

Editorial

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The articles in this issue consider the impact of managed care on the inpatient treatment of mental disorders and substance abuse (Fleming *et al*), the psychological burden on relatives of individuals affected by chronic illnesses (Holmes and Deb), means of preventing HIV infection in subjects with severe mental disorders (Johnson-Masotti *et al*) and the impact of alcohol policies on youth suicides (Markowitz *et al*).

Fleming *et al* (p. 3) analyze inpatient care for mental disorders and substance abuse in Massachusetts after the introduction of managed care. The authors consider hospitalization during the period 1994-1999, relying on two different data sources: the data base for the general hospitals (reliable and detailed information on case mix and costs for each discharge; psychoses account for 70% of mental health discharges from general hospitals) and reports from specialty psychiatric hospitals (less detailed information, consisting of inpatient costs and services only, with no demographic or clinical data). The authors report that cost reductions are slightly larger for mental health and substance abuse care than for physical health care, and that in the mental health and substance abuse group the Medicare and Medicaid costs per enrollee fell by about 25% over the four years, whereas the privately insured group's costs decreased by 19%. The authors, considering the large cost reductions for the state's Medicare and Medicaid programs and the availability of data per type of plan (managed care and fee for service) for each discharge from general hospitals, compare trends in inpatient care from 1994 to 1999 on the basis of the costs per discharge. The reduction in service costs for mental health and substance abuse is mainly due to the decline in average cost per inpatient episode: managed care has reduced both the quantity (average length of stay) and intensity (expenditure per day) of health care. Besides the usual practices that a managed care organization follows to control costs (such as utilization, gate-keeping, second opinion, and approval requirements), the authors claim that the creation of a network of providers has been a common but less understood component of managed care. The provider has access to plans only through the network, joining the network may require the reduction of prices, and a managed care plan may direct patients to the preferred providers within the network. Simulation models indicate that 50% of the cost differential between managed and non-managed plans is due to the creation of provider networks. The authors recommend further research aimed at extending the analysis to other U.S. states and at focusing on long-term trends in health outcomes between managed care and fee-for-service treatment.

Holmes and Deb (p. 13) consider the effect of chronic illness on the psychological distress of family members and on the family's ability to support the patient. According to the authors, the increasing emphasis on community-based care increases the demands on patients and their families to manage and treat their illnesses at home, while shrinking family size and demographic changes may increase the burden that a serious medical condition imposes on other family members. The study compares both the direct and indirect spillover impacts of different chronic illnesses on the psychological health of the entire family, and determines (i) which chronic conditions among cancer, diabetes, stroke-related disorders, arthritis, asthma and mental illness (including dementia) are associated with the greatest risk to the psychological well-being of family members, and (ii) which individual and family characteristics exacerbate such risks. The study relies on data from the 1996 Medical Expenditure Survey (MEPS), which collects nationally representative, health-related data for the civilian, non-institutionalized U.S. population and includes general mental health questions for each family member. The authors report that brain-related conditions, including mental illness, impose the most significant risk to the psychological well-being of family members and suggest that these families be given priority for respite care and support services, especially if they have limited financial resources and inadequate insurance coverage.

Johnson-Masotti *et al* (p. 23) review the studies on the efficacy and cost-effectiveness of the first-generation measures for preventing HIV infection in people with severe mental disorders. The few studies in this field, mostly conducted in the New York City area, show HIV positive rates of 5 to 8% among newly admitted psychiatric patients, 19.4% among patients discharged from a homeless shelter, and 22.9% among substance abuse patients admitted to psychiatric inpatient units. A multi-center study in Connecticut, Maryland, New Hampshire and North Carolina found HIV positive rates of 5% in large metropolitan areas and 1.4% in small, non-metropolitan areas. These rates are much higher than the overall 0.3-0.4% for the U.S. adult population and emphasize the increased risk of HIV infection for those affected by severe mental disorders. The authors review a number of efficacy studies on measures for the prevention of HIV infection. Such measures address changes in behavior (rather than knowledge, attitudes or beliefs) and are delivered in two forms: (i) small group interventions that emphasize behavioral skills and (ii) small group interventions that encourage these individuals to advocate

what they have learned to their peers. The authors report that these measures were of questionable efficacy in decreasing unprotected sex and number of partners, while some interventions had positive effects on condom use. They also review two explorative cost/utility analyses, which find that single-session, small group intervention is the most cost-effective prevention strategy for women, whereas advocacy training is the most cost-effective measure for men. The limitations of these studies are reported in the article. The authors claim that the high risk of HIV infection in people affected by serious mental illness warrants special attention for enhancing prevention methods aimed at changing patients' behavior, and suggest further research topics and ways of developing second-generation prevention techniques for people suffering from severe mental disorders.

Markowitz *et al* (p. 37) investigate the role of alcohol-related policies in reducing suicides among youths and young adults. The Report of the United States Surgeon General (1999) highlights the seriousness of suicide as a public health problem in the U.S. In 1999, suicides accounted for 12% of deaths among 15- to 19-year-olds and

13.5% among 20- to 24-year-olds; for these age groups, suicide ranks as the third leading cause of death after accidents and homicide. The authors, on the basis of prior research, stress the link between alcohol use and suicide ideation, suicide attempts and completed suicide among youths. They argue that if alcohol use is an underlying cause of suicide, then policies aimed at reducing consumption may also lower the incidence of suicide. Empirical analysis finds that raising the excise tax on beer is associated with a reduced number of male suicides. The rate of suicide by males aged 20 to 24 correlates directly with the availability of alcohol and inversely with the severity of the legal blood alcohol limit. Female suicides are not affected by the excise tax on beer or by the availability of alcohol, although driving laws may impact suicide by females in their teens. The authors conclude that policies aimed at reducing alcohol consumption may be successful in lowering the suicide rate in males, but have little impact on females. They report the major limitations of their study and suggest targets for further research.