

Editorial

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We are pleased to inform our readers that the second Adam Smith Award in Mental Health Policy and Economics Research was presented during the Seventh Workshop on Costs and Assessment in Psychiatry – Financing Mental and Addictive Disorders, held March 18-20, 2005, in Venice, Italy. The winning article was:

- Sara Markowitz, Pinka Chatterji, Robert Kaestner. Estimating the Impact of Alcohol Policies on Youth Suicides. *J Ment Health Policy Econ* 2003; 6: 37-46.

In addition, two Excellence in Mental Health Policy and Economics Research Awards were presented for the following articles:

- Barbara Dickey, Sharon-Lise T. Normand. Toward a Model for Testing the Relationship Between Quality of Care and Costs. *J Ment Health Policy Econ* 2004; 7: 15-21;
- Douglas L. Leslie, Robert A. Rosenheck. Benchmarking the Quality of Schizophrenia Pharmacotherapy: A Comparison of the Department of Veteran Affairs and the Private Sector. *J Ment Health Policy Econ* 2003; 6: 113-121.

We congratulate the authors of the award-winning articles and we are grateful to the associate editors for participating in the selection process.

We plan to present the third *Adam Smith Award in Mental Health Policy and Economics Research* during the Eighth Workshop on Costs and Assessment in Psychiatry, to be held in 2007. Detailed information on eligibility requirements and the review process is provided elsewhere in this issue and at www.icmpe.org.

The articles in this issue consider the process of converting services use data into costs in Australia (Mihalopoulos *et al.*), the application of willingness to pay methods to the analysis of family members' preferences in mental health (Mulvaney-Day), the effects of typical and atypical antipsychotic medication on psychiatric service utilization and cost (Rothbard *et al.*), and the use of residential and community services in Piedmont, Italy (Tibaldi *et al.*).

Mihalopoulos *et al.* (p. 61) explore the process of assigning unit costs for inpatient and community psychiatric services and its application to the analysis of the costs of some single and co-morbid psychiatric conditions (anxiety, depression, substance use). The study uses the Australian National Survey of Mental health and Wellbeing (NSMHWB) data, collecting information from over 10,500 adult respondents. They were asked to focus on the 12 months prior to the

survey and to report whether they had experienced symptoms associated with a number of mental disorders, the resulting degree of disability, their public and private admissions to psychiatric and general hospitals, and their community consultations with a range of health professionals. The costs were estimated following the recommendations in *The Manual of Resources Items and their Associated Costs*, developed by Australia's Commonwealth Department of Health and Ageing. The survey was not originally aimed at economic analysis and the authors describe the method of attaching unit costs to psychiatric admissions and community contacts. Preliminary data indicate that patients with co-morbid conditions had the highest costs, while patients diagnosed with a single substance abuse disorder had the lowest treatment costs.

Mulvaney-Day (p. 71) examines the role of willingness to pay (WTP) techniques to assess in cost benefit analysis the intangible impact of mental health treatment on individuals other than the person with illness, such as family members. The study describes the survey development process and the stages aimed at adapting and analyzing the feasibility of WTP techniques for persons who have family members with serious mental illness. The final survey included the WTP-C, a single question reformulated on the basis of the survey development process, asking the respondent how much he or she would pay for the medication for the family member with severe mental illness (SMI) that would significantly improve his or her functioning. Respondents were also asked to record 30-day expenses on behalf the family member with SMI in five broad categories: pocket money, personal expenses, medical expenses, living expenses and other. Measures of the family member's symptomatology and need for help with activities of daily living were also included in the survey. The survey was mailed to a random sample of 2000 persons belonging to the National Alliance for the Mentally Ill (NAMI), a U.S. family support and advocacy group. Out of the 810 surveys returned, 660 were eligible cases with a living family member with severe mental illness (SMI). The author reports that the response rate supports the overall feasibility of using WTP techniques with this population. Despite a concern that eliciting WTP from people who have a seriously ill family member might result in inconsistent and unreasonably high amounts, this study did not encounter a high number of potentially irrational results. This is possibly due to the explicit scenario in reminding people to place their WTP value within a budget context, and to think clearly how much they could afford.

Rothbard *et al.* (p. 83), reporting the emerging consensus

that the first line of treatment for individuals with psychotic disorders should be the newer atypical medications rather than the older neuroleptics, examine whether these are cost-effective alternatives when used in ordinary practice settings given their higher acquisition costs. The study focuses on the effects of differing classes of atypical antipsychotic medications on psychiatric services utilization and cost for persons with serious mental illness treated in usual practice settings. The authors use data from the U.S. Medicaid Managed Behavioral Health Care and Vulnerable Populations Project to examine utilization and costs for 338 individuals with severe mental illness enrolled in Medicaid programs in Florida, Oregon and Pennsylvania in 1997. Study participants were categorized based on pharmacy claims data showing use of antipsychotic medication(s) during the six months prior to the first interview. There were two classifications: all users (typical medications only, atypical only, both typical and atypical) and users of atypical medications only (clozapine, olanzepine, risperidone or a combination of atypicals) during the six months prior to the initial interview. Information about diagnosis, psychotropic medications other than antipsychotics, and substance abuse treatment were collected. Service use information (inpatient hospital days, partial hospitalization, outpatient therapy, medication management and case management) was obtained from Medicaid claims for the six-month period prior to and following the participants' initial assessment. Reimbursement data from the claims records was used to construct cost or expenditure measures for both pharmacy and service utilization. The authors report that inpatient services use was significantly higher for individuals on atypicals only and on combination atypical/typical medications when compared with those on typicals only, whereas outpatient services use was highest for those on typical medications. Six-month costs for both pharmacy and psychiatric services were significantly greater for persons in the atypical only and combination typical/atypical groups compared to those on typicals only. The authors indicate that

a longer follow-up period is needed to determine whether the cohort remaining on current atypical medications stabilizes over time while those taking the newest drug on the market become the most costly patient population.

Tibaldi *et al.* (p. 95) analyze psychiatric services provision and utilization in Piedmont and their relationship with socio-demographic characteristics. The cross-sectional study was carried out in 18 of the 22 catchment areas of Piedmont (population 4.3 million), one of the 20 regions of Italy. The authors used two instruments: the European Socio-Demographic Schedule (ESDS), for recording socio-demographic indicators on the population of a geographical catchment area, and the European Services Mapping Schedule (ESMS), for describing and classifying basic patterns of care within each catchment area (ESMS B) and for measuring services utilization over a one-month period (ESMS C) with a listing of available services (ESMS D) through the use of a mapping tree. Data on service provision (ESMS B) was obtained directly by the researchers through interviews with the director of each of the mental health departments. Mental health staff at each facility in collaboration with the researchers collected the service utilization data (ESMS C) during a one month census of service contacts. The ESDS information on socio-demographic variables was obtained from the census data. The authors report substantial variation in service use among the 18 catchment areas. The acute hospital bed occupancy rates were lower in areas with more intensive community continuing care services users and with a smaller percentage of the population living alone; the non-acute hospital bed occupancy rate was higher in areas with a larger percentage of mobile continuing care services users and a larger percentage of the local population living alone or in overcrowded conditions. The authors stress the importance of collecting data on the organization and use of residential and community services, along with area-level indicators of socio-economic conditions, in order to inform mental health policies.