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Editorial

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Our mission of providing high-level, peer-reviewed scientific information to clinicians, economists and decision makers in the mental health sector depends on the ability of The Journal of Mental Health Policy and Economics to reach them in whatever part of the world they may live. One of the barriers to international access to scientific information is language. Starting this issue, the abstracts will be available in Spanish translation and we plan to add abstract translation in other languages in the near future. The Journal's style requires long, structured and comprehensive abstracts and we expect that translation will facilitate worldwide access to research on mental health services.

Another major barrier to accessing international scientific information is the lack of adequate financial resources. During the first three years we have received several requests for a financially affordable electronic form of the Journal. We are glad to report that the "Worldwide Special Personal Electronic Subscription" (WSPES), aimed at enabling worldwide affordable contact with the Journal, is now available through the Web site www.icmpe.org. WSPES plans to serve those who need and wish to keep up with the scientific information in the field and to make an active contribution to the cause of advocating the needs of people affected by mental and addictive disorders. The International Center of Mental Health Policy and Economics (ICMPE), the new publisher of the Journal, endorses these initiatives, including the previously presented Adam Smith Award.

The articles in this issue consider the economic analysis of psychotherapy for borderline personality disorder (Hall *et al*), the analysis of mental health process indicators in South Africa (Lund and Flisher), the cost implications of parity legislation for private and public payers (Siegel *et al.*), the impact of symptoms on employment status in subjects affected by schizophrenia (Slade and Salkever), and the response to health insurance coverage by ethnic minorities (Thomas and Snowden).

Hall et al (p. 3) evaluate the economic effects of intensive psychotherapy in a group of subjects affected by borderline personality disorder (BPD). A before/after design enabled the collection of data on services use and costs of inpatient, emergency and outpatient care, diagnostic tests and medications during the twelve months before the implementation of psychotherapy and the twelve months after the completion of treatment. A cost saving in the use of health services after a one-year program of psychotherapy is observed, most of this due to reduced hospital admissions.The disaggregation of results between those who were initially high or low users of hospital services showed that while for low users the impact of psychotherapy is neutral, for high users there is on average a substantial cost saving. The authors, recognizing the intrinsic limitations of observational studies and small sample size, suggest further research on the patterns of service use in BPD and on the effectiveness and cost-effectiveness of psychotherapy, to identify those groups who will most benefit from psychotherapy.

Lund and Flisher (p. 9) consider the role of process indicators for monitoring the shift from under-resourced, racially inequitable psychiatric services, heavily reliant on long-term custodial care, to a community-based, comprehensive, integrated form of care. The authors emphasize the scarcity of data on process of care indicators in South Africa and identify, as the focus of their analysis, four public sector mental health service process indicators: bed occupancy rates, admission rates, average length of stay and default rates. The information is collected in each of the nine provinces of South Africa. The wide variability in mental health service provision among provinces and its implications for mental health policy formulation is discussed.

Siegel et al (p. 17) report that previous research on the effects of parity legislation have focused on the increase in mental health costs for private payers, while little attention has been given to the possible increase in mental health costs for public payers, particularly if employers or private insurers attempt to extrude enrollees with severe mental illness. The study uses an all-payer data set, containing information on the use of specialty mental health services (excluding private practitioners) in New York State, and examines the extent to which mental health costs shifted from private to public payers. Two separate two-year periods of service use by two cohorts of consumers, prior to the implementation of parity legislation, were considered. Consumers were classified into payer groups on the basis of how their services were paid for: "Private Only", "Public Only", "Private/Public", "Self Pay" or "Other Payers". Results show that a direct shift from Private Only to Public Only payers is rare: they first shift to having services reimbursed by both private and public payers, and during this period their total service costs are extremely high. Those who shift from private payers to having in subsequent years at least some of their services covered by public payers appear to be either young employees or young dependents who have severe mental illness or severe mental disability. Abusing substances and/or being non-white also increase the likelihood of a shift to public payers. The authors claim that the patterns observed in a period before parity

legislation provide a useful baseline against which changes that will occur under various versions of parity legislation can be meaningfully examined.

Slade and Salkever (p. 25) explore the effects of symptoms on employment status in schizophrenia and use empirical estimates to simulate the employment consequences of more effective treatment and reductions in symptoms levels. The empirical analysis uses the Schizophrenia Care and Assessment Program (SCAP), a multi-site observational, longitudinal study of treatment and outcomes for persons with schizophrenia, schizophreniform and schizoaffective disorder. Clinical assessment includes Positive and Negative symptoms, depressive symptoms and extrapiramidal side effects of antipsychotic treatment. Employment information is self-reported retrospectively for the four-week period preceding the interview and employed consumers are grouped into two main categories: non-supported jobs and supported jobs. Negative symptoms are reported to have a substantial adverse impact in both non-supported jobs and in supported jobs. Simulations indicate that only one-third of consumers would be employed in any type of job even given a large reduction in symptom levels. Positive symptoms, symptoms of depression and extrapiramidal side effects have relatively modest consequences on employment outcomes. The authors conclude that greater control of symptoms through improvements in medication efficacy alone is unlikely to lead to large increases in employment for persons with schizophrenia in the near term. The extension of supported employment opportunities and the removal of work disincentives in public income-support programs are possible measures to increase employment participation that deserve further exploration.

Thomas and Snowden (p. 35) report that the policy of promoting access to mental health services by expanding the availability of insurance and the generosity of mental health benefits should take into account that among persons with private insurance, ethnic minority populations are less likely than whites to seek mental health outpatient treatment and the same populations with Medicaid coverage (public payers) are less likely than whites to use services. The analysis uses two components of the 1987 US National Expenditures Survey (the Household Survey and the Health Insurance Plans Survey) conducted by the US Agency for Health Care Policy and Research, in order to model mental health expenditures as a function of minority status and private insurance coverage. The authors report that minorities are less responsive to private insurance than to public insurance (a difference not seen in whites) and less responsive to private insurance than whites, and suggest that insurance may not be as effective a mechanism as hoped to encourage self-initiated treatment seeking, particularly among minority and other low income populations. Non-financial barriers to care, help-seeking behaviors, and the dynamics of replacing inpatient with outpatient mental health care among minorities should be addressed by further research.