

As a nation, we've come a long way in our understanding and treatment of mental illness. We no longer treat people with mental disorders as though they were possessed by demons — the earliest explanation for their symptoms. We no longer subdue patients with heavy arm and leg chains, as was done in the 17th and 18th centuries.

Nonetheless, we still have a long way to go when it comes to caring for those with mental illness. Individuals trying to get care for mental disorders face many hurdles, including the stigma attached to a diagnosis of mental illness and limitations on insurance coverage not found for other types of illness.

Mental disorders are surprisingly common, although some experts disagree about exactly what qualifies as a mental condition requiring treatment.¹ According to the National Mental Health Association, more than 54 million Americans will be affected by one or more mental disorders in the course of a year.² The president's New Freedom Commission on Mental Health, assembled by President Bush in 2001, says 5 to 7 percent of adults will have a serious mental illness in any given year, and 5 to 9 percent of children will have a serious emotional disturbance.³ (See box, "The Five Major Categories of Mental Illness.")

Despite the prevalence of mental disorders, an estimated two-thirds of American adults and a third of children needing mental health care don't get it. The untreated rate is even higher for members of racial or ethnic minority groups.⁴ This lack of care has serious consequences for the individuals affected and for society as a whole. Unemployment, homelessness, substance abuse, incarceration and suicide all can be side effects of untreated mental illness.⁵

The World Health Organization has identified mental illness as the leading cause of disability worldwide. Mental illness, including depression, schizophrenia and bipolar disorder, accounted for an estimated 17 percent of all years lived with disability worldwide in 2000.⁶ (See chart, "Leading Causes of Disability Worldwide").

TREATMENT OF MENTAL ILLNESS

The best treatments for serious mental illness today are highly effective. Between 70 and 90 percent of individuals treated have significant reduction of symptoms, according to NAMI, the mental health advocacy organization.⁷

In the past, many individuals with serious mental illness were housed in state and county "insane asylums" where they received minimal treatment. More than 500,000 patients resided in such facilities in 1950. Since then, a

KEYFACTS

- The World Health Organization has identified mental illness as the leading cause of disability worldwide.^a
- More than 54 million American are affected by one or more mental disorders in the course of a year.^b
- In any given year, an estimated 5 to 7 percent of adults and 5 to 9 percent of children will have a serious mental disturbance.^c
- An estimated two-thirds of American adults and a third of children needing mental health care don't get that care.^d
- A majority of Americans believe that people with schizophrenia are likely to be dangerous to others. In fact, these individuals are rarely violent.^e
- Suicide claims approximately 30,000 lives each year in the U.S., and is the second leading cause of death among those 25 - 34 years old. Mental illness, often untreated, is a factor in most suicides.^f
- The economic cost of untreated mental illness is estimated at more than \$100 billion each year in the United States.^g

For key fact sources, see endnotes.

deinstitutionalization movement has swept the country, and today, only about 50,000 patients are in mental health institutions.⁸

In 1999, the U.S. Supreme Court decided a case that may have ended the era of routine institutionalization forever.

In *Olmstead vs. L.C.*, the court ruled that the unnecessary segregation of people with disabilities in institutions is a form of discrimination under the Americans with Disabilities Act (ADA). To remedy this type of discrimination, the court ruled that states must provide care in community settings, rather than institutions, to those with disabilities.⁹

Specifically, states must:

- have effective plans for identifying institutional residents who could be in more integrated community settings;
- develop and implement these plans at a "reasonable pace";
- identify the necessary funds for these plans; and

- take steps to obtain new resources so that individuals may be moved off waiting lists at a reasonable pace.¹⁰

The patients most affected by the *Olmstead* ruling are those covered by Medicaid. States began to build up their Medicaid-covered rehabilitation services for those with mental illnesses and to develop more group homes for them.

Today, a number of public and private entities provide services to those with mental disorders. This arrangement works for those willing to negotiate their way through the system, and having the personal funds or insurance coverage to do so. It does not work for others. The components of this mental health system are:

- specialty services, including psychiatrists, psychologists, psychiatric nurses and psychiatric social workers
- general medical/primary care providers, including family physicians, nurse practitioners, internists and pediatricians
- human services, including social welfare agencies,

THE FIVE MAJOR CATEGORIES OF MENTAL ILLNESS

Anxiety Disorders

Anxiety disorders are the most common mental illnesses. The three main types are phobias, panic disorders, and obsessive-compulsive disorders. People with phobias experience extreme fear from a particular object or situation. Panic disorders involve sudden, intense feelings of terror for no apparent reason, with symptoms similar to a heart attack. People with obsessive-compulsive disorder try to cope with anxiety by repeating words or phrases or engaging in repetitive, ritualistic behavior such as constant hand washing.

Mood Disorders

Mood disorders include depression and bipolar disorder, also known as manic depression. Symptoms may include mood swings such as extreme sadness or elation, sleep and eating disturbances, and changes in activity and energy levels. Suicide may be a risk with these disorders.

Schizophrenia

Schizophrenia affects how a person thinks, feels, and acts. Schizophrenia is accompanied by a variety of symptoms including hallucinations, delusions, withdrawal, incoherent speech and impaired reasoning.

Dementias

These disorders include diseases like Alzheimer's which leads to loss of mental functions, including memory loss and a decline in intellectual and physical skills.

Eating Disorders

People with anorexia nervosa and bulimia have a preoccupation with food and an irrational fear of being fat. Anorexia is self-starvation; bulimia involves cycles of bingeing, consuming large quantities of food, and purging, self-inducing vomiting or abusing laxatives. Behavior may also include excessive exercise.

Source: National Mental Health Association. "Stigma: Building Awareness and Understanding About Mental Illness." (<http://www.nmha.org/infoctr/factsheets/14.cfm>)

the criminal justice system, and educational, religious and charitable organizations

- voluntary support networks, including self-help groups and advocacy organizations.¹¹

PRIVATE HEALTH COVERAGE FOR MENTAL ILLNESS

For the vast majority of Americans, who receive their insurance coverage through their employer, access to mental health services comes with their health plan. However, most plans place a strict limit on the number of visits to a therapist per year, regardless of the patient's particular illness. The number of annual inpatient days at a mental health hospital is usually limited as well.

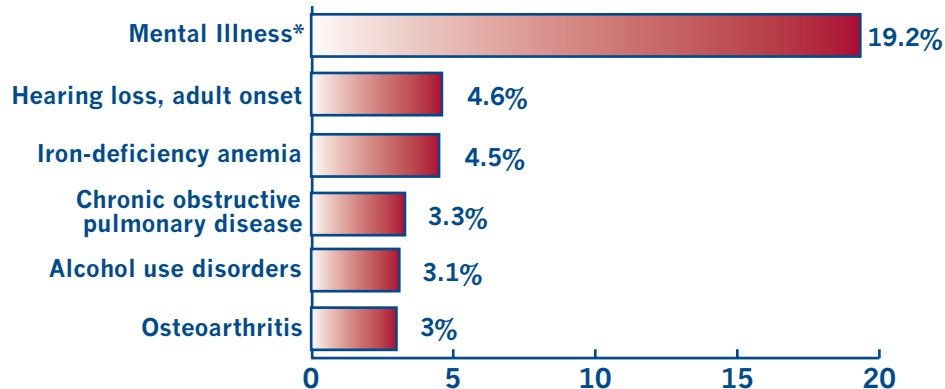
Most coverage for physical illness is not similarly limited. For example, someone with high blood pressure or congestive heart failure is not usually restricted to a specified number of visits to the doctor each year. Nor do health plans typically set a ceiling on the number of days in the hospital for such conditions.

In employer-sponsored health insurance plans, mental health services are usually covered under a separate contract known as a carve out. The insurer contracts with a specialty vendor to manage mental health benefits for all of the plan's enrollees. Insurers tend to subcontract out mental health benefits because they lack the expertise to manage them.

Such specialty vendors are known as behavioral health firms. In the late 1980s and early 1990s, most of these firms were small, regional, or local firms. But a wave of mergers has resulted in a handful of dominant companies. Mental health professionals have complained about difficulties getting approval from behavioral health firms to treat patients. Some patients have sued, arguing that they did not get the treatment they needed or were promised under their plan.

LEADING CAUSES OF DISABILITY WORLDWIDE

Percentages are the percent of total years of life lived with disability for all ages, both sexes. Estimates for 2000.



* Mental Illness = unipolar depressive disorders, bipolar affective disorder, schizophrenia, Alzheimer's and other dementias.

Source: World Health Organization (2001). "The World Health Report 2001" (www.who.int/whr2001/2001/main/en/figures/figure2.3.htm)

CHILDREN AND MENTAL ILLNESS

Mental illness spares no group, including children.¹² An estimated one in 10 children in the U.S. has a mental disorder causing some level of impairment, according to the federal National Institute of Mental Health (NIMH).¹³ Only about one in five children suffering severe mental health problems get evaluation or treatment, according to a 2004 Commonwealth Fund study.¹⁴

The mental disorders affecting children and adolescents include:

- anxiety disorders
- attention deficit and disruptive behavior disorders
- autism and other pervasive developmental disorders
- eating disorders, e.g., anorexia nervosa, bulimia
- mood disorders, e.g., major depression, bipolar disorder
- schizophrenia and
- tic disorders.¹⁵

For more information, see "Treatment of Children with Mental Disorders," from the National Institute of Mental Health (www.nimh.nih.gov/publicat/childqa.cfm).

One issue getting attention over the past few years is the appropriate use of medication in children. This is a story-rich area for reporters, since the safety and efficacy of most medications used to treat mental disorders have not been studied in children.¹⁶

Some studies that do exist are not encouraging. An April 2004 study in the British medical journal *The Lancet* concluded that four popular antidepressants used to treat thousands of depressed American children are unsafe, ineffective or both.¹⁷ One of these drugs, Paxil, has been shown to increase the risk of suicidal behavior in children and adolescents being treated for serious depression.¹⁸ An editorial in *The Lancet* condemned physicians and the pharmaceutical industry, saying research into the use of drugs with children is rife with "confusion, manipulation and institutional failure."¹⁹

Drug makers have been reluctant to test drugs in children because of ethical concerns. What if a child has an adverse reaction during a clinical trial? But the Food and Drug Administration has urged that drugs be studied in children, offering incentives to drug makers to conduct such tests.

Complicating physicians' and parents' decisions for children with mental disorders is that the reaction of a young child to a particular medication can differ from that of an older child or adolescent. The NIMH notes: "The brains of young children are in a state of very rapid development, and animal studies have shown that the developing neurotransmitter systems can be very sensitive to medications. A great deal of research is still needed to determine the effects and benefits of medications in children of all ages."²⁰

CURRENT POLICY DEBATES AND PROPOSALS

Disparity Between Mental And Physical Coverage

Advocates for the mentally ill have long complained that it is unfair for insurance plans to place more restrictions on treatment for mental illness than for other types of disorders. They have argued that this reflects a lack of knowledge about the treatments and interventions for mental illness, and that it stigmatizes those suffering from mental disorders.

In 1996, Congress responded to those criticisms by

passing legislation mandating limited mental health parity in health insurance coverage provided by businesses with 50 or more workers. Under the law, annual or lifetime limits on spending cannot differentiate among types of illness. For example, a company cannot have a lifetime limit of \$1 million for treatments of physical problems and a \$100,000 limit for mental health coverage.

As a result of this law, companies typically have one lifetime ceiling, covering total spending for physical and mental illnesses. But the parity law does not prevent companies from establishing higher deductibles or copayments for mental health benefits or from doing away with mental health coverage altogether. The law also permits companies to maintain annual restrictions on visits to a therapist or days of hospitalization.

Bills have been introduced in the U.S. Senate and House of Representatives that would eliminate some inequities between mental health and physical health services. But passage in either chamber seems unlikely in 2004.

The business community, already worried about double digit increases in health insurance premiums, generally opposes any new mental health parity law. The current limited mental health parity law expired in 2001, and has been extended three times. It is now in effect until the end of 2004. In the absence of broader federal action, more than 30 states have passed laws creating more parity between mental and physical coverage - but covering only some, not all, mental health problems.²¹

Going beyond the need for parity, the president's New Freedom Commission on Mental Health announced six goals for a transformed mental health system in its final report of 2003:

1. Americans understand that mental health is essential to overall health;
2. Mental health care is consumer and family driven;
3. Disparities in mental health services are eliminated;
4. Early mental health screening, assessment and referral to services are common practice;
5. Excellent mental health care is delivered and research is accelerated, and
6. Technology is used to access mental health care and information.²²

Medicare and Mental Health

A key policy issue is Medicare coverage for mental health, which will become more important as the baby boomer generation retires. Dementia, depression, and schizophrenia all increase with age. Depression contributes to high suicide rates among men over age 65. And schizophrenia is complicated in the elderly by the onset of other health problems.

Medicare discriminates against mental illness. For example, Medicare recipients are entitled to a lifetime benefit of 190 days of inpatient psychiatric treatment, but there is no lifetime limit on the number of days for general hospital care. For mental health services, Medicare pays for 50 percent of outpatient services from doctors, psychologists, social workers, and other providers. For physical ailments, Medicare generally reimburses 80 percent of total payments. Since Medicare does not cover prescription drugs unless a patient is hospitalized, millions of seniors and others have difficulty paying for drugs for chronic mental illnesses, such as depression and anxiety. Some limited outpatient drug coverage under Medicare will begin in 2006. (See Chapter 5, Medicare, for details.)

Cutbacks in Public Mental Health Services

The sluggish economy in recent years and the resulting state budget cuts have taken their toll on mental health services provided by states and localities. For instance, in April 2004, Los Angeles County proposed cutting \$48 million from its mental health programs for people without health insurance.²³ Officials in Orange County, Calif., also said they would have to reduce mental health services for indigents.²⁴

On the opposite coast, a state-supported program in Baltimore serving adults with psychiatric problems reported a \$600,000 budget shortfall in early 2004 because of state cutbacks.²⁵

STORY IDEAS

- What has your state done to comply with the Supreme Court's Olmstead ruling concerning community-based care for those with mental illness and other disabilities? (See "Treatment of Mental Illness" in this chapter.) If there has been any delay in acting to reduce institutionalization, why?

CANDIDATES' VIEWS

President Bush favors full parity for mental disorders with other types of medical conditions in insurance coverage, as long as this does not significantly increase the cost of health care.²⁶ Senator Kerry supports "full and unconditional mental health parity."²⁷ Moreover, the 2004 Democratic platform calls for passage of the Wellstone mental health parity legislation, which seeks to end discrimination against Americans with mental illnesses, and ensure equal treatment for mental illness in our health system.²⁸

- What do experts on mental health and homelessness in your area say about the relationship between deinstitutionalization and homelessness?
- How have cuts in your state's Medicaid budget affected those needing publicly funded mental health care? How about cuts in local mental health programs? How have they affected patients and their families?
- Some hospital emergency departments have reported a surge in people with mental health conditions. Hospital officials attribute this to cutbacks in public mental health programs. What's the situation in your community? If this is a problem, what solutions have been proposed?
- Are any efforts underway in your community to reduce the stigma of a diagnosis of mental illness?
- What are the trends in your community in coverage for mental health services in employer-sponsored health plans? Have any employers dropped mental health coverage entirely?
- What are local physicians doing about research showing the dangers of prescribing antidepressants for children and adolescents? Have they changed the way they treat young people with mental disorders? What do they think about the fact that many drugs prescribed for children with mental illness have not been tested in children?

For helpful information on how different types of mental illness are treated, three sources of helpful information are the National Institute of Mental Health

(<http://www.nimh.nih.gov/>), the advocacy organization NAMI (<http://www.nami.org/>) and the National Mental Health Association (<http://www.nmha.org/>).

SOURCES AND WEBSITES

Analysts/Advocates

Diane Archer, *Special Counsel*, Medicare Rights Center, 212/204-6216

Elisabeth Belmont, *Corporate Counsel*, MaineHealth, 207/775-7010

Gregg Bloche, *Professor of Law*, Georgetown Univ. and Johns Hopkins Univ., 202/662-9123

Stuart Butler, *Vice President and Director of Domestic and Economic Policy*, The Heritage Foundation, 202/546-4400

Nancy Chockley, *President*, NIHCM Foundation, 202/296-4426

David Cutler, *Professor of Economics*, Harvard University, 617/496-5216

Lynn Etheredge, *Consultant*, 301/654-4185

Michael Faenza, *President and CEO*, National Mental Health Association, 703/684-7722

Judy Feder, *Dean*, Georgetown Univ. Health Policy Institute, 202/687-0880

Richard Frank, *Margaret T. Morris Professor of Health Care Policy*, Harvard Medical School, 617/432-0178

Mary Jo Gibson, *Senior Policy Advisor*, AARP, 202/434-3896

Paul Ginsburg, *President*, Center for Studying Health System Change, 202/484-4699

Bob Goldberg, *Director - Center for Medical Progress*, Manhattan Institute for Policy Research, 973/379-4029

Howard Goldman, *Professor Psychiatry*, University of Maryland School of Medicine, 301/983-1671

Richard Hegner, *Consultant*, Hegner and Katz, 410/730-6583

Robert Helms, *Resident Scholar*, American Enterprise Institute, 202/862-5877

John Holahan, *Director of the Health Policy Research Center*, Urban Institute, 202/261-5666

Chris Jennings, *President*, Jennings Policy Strategies, Inc., 202/879-9344

Mila Kofman, *Research Assistant Professor*, Georgetown Univ. Health Policy Institute, 202/784-4580

Chris Koyanagi, *Policy Director*, Bazelon Center for Mental Health Law, 202/467-5730, x18

Leighton Ku, *Senior Fellow of Health Policy*, Center on Budget and Policy Priorities, 202/408-1080

Barbara Lyons, *Vice President and Deputy Director of Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, 202/347-5270

Stephen McConnell, *Vice President for Advocacy and Public Policy*, Alzheimer's Association, 202/393-7737

Brendan McTaggart, *Communications Director*, National Health Law Program, 202-289-7661

Jack Meyer, *President*, Economic and Social Research Institute, 202/833-8877, ext*812

Len Nichols, *Vice-President*, Center for Studying Health System Change, 202/484-5261

Edwin Park, *Health Policy Analyst*, Center on Budget and Policy Priorities, 202/408-1080

Ron Pollack, *Executive Director*, Families USA, 202/628-3030

Diane Rowland, *Executive Vice President and Executive Director of Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, 202/347-5270

David Satcher, *Director of National Center for Primary Care*, Morehouse School of Medicine, 404/752-1500

Henry Simmons, *President*, National Coalition on Health Care, 202/638-7151

Cathy Schoen, *Vice President of Health Policy Research and Evaluation*, Commonwealth Fund, 212/606-3864

Ken Thorpe, *Robert Woodruff Professor and Chair Department of Health Policy and Management*, Rollins School of Public Health at Emory University, 404/727-3373

Government and Related Groups

Georges Benjamin, *Executive Director*, American Public Health Association, 202/777-2501

Jeffery Buck, *Center for Mental Health Services*, SAMHSA, 301/443-0588

Joan Henneberry, *Director of the Health Policy Studies Division*, National Governors Association, 202/624-5300

Michael Hogan, *Director*, Ohio Department of Mental Health, 614/466-2337

Joy Wilson, *Director of the Health Committee*, National Conference of State Legislatures, 202/624-5400

Stakeholders

Mark Covall, *Executive Director*, National Association of Psychiatric Health Systems, 202/393-6700

Mary Grealy, *President*, Healthcare Leadership Council, 202/452-8700

Val J. Halamandais, *President*, National Association for Homecare and Hospice, 202/547-7424

Karen Ignagni, *President and CEO*, America's Health Insurance Plans, 202/778-3203

Kate Sullivan, *Director of Health Care Policy*, US Chamber of Commerce, 202/463-5734

Families USA

www.familiesusa.org

Health Care Leadership Council

www.hlc.org

Health Research and Educational Trust

www.hret.org

Kaiser Family Foundation

www.kff.org

Kaiser Family Foundation State Health Facts Online

www.statehealthfacts.kff.org

National Association of State Mental Health Program Directors Research Institute, Inc.

<http://nri.rdmc.org>

National Coalition on Health Care

www.nchc.org

National Institute of Mental Health

www.nimh.nih.gov

Robert Wood Johnson Foundation

www.rwjf.org

Substance Abuse and Mental Health Services Admin.

www.samhsa.gov/index.aspx

Surgeon General's Report on Mental Health

www.surgeongeneral.gov/library/mentalhealth

U.S. Census Bureau (health insurance data)

www.census.gov/hhes/www/hlthins.html

Urban Institute

www.urban.org

Websites

Alliance for Health Reform

www.allhealth.org

American Academy of Child and Adolescent Psychiatry

www.aacap.org

California HealthCare Foundation

www.chcf.org

Center for Studying Health System Change

www.hschange.org

Center for the Advancement of Children's Mental Health

<http://www.endpoint.com/kidsmentalhealth/>

Commonwealth Fund

www.cmwf.org

Covering the Uninsured

www.coveringtheuninsured.org

ENDNOTES

- a World Health Organization (2001). "World Health Report 2001." (www.who.int/whr2001/2001/main/en/figures/figure2.3.htm). Retrieved on July 20, 2004.
- b National Mental Health Association. "MHIC: Mental Illness and the Family." (www.nmha.org/infoctr/factsheets/14.cfm). Retrieved April 30, 2004.
- c President's New Freedom Commission on Mental Health (2003). "Achieving the Promise: Transforming Mental Health Care in America - Goal 1." April. (http://www.nami.org/Template.cfm?Section=New_Freedom_Commission&Template=/ContentManagement/ContentDisplay.cfm&ContentID=9500). Retrieved July 20, 2004.
- d National Mental Health Association. "Medicaid and Mental Health." (www.nmha.org/access/medicaidFactSheet.cfm). Retrieved April 23, 2004.
- e President's New Freedom Commission on Mental Health (2003). "Achieving the Promise: Transforming Mental Health Care in America- Goal 1." April. (http://www.nami.org/Template.cfm?Section=New_Freedom_Commission&Template=/ContentManagement/ContentDisplay.cfm&ContentID=9500). Retrieved July 20, 2004.

- ^f President's New Freedom Commission on Mental Health (2003). "Achieving the Promise: Transforming Mental Health Care in America- Goal 1." April. (http://www.nami.org/Template.cfm?Section=New_Freedom_Commission&Template=/ContentManagement/ContentDisplay.cfm&ContentID=9500). Retrieved July 20, 2004.
- ^g NAMI. "About Mental Illness." (http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm). Retrieved April 23, 2004.
- ¹ Mechanic, David (2003). "Is The Prevalence Of Mental Disorders A Good Measure of the Need for Services?" Health Affairs, September/October. (www.healthaffairs.org).
- ² National Mental Health Association. "MHIC: Mental Illness and the Family." (www.nmha.org/infoctr/factsheets/14.cfm). Retrieved April 30, 2004.
- ³ President's New Freedom Commission on Mental Health (2003). "Achieving the Promise: Transforming Mental Health Care in America - Goal 1." April. (http://www.nami.org/Template.cfm?Section=New_Freedom_Commission&Template=/ContentManagement/ContentDisplay.cfm&ContentID=9500). Retrieved July 20, 2004.
- ⁴ National Mental Health Association. "Medicaid and Mental Health." (www.nmha.org/access/medicaidFactSheet.cfm). Retrieved April 23, 2004.
- ⁵ NAMI. "About Mental Illness." (http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm). Retrieved April 23, 2004.
- ⁶ World Health Organization (2001). "World Health Report 2001." (<http://www.who.int/whr2001/2001/main/en/figures/figure2.3.htm>). Retrieved on July 20, 2004.
- ⁷ NAMI. "About Mental Illness." (http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm). Retrieved April 23, 2004.
- ⁸ Monahan, John, Marvin Swartz, & Richard J. Bonnie. (2003). "Mandated Treatment In The Community For People With Mental Disorders." Health Affairs, September/October, p. 28. (www.healthaffairs.org).
- ⁹ Bazelon Center for Mental Health Law (1999). "Under Court Order: What the Community Integration Mandate Means for People with Mental Illnesses: The Ruling." (<http://www.bazelon.org/issues/disabilityrights/resources/olmstead/under/ruling.htm>). Retrieved April 23, 2004.
- ¹⁰ Bazelon Center for Mental Health Law (1999). "Obligations on States." (<http://www.bazelon.org/issues/disabilityrights/resources/olmstead/under/obligation.htm>). Retrieved April 23, 2004.
- ¹¹ National Center for Policy Analysis (2002). "Mental Health: Topic Overview." (<http://www.debate-central.org/topics/2002/overview.html>). Retrieved May 14, 2004.
- ¹² National Institute of Mental Health (2004). "Child and Adolescent Mental Health." (<http://www.nimh.nih.gov/healthinformation/childmenu.cfm>). Retrieved April 23, 2004.
- ¹³ National Institute of Mental Health. "Treatment of Children with Mental Disorders." (<http://www.nimh.nih.gov/publicat/childqa.cfm>). Retrieved April 23, 2004.
- ¹⁴ The Commonwealth Fund (2004). "Some Successes, Many Shortfalls in Quality of Health Care Provided American Children." News release, April 15. (http://www.cmwf.org/media/releases/leatherman700_release04152004.asp). Retrieved April 28, 2004.
- ¹⁵ National Institute of Mental Health. "Treatment of Children with Mental Disorders." (<http://www.nimh.nih.gov/publicat/childqa.cfm>). Retrieved April 23, 2004.

- 16 National Institute of Mental Health. "Treatment of Children with Mental Disorders." (<http://www.nimh.nih.gov/publicat/childqa.cfm>). Retrieved April 23, 2004.
- 17 Vedantam, Shankar (2004). "Antidepressants Called Unsafe for Children." Washington Post, April 23. (www.washingtonpost.com). Retrieved April 23, 2004.
- 18 U.S. Food and Drug Administration (2003). "FDA Statement Regarding the Anti-Depressant Paxil for Pediatric Population." June 19. Retrieved from (www.nexis.com).
- 19 Vedantam, Shankar (2004). "Antidepressants Called Unsafe for Children." Washington Post, April 23. (<http://www.washingtonpost.com>). Retrieved April 23, 2004.
- 20 National Institute of Mental Health. "Treatment of Children with Mental Disorders." (<http://www.nimh.nih.gov/publicat/childqa.cfm>). Retrieved April 23, 2004.
- 21 Depression and Bipolar Support Alliance (2004). "Mental Health Parity Update." (www.Dbsalliance.org/advocacy/wellstoneact.html). Retrieved May 5, 2004.
- 22 President's New Freedom Commission on Mental Health (2003). "Achieving the Promise: Transforming Mental Health Care in America: Executive Summary." (www.mentalhealthcommission.gov/reports/finalreport/fullreport.htm). Retrieved April 20, 2004.
- 23 Fox, Sue (2004). "L.A. County Calling for More Cuts." Los Angeles Times, April 20. (www.nexis.com).
- 24 Pfeifer, Stuart (2004). "Orange County: Cut, Slice, Trim." Los Angeles Times, April 28. (www.nexis.com).
- 25 Powder, Jackie (2004). "Cutbacks Force Agencies to Trim Staff, Services for Mentally Ill." Baltimore Sun, February 29. (www.nexis.com).
- 26 Rovner, Julie (2002). "All Things Considered." Transcript of NPR program, April 29. (www.nexis.com).
- 27 Kerry/Edwards Campaign 2004. "Kerry Unveils Plan to Provide Freedom, Independence and Choices for Americans With Disabilities." January 5, 2004. http://www.johnkerry.com/pressroom/releases/pr_2004_0105b.html. Retrieved August 24, 2004.
- 28 Report of the Platform Committee. "Strong at Home, Respected in the World: The Democratic Platform for America," p29. http://www.cfr.org/pdf/dem_platform.pdf. Retrieved August 24, 2004.

