

HEALTH POLICY REPORT

The Mental Health Maze and the Call for Transformation

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In an early effort to establish his credentials as a “compassionate conservative” during the 2000 presidential campaign, George W. Bush pledged that if he were elected, he would create a commission to conduct a comprehensive review of the care of people with mental illness — the first such examination to be undertaken in almost 25 years. In April 2002, in fulfillment of his campaign pledge, Bush announced the creation of the President’s New Freedom Commission on Mental Health, the goal of which was to “recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities.”¹ Six months into its one-year mandate, in an interim report that had been requested by the President, the commission issued a blunt assessment: “The [mental health] system is in shambles.”² On July 22, 2003, the Bush administration released the commission’s final report without the presence of the President, the fanfare of a White House ceremony, or even a news conference, but with a powerful message: the United States should fundamentally transform its system for treating people with mental illness.

On the day President Bush had announced his intentions for the commission (April 29, 2002), he had been visiting New Mexico, the home state of Senator Pete V. Domenici, a Republican who has long been a strong advocate for people with mental illness. With Domenici at his side, Bush had said, “Our country must make a commitment. Americans with mental illness deserve our understanding and they deserve excellent care. They deserve a health system that treats their illnesses with the same urgency as a physical illness.” Bush identified three major obstacles to the receipt of “excellent care”: the stigma attached to mental illness, unfair limits that stem from inadequate health insurance, and a fragmented system for delivering services. The commission did not address substance-abuse disorders, even though the American Psychiatric Association

defines them as mental disorders. The prevalence of coexisting substance-abuse disorders in people who have a mental illness ranges from 30 to 70 percent, depending on the population under study.

In transmitting the final report of the commission,³ its chairman, Michael F. Hogan, the director of the Ohio Department of Mental Health, wrote in a cover letter that

after a year of study . . . the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative — a life in the community for everyone — can be realized. . . . The time has long passed for yet another piecemeal approach to mental health reform. Instead, the Commission recommends a fundamental transformation of the nation’s approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life’s challenges. . . . Building on the principles of the New Freedom Initiative, the recommendations we propose can improve the lives of millions of our fellow citizens now living with mental illnesses.

The commission’s declaration — that recovery from mental illness should be the overriding goal of the mental health system — marked the first time this view formed the basis of a major federal policy document. Its scientific foundation was derived from an earlier report, issued in 1999, by the last surgeon general to serve in the Clinton administration, Dr. David Satcher.⁴ But in the commission’s deliberations, the theme evolved, as Hogan has written recently, “with multiple meanings and implications. Often thought of as an end state of complete wellness and freedom from illness, a more universal idea of recovery emerged from . . . individuals with mental illness, who tended to describe recov-

ery as a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment.”⁵ Hogan said the commission’s emphasis on recovery reflected the influence of Rosalyn Carter, the former first lady, who had spoken to the group. Carter had told the commission that “the biggest single difference in mental health now, compared with the time of our commission, [is that] today we know that recovery is possible for every person with a mental illness.”⁵

Leading advocacy organizations, recognizing the potential power of the Bush commission’s strongly worded report, seized on it as a new call to arms that could strengthen their efforts to improve care for people with mental illness. Although these organizations have different, and sometimes competing, agendas, they created the Campaign for Mental Health Reform in order to speak with one voice in pressing the administration and Congress to implement the commission’s recommendations. But all these advocacy organizations, sensitive as they are to the nuances of moving an ambitious agenda through a Republican-controlled Congress and reluctant to antagonize the Bush administration, have chosen to play down the absence of an ingredient that was noticeably missing from the commission’s report. In following the President’s directive to “focus on those policies that maximize the utility of existing resources,”¹ the commission did not explicitly recommend the investment of any new moneys to finance the transformation for which it called.

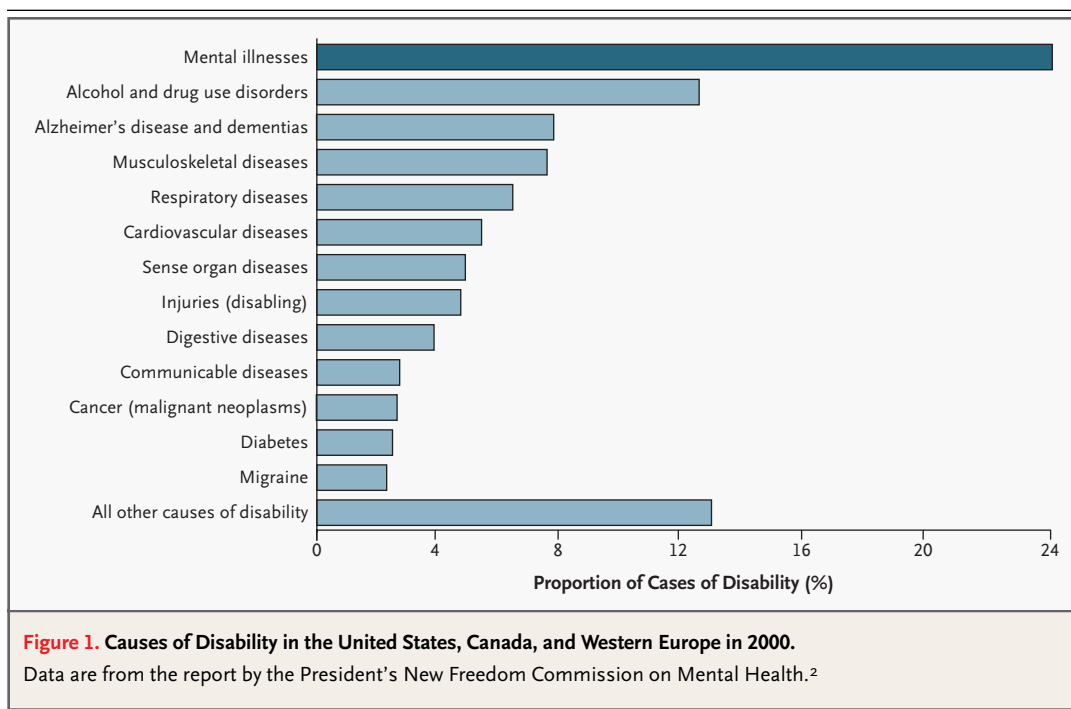
A MAJOR PIECE OF A LARGE
CHALLENGE

The mental health commission is but one component of the President’s New Freedom Initiative, which included 10 proposals designed to “tear down the barriers that face Americans with disabilities,” according to a White House announcement issued in February 2001. The initiative seeks to promote increased opportunities in education and employment for people with various forms of mental and physical disabilities. In part, the initiative grew out of the administration’s belief that creating such opportunities is a more effective approach to helping vulnerable people than relying on public welfare programs, which, in the administration’s view, foster dependence in the beneficiaries. Among the recommended steps, Bush called for the prompt mobilization of resources to implement a decision handed down by the Supreme Court in 1999, in *Olm-*

*stead v. L.C.*⁶ The Court held that the unnecessary institutionalization of people with disabilities is discrimination under the Americans with Disabilities Act. Roughly 54 million Americans, or about 20 percent of the population, have a disability.⁷ For almost half of these people, sensory, physical, cognitive, or emotional conditions severely limit their ability to perform activities of daily living at home and in the community.³ As compared with all other diseases, mental illness ranks first among the causes of disability in the United States, Canada, and Western Europe, according to the World Health Organization (Fig. 1).²

In his charge to the commission, Bush directed its 22 members, 15 of whom he had appointed and 7 of whom were *ex officio* members representing different federal agencies, to examine the mental health system and make recommendations that could be implemented by private and public providers, health plans, patient advocacy groups, and federal, state, and local governments. But by directing the commission to focus on people who have serious mental illness, Bush, by definition, limited its scope largely to the public agencies and hospitals that care for such patients. Nevertheless, the directive that the commission also study the role of the private sector is important, because managed-care companies that focus on behavioral health have fundamentally altered the way mental health care is delivered and paid for in the United States.^{8,9}

Most insured employees receive mental health care from these for-profit companies through contracts that employers negotiate with the companies. Working in tandem with employers who foot the bill and their benefits consultants, these companies have pared expenditures for mental health care by reducing the length of inpatient hospital stays for many patients, placing stringent limits on the number of outpatient psychiatric visits that are allowed, and restraining or cutting rates of reimbursement for providers. They have also relied heavily on the use of prescribed drugs and other regimens for the control of illness that are less expensive than traditional counseling.¹⁰ The imposition of financial controls and the resultant reduction in the growth of expenditures for mental health care services have been welcomed by most employers but viewed as disastrous by many psychiatrists. Many practitioners have opted out of managed care altogether or have reduced the number of patients they treat who are covered by such plans. Managed care has also taken a toll on academic psychiatry.¹¹



In response to Bush's charge, the commission tied all its 19 major recommendations to six overriding goals: building greater understanding among Americans that mental health is essential to overall health; placing consumers of mental health services at the center of their care; eliminating disparities in the delivery of mental health care services; making early screening, assessment, and referral to mental health services common practice; delivering excellent mental health care and accelerating research; and exploiting available information technology to improve access to and coordination of mental health care (Table 1).

THE GOALS OF THE COMMISSION

The commission's first goal — the recognition of mental health care as a critical component of a person's overall health status — is similar to a goal articulated in 1999 in the surgeon general's report on mental illness.⁴ The commission said it "strongly supports the president's call for federal legislation to provide full parity between insurance coverage for mental health care and for physical health care."^{12,13} To reach this goal, the commission also urged that efforts to prevent suicide, which takes the lives of some 30,000 Americans every year, be strengthened by more aggressive implementation

of the National Strategy for Suicide Prevention.¹⁴ About 90 percent of those who take their lives have a mental disorder that is often undiagnosed or untreated.³ The rate of suicide among teenagers has tripled since the 1950s. A campaign by the U.S. Air Force, which halved the rate of suicide in its ranks between 1994 and 2002, was one of the model programs cited by the commission.¹⁵

The commission cited the fragmentation of services and programs that pervades the delivery system as the most serious obstacle to the achievement of its second goal, that of making mental health care compatible with the interests of patients and their families. The commission depicted the consequence of this fragmentation in its interim report:

Adults with serious mental illness, one of our nation's most vulnerable groups, suffer greatly from the fragmentation and failings of the system. The evidence of our failure to help them is most apparent and most glaring on our nation's streets, under our bridges, and in institutions like nursing homes and jails. Some are homeless, and some are dependent on alcohol and drugs. Many are unemployed, and many go without any treatment. Most strikingly, less than 40 percent of those with serious mental illness receive

Table 1. The Goals and Recommendations of the President's New Freedom Commission on Mental Health.*

Goal 1: Understanding that mental health is essential to overall health
Recommendations
Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention
Address mental health with the same urgency as physical health
Goal 2: Making mental health care consumer-driven and family-driven
Recommendations
Develop an individualized plan of care for every adult with a serious mental illness and for every child with a serious emotional disturbance
Involve consumers and families fully in orienting the mental health system toward recovery
Align relevant federal programs to improve access and accountability for mental health services
Create a comprehensive state mental health plan
Protect and enhance the rights of people with mental illnesses
Goal 3: Eliminating disparities in mental health services
Recommendations
Improve access to high-quality care that is "culturally competent"
Improve access to high-quality care in rural and geographically remote areas
Goal 4: Making early mental health screening, assessment, and referral to services common practice
Recommendations
Promote the mental health of young children
Improve and expand school mental health programs
Screen for coexisting mental and substance-use disorders and link with integrated treatment strategies
Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports
Goal 5: Delivering excellent mental health care and accelerating research
Recommendations
Accelerate research to promote recovery and resilience and ultimately to cure and prevent mental illnesses
Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation
Improve and expand the workforce providing evidence-based mental health services and supports
Develop the knowledge base in four understudied areas: disparities in mental health care, long-term effects of medication, trauma, and acute care
Goal 6: Using information technology to improve access to mental health care and information
Recommendations
Use health and information technology to improve access to and coordination of mental health care, especially in remote areas and underserved populations
Develop and implement integrated electronic health-record and personal-health-information systems

* Adapted from the report of the President's New Freedom Commission on Mental Health.²

stable treatment. An estimated 25 percent of homeless persons have a serious mental disorder and, for the most part, do not receive any treatment.²

State (and, in some jurisdictions, county) mental health agencies have the primary responsibility for delivering services to people with serious mental illness, yet the influence of these agencies over the wide array of programs that patients and their families need is strictly limited (Hogan M: personal communication).¹⁶ The Substance Abuse and Mental Health Services Administration, which is the focal point of federal advocacy of the provision of such services, also operates with limited scope, providing less than 3 percent of the revenues (about \$440 million) on which state and territorial mental health agencies relied in 2002.³ The way in which medical services are delivered to people with serious mental illness is unique in that the care of these patients is entrusted to a distinct, largely state-operated, disease-specific delivery system. Recent reports that have summarized the status of the states' public mental health care systems, one of which was focused specifically on Colorado's system, have been as critical of these systems as the President's commission was.^{16,17}

The federal government alone operates 42 programs that serve people with mental illness.¹⁸ The two largest programs — Supplemental Security Income and Social Security Disability Insurance — provide monthly payments to those of modest means who cannot work because of mental illness. In 2002, these payments totaled \$21 billion. The largest federal programs that finance health care — Medicare and Medicaid — though not focused on mental health care, nevertheless have a major role in financing the care of people with mental illness. Through Medicare and Medicaid, the federal government spent about \$24 billion on mental health care in 1997.¹⁹⁻²¹ Other federal programs that are funded separately — each with its own complex, often contradictory set of rules — include child welfare, criminal justice, education, housing, rehabilitation, and substance abuse.³ The commission asserted that, "if this current system worked well, it would function in a coordinated manner, and it would deliver the best possible treatments, services, and supports." To achieve that coordination and level of care, the commission said, would require placing patients at the center of a system that is community-based, "with providers working

in full partnership with the consumers they serve to develop individualized plans of care that could overcome the problems that result from fragmented services or systems.”

The commission’s third goal envisioned a transformed mental health care system in which all Americans would share equally in the best available services and outcomes, regardless of race, ethnic background, sex, or geographic location.^{3,22} Given that African Americans, Native Americans, Asian Americans, Hispanic Americans, and persons who live in rural areas are neglected by the mental health care delivery system, they bear a disproportionately high burden of disabilities that derive from mental disorders. A key to improving the delivery of mental health care services to these groups is the cultivation of a workforce that is capable of providing “culturally competent” care. Critical to this goal, the commission said, is making certain that general providers of health care, emergency room staff, and first responders (law-enforcement personnel and emergency medical technicians) receive education and training in mental health care “to overcome the uneven geographic distribution of psychiatrists, psychologists, and psychiatric social workers.”

To achieve its fourth goal, the commission said that the early detection of mental health problems in children and adults through routine and comprehensive testing and screening should be an “expected and typical occurrence.” The relative lack of such interventions contributes to the high rates of failure in school among children with mental illness and of disability among adults with mental illness.³

The commission’s fifth goal called for improvement in the quality of mental health care through the “consistent use of evidence-based, state-of-the-art medications and psychotherapies. . . . Science will inform the provision of services, and the experience of service providers will guide future research. . . . Knowledge about evidence-based practices (the range of treatments and services of well-documented effectiveness), as well as emerging best practices (treatments and services with promising but less thoroughly documented evidentiary base), will be widely circulated and used in a variety of mental health specialties and in general health, school-based, and other settings.”

The commission’s sixth goal was to transform the mental health care system through the greater use of advanced information technology that could empower consumers who are in need of services and their families.

Although the commission’s report adhered to the administration’s preference for not explicitly calling for the investment of new resources, it is obvious that many of its recommendations could not be implemented without such an investment. For example, as part of achieving its second goal, the commission recommended making affordable housing available to people with serious mental illness. To accomplish this goal, it urged the Department of Housing and Urban Development to execute a plan for the construction of 150,000 housing units primarily for the homeless.²³ Even though there was no mention of how these units were to be financed, the report stated, “The commission recommends that individuals who have a history of serious mental illnesses be given fair access to these 150,000 units of supportive housing.”³

THE INFLUENCE OF THE CARTER COMMISSION

The commission’s goals describe an ideal system of care that is far removed from the chaotic maze of programs that currently serve people who have a mental illness. Given the many competing claims for federal revenues in a budget that is already in deep deficit, achieving all these goals is an impossible dream, which prompts the question of why a commission would embark on such an ambitious course when modest incremental improvements would seem to be a more realistic prospect for the foreseeable future. The answer derives from lessons that Hogan and his colleagues learned from the experience of the commission created by President Jimmy Carter in 1977.²⁴ The Carter Commission on Mental Health had proposed an ambitious agenda for reform, but before its major recommendations could be implemented, they fell victim to the dramatically different attitude toward the role of government in the provision of human services that Ronald Reagan brought to the White House in 1981. Indeed, the Mental Health Systems Act of 1978, the centerpiece of the recommendations of the Carter commission, was repealed by the Omnibus Budget Reconciliation Act of 1981, which contained the first round of budget reductions proposed by the Reagan administration and enacted by Congress.

Conventional wisdom has held that during the eight years of the Reagan presidency (1981 to 1989), mental health care policy, particularly at the federal level, went into decline. But in 1991, in spite of the

Reagan administration's efforts to slow the growth of the major federal programs (Medicaid, Medicare, and Social Security) that serve people with mental illness, an inventory of these programs documented that, in fact, many improvements had been made during the Reagan years.²⁵ Hogan and the other commissioners concluded that their recommendations should be comprehensive but should also advocate for incremental improvements, which, if made by public and private parties, could quickly improve the lives of people with mental illness. Hogan recently wrote, "Given the rare occasion of presidential attention on mental health, using the commission's processes and report to galvanize change at all levels — not just the federal government — became an imperative. . . . These experiences of an earlier commission shaped our thinking."⁵

Hogan learned another important lesson from the Carter commission and its aftermath. The 15 commissioners appointed by Bush were a diverse group comprising mental health professionals, persons with mental illness, and family members from all over the country. They were leaders in their communities and states but, for the most part, they were not national policy experts on mental health issues. The mix of the commissioners was leavened by the appointment of the seven *ex officio* members who represented federal agencies with major responsibility, directly or indirectly, for mental health care. Because the commission met only once a month and because its members were not steeped in policymaking for health care, Hogan, with the backing of the other commissioners, created subcommittees that could delve deeply into specific issues.

The subcommittee structure enabled Hogan to recruit knowledgeable policy experts who wrote the papers that served as the basis of many of the commission's discussions and much of its decision making. By participating in the subcommittees these experts, most of them advocates of policies that would expand the federal role in mental health care well beyond the role the Bush administration favors, were able to have a major influence on the commission's report, even though they were not members of the commission. In an interview, Hogan said that the expertise of the policy specialists allowed the commission to probe "a little deeper" than it would have gone on its own, "and perhaps subsequently [their work] will be published as working papers. The Carter Commission did this,

and its working papers became a resource for advocacy."²⁶

RESPONSES TO THE COMMISSION'S
REPORT

In a city driven by priorities that are deemed more pressing than the commission's report, it is not surprising that the report has generated only limited interest outside the field of mental health care. It won applause from Senator Domenici, who is the chief sponsor of legislation (the proposed Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003) that would grant full parity for mental health benefits as compared with medical and surgical benefits provided through employer-sponsored health insurance. Benefit differentials persist, as data from a recent survey of employers show.¹⁰ The Wellstone mental health care bill, which has been endorsed by the President, 67 senators, and 240 members of the House, would prohibit a private health plan that provides a mental health care benefit from offering less generous coverage for such care than the coverage it provides for physical illnesses. Small employers would be exempt from the requirement. In a news release, Domenici praised Bush's support of full parity.

Despite endorsement by the administration and many legislators, parity legislation has been stalled for years, because the Republican chairmen of the relevant committees and the party's congressional leadership have not pressed for its enactment. The Senate Health, Education, Labor, and Pensions Subcommittee on Substance Abuse and Mental Health Services, which is chaired by Senator Mike DeWine (R-Ohio), held a hearing November 4 on the commission's report, at which Senators Edward M. Kennedy (D-Mass.) and Hillary R. Clinton (D-N.Y.) pressed the administration's witness, Charles Currie, administrator of the Substance Abuse and Mental Health Services Administration, to move ahead quickly with an implementation plan.

In contrast to the relative inactivity in Congress, the mental health care community mobilized quickly after the release of the commission's report. Putting aside parochial interests that have often divided advocates for people with mental illness, four organizations — the Bazelon Center for Mental Health Law, the National Alliance for the Mentally Ill, the National Association of State Mental Health Program Directors, and the National Mental Health

Association — came together to create the Campaign for Mental Health Reform. Nine other organizations, including the American Psychiatric Association, quickly joined the campaign. In addition to pursuing implementation of the commission's recommendations, the campaign will focus on other federal policy issues, weighing in on the reauthorization of the Substance Abuse and Mental Health Services Administration, funding for the federal mental health care block grants to the states, Medicaid, Medicare, and housing programs. Testifying before the commission at its January 2003 meeting, Chris Koyanagi, policy director of the Bazelon Center for Mental Health Law, said that the advocacy community had already reached consensus on legislative proposals dealing with these issues.

In responding to the commission's report, the American Psychiatric Association complimented the commission for its courage in documenting the deplorable condition of the mental health care system. The association's president, Dr. Marcia K. Goin, questioning whether it was realistic to expect that a President's commission would "really tell it like it is," said that the Bush commission did just that. "The final report recounts that the mental health system is in shambles, fragmented and needs complete restructuring."²⁷ However, Goin noted the commission's limited attention to "the current crisis about the availability of acute care psychiatric beds. . . . The flood of psychiatric hospital closures occurring across the country is having a profound effect on emergency rooms, families and communities." The commission did attempt to study this issue, but finding that there were inadequate data to document the scope of the problem, it recommended closer federal tracking. In a recent article, Saul Feldman, an executive of a managed-care company for behavioral health, took the commission to task for minimizing problems that have emerged as the consequence of a shortage of psychiatrists.²⁸

CONCLUSIONS

To implement its recommendations, the commission urged a governmentwide effort that would match the sweep of the commission's ambitious plan. Its final report stated, "The commission recommends that DHHS [the Department of Health and Human Services] take the lead responsibility

to develop a cross-department mental health agenda with the goal of better aligning federal policy on mental health treatment and support services across agencies and reducing fragmentation in services. The HHS secretary should require that key agencies and programs that serve people with serious mental illnesses coordinate their responsibilities" — the key agencies being all the relevant ones in that department plus others in the Departments of Housing and Urban Development, Justice, and Veterans Affairs.

The administration lodged responsibility for implementation of the report in the DHHS; in turn, DHHS secretary Tommy G. Thompson directed Charles Curie, administrator of the department's Substance Abuse and Mental Health Services Administration, to take charge of the task. Curie assigned the responsibility to Kathryn Power, then the new director of the agency's Center for Mental Health Services and a former director of Rhode Island's state mental health care program. On the basis of its name, the Substance Abuse and Mental Health Services Administration is the most relevant agency within the department to assume this assignment, but its resources are limited, leaving one to wonder whether Thompson's directive reflects the low-key manner in which the Bush administration chose to release the report more than it does the fundamental transformation of the system that was called for by the commission.

An alternative approach, given the breadth of the recommendations, would have been the creation of a department-wide or an interdepartmental task force chaired by Secretary Thompson or one of Bush's trusted White House lieutenants. At the least, development of the Substance Abuse and Mental Health Services Administration's implementation plan bears close watching, given the agency's modest reach within the vast department, much less across the government. In any event, the mental health care movement has recognized the value of the exercise and is mobilizing its assets. Much like the Carter commission before it, the Bush commission has provided a report that will be the clarion call for this and future administrations to pursue dramatic improvements in the mental health care delivery system — a system that, as Bush envisioned in his charge, should enable people with serious mental illness to "live, work, learn, and participate fully in their communities."

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