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Editorial

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The Editors, Editorial Board and Publisher of The Journal of Mental Health Policy and Economics are delighted to announce the creation of an Award intended to support excellence in the field of mental health policy and economics. The Journal, conscious of its role and responsibility in stimulating internationally high quality interdisciplinary research in the field of mental health policy and economics has proposed to introduce a retrospective evaluation of the published articles, recognizing those studies considered of exceptional value.

The publisher enthusiastically endorsed the project and decided to formalize this process through the establishment of the inaugural *'Adam Smith Award'*. The award will be given to the article published in *The Journal of Mental Health Policy and Economics* during the years 2001 and 2002 that will be considered by the Editorial Board of exceptional value for the development of the interdisciplinary field of mental health policy and economics. Two 'Excellence in Mental Health Policy and Economics Awards' have also been established.

The Award Ceremony will be held during the 'Sixth Workshop on Costs and Assessment in Psychiatry – Mental Health Policy and Economics – The Value of Research', Venice, March 28–30, 2003). Further information is presented in this issue.

Adam Smith has been considered a forerunner of the field of health economics. In particular, we think he can be considered a forerunner of the role of economic research in informing the health policy formulation that copes with catastrophic illnesses. In the Introduction to 'The Wealth of the Nations' he claims *'The savage nations of hunters and fishers… are so miserably poor, that only from mere want, they are frequently reduced or, at least* they think *themselves reduced, to the necessity sometimes of directly destroying, and sometimes of abandoning their infants, their old people and those afflicted with lingering diseases to perish with hunger or to be devoured by wild beasts'* (Adam Smith, 1776).

We think the dilemma in these few sentences, which refers to the financing and treatment of catastrophic illnesses ('are we *really* reduced to deny care and support?'), is still the main question societies are expected to ask themselves and solve in a proper and articulated way, and economic research is expected to give its scientific contribution in the analysis of the value of interventions and of the efficiency of their management in various environments. Many catastrophic illnesses are related to the mental health sector (such as severe mental disorders, mental retardation, addictive disorders, dementias) and we expect this initiative will further encourage the financing and development of high quality research aimed at replying to these questions in the field of mental and addictive disorders.

The articles presented in this issue consider the consequences of increasing staff in nursing homes, both special care (SCU) and traditional care units (Holmes *et al.*), the lost productivity among full-time workers with mental disorders, both in term of days of absence from work and days of restricted activities while at work (Lim *et al.*), the risk of adjustment models aimed at predicting future health care costs for mental disorders in capitation contracts (Kapur *et al.*), the economic analysis of a training and educational intervention for the staff in the nursing homes (Richardson *et al.*), the impact of mental and addictive disorders on the income and employment among the homeless people (Zuvekas and Hill).

The study by Holmes determines the extent to which addition of staff would result in diminution of deviant behavior among residents of special care unit (SCU) and traditional units. An increasing percentage of the 17000 nursing homes in the US (currently 20%) has units targeted at the special care of dementia. They are expected to provide more staff time and more specialized staff arrangement.

The study relied on 10 randomly-selected nursing homes (five with and five without SCU) located in downstate New York, and random samples of 40 residents were drawn from each of the facilities, equally divided between SCU and non-SCU residents.

The residents' behavior was assessed, the clinical staff time data collected and the type and duration of care, as well as the recipient of the care, recorded. During the 15 months follow-up there was a significant reduction of behavior disorder associated with more provision of aid time in SCUs, contrasted with non-SCUs. Behavior disorder remained more or less constant in the non-SCU at all the levels of nursing aid input, while among SCU residents relatively small incremental service use and reimbursement for aide services was accompanied by relatively robust changes in behavior.

The authors claim that an important ingredient in relation to the reduction of behavior disorder is not membership in an SCU per se, but the provision of more aide time within SCUs. Incremental expenditures have little or no effect in non-SCUs and even in SCUs a state of equilibrium is

reached at which further incremental expenditures can be expected to have little result. Further research is expected to explore the different levels of efficiency of SCUs for various levels of incremental costs.

The Lim *et al*. study, focuses on the analysis of individual mental disorders and their comorbidities as predictors of work impairment in term of work loss (substantially identifiable with absenteeism) and work cut-back (number of days unable to perform usual activities). The greater impact on work impairment of different types of disorder in some occupations than others, and whether work impairment in those with a disorder is related to treatment seeking, were also explored. The study relies on the data on full-time workers identified by the 'Australian National Survey of Mental Health and Well-being', modelled on the US National Comorbidity Survey.

Depression, generalized anxiety and personality disorders were found predictive of work impairment after controlling for impairment due to physical disorders. Affective disorders were associated with the greatest amount of work loss and cutback days among people with only one disorder. The combination affective-anxiety disorders had the greatest number of work loss days among people with either single or comorbid disorder and the largest amount of work cutback. No relationship was found between type of occupation and impact of different types of disorders on work impairment. Only 15% of people with any mental disorder had sought help in the past month.

Authors consider the importance of further exploring the economic impact of work cutback underlining the need of developing measures aimed at enhancing the reliability of its assessment. They also consider the worksite an ideal setting for mental health promotion and prevention, in consideration of the large economic losses in productive work due to the disorders and to the low aid-seeking by these subjects for illnesses that can be succcessfully treated.

The article by Kapur *et al*. refers to capitation contracts in the US. These contracts, introduced by managed care, are increasingly used in publicly funded US mental health systems. The use of capitation for paying providers of care may increase the risk of disenrollment or adverse outcomes among high cost people with severe mental illness. Risk adjustment payments to providers, if models that are able to predict reliably services use and costs are identified, may be likely to reduce providers' incentives to avoid or under-treat these patients.

The study focuses on developing a risk adjustment system specifically for individuals who are publicly funded and severely mentally ill. Authors apply the risk adjustment model to predict costs incurred by subjects affected by severe mental disorders during the first year of a pilot (not risk adjusted) capitation program for the severely mentally ill in California, using data from the previous years. A number of variables are considered for developing the risk adjusted model: demographics, indications of insurance coverage, diagnosis, function indexes and costs. The study indicates that the model that incorporates demographic characteristics, diagnostic information and costs data from two previous years explains only about 16 percent of the in-sample variation in costs and 10 percent of the out-sample variation in costs. A model excluding prior cost covariates explains only about 5 percent of the variations in costs.

The authors claim that risk adjustment methods, as developed to-date, do not have the requisite predictive power to be used as the sole measure in setting capitation rates and similarly to other researchers suggest that some degree of financial risk sharing between providers and public mental health agencies should be introduced in payments to providers, in order to compensate capitation limitations in predicting services use and costs.

The article by Richardson *et al*., analyse the economic impact of a training and educational program for staff in nursing or residential homes in UK.

A randomized controlled trial considered those residents who were perceived by the staff as being difficult to manage and presenting an active management problem in the home. Twelve homes in South Manchester were involved and the staff of each of them indicated 10 residents. Six of the homes received the intervention, while the others were the control arm of the study. Data on resources used were collected retrospectively for each resident both before the intervention commenced and again after the entire intervention had been completed. In both cases, resources use over the previous six months period was analyzed.

The authors claim that while this intervention showed benefits in terms of depression and cognitive impairment results, there were no significant differences in the total cost per person in the homes that received the intervention and the control homes due to reductions in the use of other resources such as GPs visits to nursing and residential homes.

The article by Zuvekas and Hill investigates the characteristics that impeded homeless people in the labor market and in government program participation, paying particular attention to the major mental disorders and addictive disorders. The study relies on a survey of a sample of homeless adults randomly selected from area shelters and meal providers in California and re-interviewed six months later, regardless of domiciliary status. About one fourth of the homeless persons in the sample have had a major mental disorder (schizophrenia, manic depressive disorder, major depression) at some point in their life-time and three forth of homelesses have had a drug or alcohol disorder.

The analysis shows that a surprisingly large number of homeless people work, but few homeless people are able to generate significant income from employment alone. With respect to government transfer programs, the authors found low rates of participation and that these rates vary considerably by type of disability. In particular, major mental disorders and addictive disorders are associated with a lower probability of participating in federal (more generous) disability programs than those with physical disability.

Authors claim that the low rates of participation suggest the need for continued and multisite research aimed at analysing barriers to access to income support programs among eligible homeless population, and at identifying the interventions which can eliminate these barriers.