

Editorial

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The articles in this issue consider the value of systematic reviews for economic analysis and health policy decision making (Gilbody and Petticrew), the research opportunities in managed care environments (Goldman *et al.*), the analysis of outcomes and costs of medical algorithms for severe mental disorders (Kashner *et al.*), the impact of major depression on the labour force (Marcotte *et al.*) and the costs of drug addiction in the United States. Three commentaries consider some aspects of the articles by Gilbody and Petticrew and Goldman.

Gilbody and Petticrew (p. 99) analyze the role of systematic reviews in summarizing primary research data, their role in economic analysis and their potential for informing mental health policy. The article, coming from the United Kingdom National Health Service Centre for Reviews and Dissemination, is an example of the attention given by governmental institutions in some countries to an evidence-based health policy decision making.

Some examples are presented, taken from the introduction of new drugs and for methods of delivering psychiatric care in the community for severe mental disorders. The authors indicate that systematic reviews produce the best estimates of clinical efficacy. However, they cannot produce valid and believable conclusions when the primary research literature is of poor quality or biased. They infer that systematic reviews are often costly and time consuming, but may have a function in highlighting poor quality research and be cost-effective in avoiding unnecessary primary research. They claim that only the use of methodologically sound systematic reviews as the source of evidence will ensure that decision-making in mental health is rational and scientific, and that this is a laudable goal for mental health policy and practice.

The issues considered in the article stimulated two commentaries from different countries: the US (Sturm, p. 141) and Germany (Sauerland, p. 137).

The article by Goldman *et al.* (p. 107) focuses on the development of research in the managed care environment in the United States and explores the opportunities of collaboration among payers, managed care companies and academic researchers. In the past, sources of data about health care delivery were limited to claims files of insurance companies or government payers; more clinical information had to be collected on a case by case basis from individual clinicians, clinics or hospitals. Now, managed care organisations are the major repository of information

about health care delivery, but a number of difficulties are recognised.

The authors claim that there is a limited tradition in health services sciences of analysing administrative data and there is a need for stronger analytic methods to assure the internal validity of the weaker non-experimental design data analyses. Researchers also have limited experience with complex management information systems. On the managed care side, information systems departments are unfamiliar with research, may have difficulties in identifying and extracting appropriate data, and may decrease their involvement in research activities due to the pressures of day-to-day operations. The authors describe a few collaborative studies and claim that challenges such as universal access and the linkages between the quality and cost-effectiveness of care can only be met successfully if alliances among the payers, managed care companies and academic research communities, are built. Dickey (p. 135), gives a commentary on this paper.

The article by Kashner *et al.* (p. 111) analyses the strategy of measuring costs in a multi-site study based in Texas that analyses outcomes and costs of medication algorithms for bipolar disorder, schizophrenia and depression. The authors claim that the cost estimates of algorithm-based practices should measure opportunity costs, employ structured data collection methods, analyse general and psychiatric services use and reflect the costs by payer status in different economic environments. These analyses are aimed at informing clinicians, patients and third party payers to balance costs and outcomes in their own decisions. Planners should consider consumer wants and economic costs when developing and testing new algorithms.

Marcotte *et al.* (p. 123), analyse the impact of major depression in the labour force on the basis of the data from the National Comorbidity Survey. Among people in the labour force, major depression is more prevalent among the unemployed than among the employed. Further research is needed to analyse whether unemployment itself triggers depressive episodes or if workers who are depressed are more likely to be fired or leave.

Cartwright (p. 133), describes the costs of drug abuse in US. The study was performed jointly by the National Institute of Drug Abuse (NIDA) and the National Institute of Alcoholism and Alcohol Addiction (NIAAA). Particularly relevant is the low percentage of treatment and prevention expenditures (4.5%) of total societal costs.

The article by Cartwright inaugurates the new Journal Section, '*Brief Data Report*'.

We encourage the submission of reports from various countries, with a brief description of the financing and provision of mental health services, and the concise presentation of significant available data on mental health services use and costs. In particular, officials in governmental institutions are encouraged to submit to the Journal data on their country, including those

already published in administrative reports of limited circulation.

We hope this issue will enable readers to further enhance their knowledge on the various services for mental disorders and addictions provided in several countries, and the available information on service use and costs.

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