 2008-2012

Annual Trend in Behavioral Claims	1.065					
	2008	**2009**	**2010**	**2011**	**2012**	**All 5 Years**
Fully Insured Enrollment	2,329,685	2,329,406	2,344,491	2,356,243	2,358,085	
Low Scenario						
Annual Impact Claims (000s)	$ 18.2	$ 19.4	$ 20.6	$ 22.0	$ 23.4	$ 103.6
Annual Impact Administration (000s)	$ 2.5	$ 2.6	$ 2.8	$ 3.0	$ 3.2	$ 14.1
Annual Impact Total (000s)	$ 20.7	$ 22.0	$ 23.5	$ 25.0	$ 26.6	$ 117.8
Premium Impact (PMPM)	$ 0.0007	$ 0.0008	$ 0.0008	$ 0.0009	$ 0.0010	$ 0.0008
Mid Scenario						
Annual Impact Claims (000s)	$ 1,199.1	$ 1,277.1	$ 1,360.1	$ 1,448.5	$ 1,542.7	$ 6,827.5
Annual Impact Administration (000s)	$ 163.5	$ 174.1	$ 185.5	$ 197.5	$ 210.4	$ 931.0
Annual Impact Total (000s)	$ 1,362.7	$ 1,451.2	$ 1,545.6	$ 1,646.0	$ 1,753.0	$ 7,758.5
Premium Impact (PMPM)	$ 0.0488	$ 0.0520	$ 0.0554	$ 0.0590	$ 0.0628	$ 0.0556
High Scenario						
Annual Impact Claims (000s)	$ 3,203.6	$ 3,411.9	$ 3,633.6	$ 3,869.8	$ 4,121.4	$ 18,240.3
Annual Impact Administration (000s)	$ 436.9	$ 465.3	$ 495.5	$ 527.7	$ 562.0	$ 2,487.3
Annual Impact Total (000s)	$ 3,640.5	$ 3,877.1	$ 4,129.1	$ 4,397.5	$ 4,683.4	$ 20,727.6
Premium Impact (PMPM)	$ 0.1305	$ 0.1390	$ 0.1480	$ 0.1576	$ 0.1679	$ 0.1486

INTRODUCTION

Summary of Proposed Bill

S. 2518 would authorize coverage consisting of a range of inpatient, intermediate, and outpatient services that permit medically necessary and active and non-custodial treatment for mental disorders in the least restrictive clinically appropriate setting for children and adolescents under 19, including collateral services. Collateral services are described as face-to-face or telephonic consultation of at least 15 minutes in duration by a licensed mental health professional determined to be necessary to make a diagnosis, and to develop and implement a treatment plan. The bill does not specifically mention the types of individuals with whom medical professionals would consult. In discussions with advocates for the bill, the range of collateral contacts mentioned included parents, foster parents, teachers, primary care clinicians, pediatricians, police, parole officers, and youth services.

Under the S. 2518, intermediate services are to be defined by the Division of Insurance in consultation with the Department of Mental Health. Such services would include, but need not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Public Health or the Department of Mental Health.

The proposed bill would also mandate additional disclosure and reporting requirements for managed behavioral health organizations (MBHO). Carriers would be responsible for an MBHO's failure to comply with statutory requirements, and to provide the name and telephone number of the contracting MBHO on enrollment cards. Carriers would be required to provide information to enrollees regarding emergency mental health services including the option of calling the local pre-hospital emergency medical service system if the insured individual has an emergency mental health condition requiring pre-hospital emergency services. In addition, the bill states that no insured individual should be discouraged from using the local pre-hospital emergency medical service, or be denied coverage for medical and transportation expenses incurred as a result of such emergency mental health condition. The bill also specifies that, if the MBHO requires an enrollee to make contact within 48 hours of receiving emergency services, notification already given to the MBHO, carrier or primary care physician by the attending emergency physician would satisfy that requirement. Carriers would be required to summarize the process by which clinical guidelines and utilization review criteria are developed for behavioral health services. Carriers would be require to provide a statement that the Office of Patient Protection is available to assist consumers, a description of the grievance and review processes available to consumers under chapter 176O, and relevant contact information to access the office and these processes.

METHODOLOGICAL APPROACH

Approach for Determining Medical Efficacy

M.G.L. c. 3, § 38C (d) requires the Division to assess the medical efficacy of mandating the benefit, including the impact of the benefit to the quality of patient

care and the health status of the population and the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services or not providing the treatment or services. To determine the medical efficacy of S. 2518, the Division conducted a literature review on the availability and efficacy of collateral services billing and use of intermediate level services related to the diagnosis and treatment of mental health disorders in children.

Approach for Determining Fiscal Impact of the Bill

M.G.L. c. 3, § 38C (d) requires the Division to assess nine different measures in estimating the fiscal impact of a mandated benefit:

(1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or the service over the next 5 years;
(2) the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years;
(3) the extent to which the mandated treatment or services might serve as an alternative to a more expensive or less expensive treatment or service;
(4) the extent to which the insurance coverage may affect the number or types of providers of the mandated treatment or service over the next 5 years;
(5) the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of large employers, small employers, employees and nongroup purchasers;
(6) the potential benefits and savings to large employers, small employers, employees and nongroup purchasers;
(7) the effect of the proposed mandate on cost shifting between private and public payors of health care coverage;
(8) the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment; and
(9) the effect on the overall cost of the health care delivery system in the commonwealth.

To estimate the fiscal impact of collateral services, the Division:

1.) estimated the size of the affected insured population;
2.) estimated the per member per month cost in a sample population for which the benefit is already covered;
3.) adjusted the per member per month cost for differences between the sample population and the target population (i.e., the fully insured under-65 population); and
4.) estimated the impact on administrative expenses of the relevant insurers.

Following these steps, estimates were made for the entire covered population for a five-year timeframe (2008-2012) for a range of “low case” to “high case” scenarios.

For more detailed information on the methodological approach used to calculate the impact of collateral services (including the approach to calculating administrative costs), refer to the appendix to this report prepared by Compass Health Analytics, Inc.

MEDICAL EFFICACY

Mental Health Disorders in Childhood

In the United States, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment.[1] It is estimated that about one in five of such children receive specialty mental health services,[2] indicating that a substantial proportion of children have an unmet need for services.

The Diagnostic and Statistical Manual (DSM) of Mental Disorders identifies mental disorders involving onset in childhood and adolescence. These include anxiety disorders; attention-deficit and disruptive behavior disorders; autism and other pervasive developmental disorders; eating disorders (e.g., anorexia nervosa); elimination disorders (e.g., enuresis, encopresis); learning and communication disorders; mood disorders (e.g., major depressive disorder, bipolar disorder); schizophrenia; and tic disorders (Tourette's disorder). It is not uncommon for a child to have more than one disorder. For example, children with pervasive developmental disorders often suffer from ADHD, and anxiety disorders may occur in combination with mood disorders. Learning disorders and substance use disorders are also commonly co-occurring with other disorders. While these conditions often begin in childhood, many can persist across the lifespan.

The National Comorbidity Survey Replication found that half of all lifetime DSM disorders start by age 14.[3] If left untreated, child onset mental health disorders may have substantial, deleterious effects on educational attainment and long-term earning potential. Child mental disorders often persist into adulthood with data indicating that 74 percent of 21 year olds with mental disorders had prior problems. As adults, children with co-occurring depression and conduct disorders, for example, use more health care services and have higher health care costs than other adults.[4]

In comparison with adults, diagnosis and treatment of disorders in childhood can present challenges. Many children have greater difficulty than adults verbalizing thoughts and emotions, presenting a challenge to diagnosis and treatment. The *Surgeon General's Report on Mental Health* noted that, for this reason, clinicians are often reliant on parents, teachers, and other professionals to better assess behavioral or emotional problems in children.[5] In addition, because child development involves rapid change, clinical diagnosis is complicated by the fact that behaviors appropriate at one age are indicative of a mental health disorder at another age. Finally, diagnostic criteria and evidence-based treatment for most mental health disorders in children have been adopted from those developed for adults. Limited research evidence is available to comprehensively understand the applicability of diagnostic methods and treatments for adults in the child population.

A range of treatments are available to care for children and adolescents with mental and emotional health problems. Most psychotherapies are considered effective for children and adolescents since they lead to greater improvements compared with no treatment.[6-14] Less is known about the efficacy of psychotherapies to treat specific childhood diagnoses, however.[15] In addition, pharmacological therapies are increasingly being used to treat children and adolescents. A dramatic increase has occurred in the use of psychotropic medication for treating children over the last decade. However, there are important knowledge gaps with regard to the efficacy and safety of using these medications in the treatment of a child population.[16] For many prescribed medications, studies of safety and efficacy for children and adolescents are lacking. The absence of research on children and adolescents has led to extensive "off-label" use of psychotropic medications. In the last few years, the Food and Drug Administration (FDA) has identified risks associated with a number of psychotropic drugs commonly used to treat children. For example, the FDA issued a black box warning related to pediatric antidepressant use and suicide risk in October 2004 and a public advisory in 2005 related to risks associated with a commonly used Attention Deficit Hyperactivity Disorder drug.

Collateral Services

Collateral services under S. 2518 would involve face-to-face or telephonic consultation of at least 15 minutes in duration by a licensed mental health professional determined to be necessary to make a diagnosis, and to develop and implement a treatment plan. The Division examined the use of billable collateral services in other contexts. Through its MBHO, Massachusetts Behavioral Health Partnership (MBHP), and through its Managed Care Organizations (MCOs), MassHealth covers three types of consultation services: case consultation, family consultation, and collateral contact. Case consultation involves provider to provider telephonic or face-to-face contact in 15 minute units. Family consultation involves provider to family member telephonic or face-to-face contact in 15 minute units. Collateral contact involves provider contact with non-clinicians who are professionally involved with the child such as teachers, police, parole officers, coaches, or day care providers. Commercial insurers in Massachusetts do not reimburse providers separately for collateral services. They view these services as "bundled" into clinician visit reimbursement rates. The Division was not able to identify private insurers in other states that typically reimburse mental health providers for collateral services in the manner proposed under S. 2518.

Child advocates stress the importance of reimbursing collateral contacts on the basis of the role these services could play in early diagnosis and treatment of mental health disorders.[17] They suggest that early identification and treatment can substantially reduce the long-term direct and indirect societal costs of mental illness. The President's *New Freedom Commission on Mental Health Report* identified a need to address the problem of fragmentation across multiple programs and services and different funding sources as a strategy for improving health outcomes.[18] Collateral services have the potential to reduce fragmentation in the delivery of mental health care for children and adolescents. However, no published studies are available to assess the effects of collateral services on coordination or health outcomes. In addition, research evidence indicates that parents of

children with mental health disorders spend significant time coordinating their child's health care. Compared to parents of children with other special health care needs, a recent study indicated that parents of children with mental health disorders spent significantly more time coordinating their child's care.[19] No published research is available to assess whether billing for collateral services would lower the coordination burden on families.

In contrast, insurers have expressed a number of concerns related to billing for collateral services under the proposed bill. First, they indicated concern about the absence of established standards for determining the medical necessity of collateral contacts. Second, they expressed a concern that if collateral services were provided for children's mental health care, similar billable services would need to be offered for physical health care. Finally, they noted the difficulty in managing the collateral services benefit and the additional costs that would be required to conduct utilization review of these services. Specifically, they noted the difficulty health plans would face in validating that a collateral contact occurred, and ensuring that contact was of the appropriate duration and was necessary to make a diagnosis. No published research is available to assess these claims.

Intermediate Level Services

Child advocates in the Commonwealth have expressed the view that commercial insurers rely heavily on outpatient and inpatient services in treating children with mental health conditions, and that greater use of intermediate level services is warranted.

Research indicates the effectiveness of a range of intermediate level treatment interventions for children and adolescents. Partial hospitalization, also called day treatment and partial care, has been a growing treatment modality for youth with mental disorders. The *Surgeon General's Report on Mental Health* reports that research on partial hospitalization as an alternative to inpatient treatment "generally finds benefit from a structured daily environment that allows youth to return home at night to be with their family and peers."[20] Residential treatment centers, a slightly less restrictive form of care than inpatient hospitalization, constitutes a second category of intermediate services. Although only about eight percent of children receive treatment in this setting, they account for nearly one-fourth of the national outlay on child mental health according to one report.[21] However, the Surgeon General's Report indicated that there is only weak evidence for their effectiveness.[22] Comprehensive community-based interventions including case management, home-based services, therapeutic foster care, therapeutic group homes, and crisis services are also considered intermediate level services. Uncontrolled studies offer some information on the effectiveness of these treatments. Of these interventions, the Surgeon General's Report identified the most convincing evidence of effectiveness of home-based services and therapeutic foster care.[23]

Regulation of MBHOs

In Massachusetts, the majority of private insurers sub-contract with MBHOs to provide behavioral health benefits. MBHOs, specialty managed behavioral health 'carve-out'

firms, have emerged as the dominant approach to managing mental health care over the last decade. The carve-out industry has grown rapidly in the U.S. with 164 million individuals covered in 2002 compared to 70 million in 1993, according to one estimate.[24] Behavioral health carve-out firms typically use specialized expertise to establish networks of mental health specialty providers, negotiate volume discounts, identify evidence-based treatment protocols, and develop other incentive programs to manage utilization and quality of care. The financial arrangement between health plans and carve-out firms ranges from full/partial risk sharing to administrative services only contracts. Likewise, the scope of services covered by carve-outs ranges from full service behavioral health contracts to stand-alone utilization review, case management, or employee assistance program services. Concern has been raised by child welfare advocates in the state that Division of Insurance does not have sufficient authority to collect and report service data on MBHOs and to regulate the activities of these companies.[25]

FISCAL IMPACT OF MANDATE

1. The Division is required to assess the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years.

Exhibit 2 displays the projected impacts for the years 2008-2012 for three scenarios. Over the five year period, the mid-scenario impact averages approximately $1.5 million per year, which is 5 ½ cents per member per month, or about 0.01% of premium.

Exhibit 2

Estimated Cost Impact of SB2518, An Act Relative to Children's Mental Health, on Fully-Insured Health Care Premiums 2008-2012

Annual Trend in Behavioral Claims	1.065					
	2008	**2009**	**2010**	**2011**	**2012**	**All 5 Years**
Fully Insured Enrollment	2,329,685	2,329,406	2,344,491	2,356,243	2,358,085	
Low Scenario						
Annual Impact Claims (000s)	$ 18.2	$ 19.4	$ 20.6	$ 22.0	$ 23.4	$ 103.6
Annual Impact Administration (000s)	$ 2.5	$ 2.6	$ 2.8	$ 3.0	$ 3.2	$ 14.1
Annual Impact Total (000s)	$ 20.7	$ 22.0	$ 23.5	$ 25.0	$ 26.6	$ 117.8
Premium Impact (PMPM)	$ 0.0007	$ 0.0008	$ 0.0008	$ 0.0009	$ 0.0010	$ 0.0008
Mid Scenario						
Annual Impact Claims (000s)	$ 1,199.1	$ 1,277.1	$ 1,360.1	$ 1,448.5	$ 1,542.7	$ 6,827.5
Annual Impact Administration (000s)	$ 163.5	$ 174.1	$ 185.5	$ 197.5	$ 210.4	$ 931.0
Annual Impact Total (000s)	$ 1,362.7	$ 1,451.2	$ 1,545.6	$ 1,646.0	$ 1,753.0	$ 7,758.5
Premium Impact (PMPM)	$ 0.0488	$ 0.0520	$ 0.0554	$ 0.0590	$ 0.0628	$ 0.0556
High Scenario						
Annual Impact Claims (000s)	$ 3,203.6	$ 3,411.9	$ 3,633.6	$ 3,869.8	$ 4,121.4	$ 18,240.3
Annual Impact Administration (000s)	$ 436.9	$ 465.3	$ 495.5	$ 527.7	$ 562.0	$ 2,487.3
Annual Impact Total (000s)	$ 3,640.5	$ 3,877.1	$ 4,129.1	$ 4,397.5	$ 4,683.4	$ 20,727.6
Premium Impact (PMPM)	$ 0.1305	$ 0.1390	$ 0.1480	$ 0.1576	$ 0.1679	$ 0.1486

2. The Division is required to assess the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years.

There is no data available that would permit the Division to quantify the extent to which the proposed bill might affect the appropriate or inappropriate use of the treatment or service over the next five years. Under S. 2518, mental health providers who believe that consultation with third parties would better equip them to make a diagnosis might be expected to provide more effective treatment as a result of a more accurate diagnosis and/or a more appropriate treatment plan. However, these services may increase health care costs and the appropriate use of these services maybe hard for an insurer to quantify.

3. The Division is required to assess the extent to which the mandated treatment or services might serve as an alternative to a more expensive or less expensive treatment or service.

There is no data available that would permit the Division to quantify the extent to which the mandated treatment might serve as an alternative for more expensive or less expensive treatments. As noted above, should reimbursement for additional treatment facilities for children become available, costs may in fact increase. However, one could expect that insurers may initially approve care in less expensive outpatient settings, if medically appropriate, prior to approving care in intermediate level settings.

4. The Division is required to assess the extent to which the insurance coverage may affect the number or types of providers of the mandated treatment or service over the next 5 years.

There is no data available that would permit the Division to quantify the extent to which the mandated treatment may result in establishment of additional inpatient or residential treatment facilities. Should S. 2518 become law, providers may determine that demand for additional intermediate level services may increase and it is possible that additional treatment facilities could be established to provide this specialized care.

5. The Division is required to assess the effects of the mandated benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of large and small employers, employees and non-group purchasers.

Exhibit 2 above includes administrative cost estimates. Incremental administrative expenses would be incurred for activities associated with the implementation of the mandate such as modifications to benefit plan materials, claims processing system changes, training/ communication material for staff, etc. In addition, the proposed bill would mandate additional disclosure and reporting requirements for managed behavioral health organizations (MBHOs). These marginal administrative costs would be greater than zero, but less than the average administrative cost percentage that the administrative adjustment applied to these estimates allows.

In addition, incremental margin is required in order for the insurer to maintain adequate reserve levels as required by the Massachusetts Division of Insurance. Required reserves are based on the claim levels for the insurer, and since the mandate would increase claim levels, it would

increase required reserve levels and therefore incrementally increase the total dollars of margin required to meet those reserve levels.

6. The Division is required to assess the potential benefits and savings to large and small employers, employees and non-group purchasers.

Some clinicians argue that early treatment, using a multidisciplinary approach, offers many patients the best opportunity to improve and many to recover. Some small employers could benefit by increased employee satisfaction if employees' family members benefit from additional services offered by this mandate. This mandate would not affect the many large employers who are self-insured unless they choose to adopt this standard.

7. The Division is required to assess the effect of the proposed mandate on cost-shifting between private and public payers of health care coverage.

There is no data available that would permit the Division to quantify the extent to which the mandate would shift costs between private and public payers of health care coverage. The proposed mandate only applies to commercial insurers, HMOs and BCBSMA and the Group Insurance Commission. However, insurers have raised concerns that the legislation would broaden coverage of mental health services resulting in a cost-shifting of services from school systems and the Department of Education to the private health insurance market.

8. The Division is required to assess the cost to health care consumers of not mandating the benefit in terms of out-of-pocket costs for treatment or delayed treatment.

There is no data available that would permit the Division to quantify the extent to which the mandate would affect out-of-pocket costs or treatment delays. Insured employees who currently pay for intermediate level treatment for their children out-of-pocket could possibly experience some savings should their insurers offer additional intermediate level services. Likewise, parents involved in coordinating their child's care across providers (e.g., mental health specialists, pediatricians) and other professionals (e.g., teachers) may experience a reduction in time costs associated with coordination if collateral services are paid for under the proposed bill. Delays in treatment might be avoided if collateral services lead to an earlier diagnosis of a condition.

9. The Division is required to assess the effects on the overall cost of the health care delivery system in the Commonwealth.

The estimated overall impact on health insurance premiums and spending is included in Exhibit 2 above.

ENDNOTES

[1] (Burns, et al., 1995; Shaffer, et al., 1996)

[2] (Burns, et al., 1995)

[3] Kessler, RC, P Berglund, O Demler, R Jin, KR Merikangas, and EE Walters (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication *Archives of General Psychiatry* 62: 593-602.

[4] Knapp M, McCrone P, Fombone E et al. (2002). The Maudsley Long-term Follow-up of Child and Adolescent Depression: Impact of Comorbid Conduct Disorders on Service Use and Costs in Adulthood. British Journal of Psychiatry, 180: 19-23.

[5] U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[6] Casey, R. J., & Berman, J. S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin, 98*, 388–400.

[7]Hazelrigg, M. D., Cooper, H. M., & Borduin, C. M. (1987). Evaluating the effectiveness of family therapies: An integrative review and analysis. *Psychological Bulletin, 101*, 428–442.

[8] Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 55*, 542–549.

[9] Kazdin, A. E., Siegel, T. C., & Bass, D. (1990). Drawing on clinical practice to inform research on child and adolescent psychotherapy: Survey to practitioners. *Professional Psychology: Research and Practice, 21*, 189–198.

[10] Baer, R. A., & Nietzel, M. T. (1991). Cognitive and behavioral treatment of impulsivity in children: A meta-analytic review of the outcome literature. *Journal of Clinical Child Psychology, 20*, 400–412.

[11] Grossman, P. B., & Hughes, J. N. (1992). Self-control interventions with internalizing disorders: A review and analysis. *School Psychology Review, 21*, 229–245.

[12] Shadish, W. R., Montgomery, L. M., Wilson, P., Wilson, M. R., Bright, I., & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology, 61*, 992–1002.

[13] Weisz, J. R., & Weiss, B. (1993). *Effects of psychotherapy with children and adolescents.* Newbury Park, CA: Sage

[14] Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. *Psychological Bulletin, 117*, 450–468.

[15] Lonigan, C. J., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial interventions for children: An overview. *Journal of Clinical Child Psychology, 27*, 138–145.

[16] Jensen, P. S., Bhatara, V. S., Vitiello, B., Hoagwood, K., Feil, M., & Burke, L. B. (1999). Psychoactive medication prescribing practices for U.S. children: Gaps between research and clinical practice. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 557–565.

[17] Children's Mental Health in the Commonwealth: The Time is Now (2006). Report by MSPCC and Children's Hospital Boston. http://www.jbcc.harvard.edu/infoAdvocates/MentalHealtInMass12-06.pdf

[18] The President's New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America: Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD.

[19] Busch SH, CL Barry (2007). Child Mental Health Disorders: Assessing the Burden on Families. *Health Affairs* 26(4): 1088-1095.

[20] U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[21] Burns, B. J., Hoagwood, K. & Maultsby, L. T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In M. H. Epstein, K. Kutash, & A. J. Duchnowski (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 686–707). Austin, TX: Pro-Ed.

[22] U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[23] Ibid.

[24] Oss M.E., Jardine E.L., Pesare M.J. (2003). Open Minds Yearbook of Managed Behavioral Health and Employee Assistance Program Market Share in the U.S. 2002-2003. Gettysburg, PA: Open Minds Publication.

[25] Children's Mental Health in the Commonwealth: The Time is Now (2006). Report by MSPCC and Children's Hospital Boston. http://www.jbcc.harvard.edu/infoAdvocates/MentalHealtInMass12-06.pdf