DBSA-CA NEWS

Depression and Bipolar Support Alliance–California
(formerly California Depressive and Manic-Depressive Association)

Volume 14, No 2 Spring 2009

DBSA

CALIFORNIA

You may now contact us
via our new e-mail address:
CDMDA@AOL.com

Website: http://www.california
DBSA.org

Benefiting from mental health parity

Determining coverage, understanding the limits, appealing decisions

Two significant changes in health insurance coverage of mental health and substance abuse disorders, enacted into law in 2008, will begin taking effect in 2010. The laws are part of a nationwide push for mental health parity, which aims to provide coverage for psychiatric disorders on a par with other medical disorders. Until recently, it was perfectly legal for many insurers to limit care for mental health and substance abuse services and require patients to pay more out-of-pocket costs for such services than they would pay for care for diabetes, heart disease, or other medical conditions.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, signed into law on Oct. 3, 2008, affects large employers, Medicaid managed care plans, and some State Children's Health Insurance Program plans. In July 2008, Congress enacted the Medicare Improvements for Patients and Providers Act, which phases in mental health parity for Medicare recipients. These new laws supplement mental health parity laws now in force in every state but Idaho and Wyoming.

An ongoing challenge for patients and clinicians, however, is to navigate the patchwork of parity provisions at the state and national levels. Further complicating matters is the larger health care environment. Although the Congressional Budget Office estimates that adding mental health parity will increase health insurance premiums by less than 0.4% a year, health care costs overall have been increasing dramatically. The Kaiser Family Foundation reported that average employer -sponsored premiums for family coverage increased 119% between 1999 and 2008.

It is therefore likely that employers and health insurers will continue to take steps to contain health insurance costs in the years ahead. Thus while parity may exist in the law, managed care constraints may limit the mental health care benefits patients can receive and services providers can offer.

The Wellstone-Domenici Act

The Wellstone-Domenici Act applies to any organization with 50 or more employees that offers group health insurance with mental health or substance abuse coverage. The law applies to self-funded plans, which is signficant, because more than half of employer-sponsored plans are self-funded and therefore have not been subject to state mental health parity laws. The Wellstone-Domenici Act also goes well beyond

*Continued on page 3 (***Mental Health Parity**)

Phone psychotherapy for depression

Although a clinician and patient usually meet in person during psychotherapy sessions, they can also talk by phone. Now an analysis of 12 studies concludes that although phone psychotherapy may only be half as effective as in-person therapy for treating depression, patients are less likely than those undergoing psychotherapy in a clinician's office to drop out of therapy before it has a chance to work

Dr. David Mohr, a professor of preventive medicine at the Feinberg School of Medicine at Northwestern University, collaborated with investigators at four other institutions to analyze outcomes of phone psychotherapy in depressed patients. They found that phone psychotherapy signthcant1y reduced symptoms of depression when compared to control conditions, although it was only about half as effective as face-to-face psychotherapy.

Therapy can work only when patients continue long enough to receive the benefit. When the researchers examined attrition rates, they found that patients were less likely to drop out of phone psychotherapy than the in-person version. About 8% of patients dropped out of phone psychotherapy, while a separate analysis found that 47% of patients dropped out of face-to-face psychotherapy.

Dr. Mohr first became interested in phone psychotherapy while treating patients with multiple sclerosis, who were unable to travel for in-person therapy sessions. He is now conducting a randomized controlled study of this method; results are expected in two or three years.

Mohr DC, et al. "The Effect of Telephone-Administered Psycho-therapy on Symptoms of Depression and Attrition: A Meta-Analysis," Clinical Psychology: Science and Practice (Sept. 2008): Vol. 15, No. 3, pp. 243—53.

Source: Harvard Mental Health Newsletter
December, 2008

Pristiq® approved for major depression in adults

February 29, 2008, MADISON, NJ—The U.S. Food and Drug Administration (FDA) has approved Wyeth Pharmaceuticals' once-daily medication desvenlafaxine succinate (brand name Pristiq) to treat adults with major depressive disorder, Wyeth announced in February.

Pristiq is a medication in a class known as serotonin-norepinephrine reuptake inhibitors.

"Pristiq is an important new therapeutic option for patients and clinicians because no single therapy works for all people with major depression," said Philip Ninan, MD, vice-president of Wyeth Medical Affairs, Neuroscience.

Source: Esperanza
Premiere Issue

JOIN DBSA-California TODAY!

Please fill out form and return to:
DBSA-California
16280 Whispering Spur
Riverside, CA 92504

___ I wish to support the Depression and Bipolar Support Alliance of California by becoming a member.
Individual $20.00 per year ___
Contribution for Annual Conference $30.00 ___
(This does not mean chapter membership)
Lifetime membership $100.00 ___
Additional Contributions Welcome
___ Our organization is willing to let DBSA-Cal use our group's name for fundraising.

Group's Name_____

_____ _____
Name date

_____
Address

_____ _____ _____
City, State, Zip

_____
Phone

_____
eMail

DO YOU HAVE BIPOLAR DISORDER?

Have you gained weight taking medication to treat bipolar disorder?

Bipolar Disorder Research Study

Being conducted at UCLA

If you are 18 to 65 and have gained weight taking medications to treat bipolar disorder, you may be eligible to participate in a yearlong research study.

Please call (310) 794-9913 for more information.

You will receive free medication as part of this study.

UCLA MOOD DISORDERS RESEARCH PROGRAM

Mark Frye, M.D. ■ Lori Altshuler, M.D.
Natalie Rasgon, M.D. P.h.D.

SPONSORSHIP

We are looking for sponsorship of our quarterly DBSA-Cal Newsletter.
Any person, business, or organization that would like to help, please call (951)780-3366 and leave a message.
Thank You

MENTAL HEALTH PARITY

(Cont'd from Page 1)

the scope of an earlier 1996 federal parity law, which prohibited annual or lifetime financial limits on mental health coverage, but allowed other restrictions to continue, such as limits on outpatient visits or inpatient days.

Conditions covered. The Wellstone-Domenici Act allows health insurers to determine which mental health and substance abuse disorders they will or won't cover—as all do now for medical conditions. In practical terms, insurers tend to limit coverage to treatments and services deemed "medically necessary."

Medical necessity. Medically necessary care can be defined as generally accepted treatments that meet usual community standards of care. The definition generally excludes anything deemed experimental or not yet proven.

In practice, insurers have established their own definitions for medical necessity but have not made those definitions public. The Wellstone-Domenici Act now requires that an insurer provide, upon request, its criteria for determining medical necessity. When appealing a decision, the person making the claim needs to argue that a particular service was necessary, using the same criteria.

Excluded services. Health plans rarely list what services they cover. Sometimes the fastest way for patients to understand what mental health or substance abuse services are not covered is to look at the list of excluded conditions, which is usually contained in the back of a policy or in an appendix.

Managed care controls. Most group health plans now incorporate some form of managed care. Only 3% of employer-sponsored plans offer "conventional" fee-for-service coverage (which hardly makes it conventional any more). Well-known methods for managing both care and cost include requirements that patients receive prior authorizations for certain services, receive care only for certain periods of time (designated by utilization reviews), and receive care only from those clinicians who are part of "preferred provider networks" or other pre-approved lists.

Carve-outs. In addition, many managed care companies choose to "carve out" or subcontract the management of mental health and substance abuse coverage to an independent behavioral health care company. Insurers say the goal is to provide specialty services or negotiate discounts, but in practical terms it may mean that patients may have to deal with two sets of administrators—one for mental health and substance abuse services, and another for other medical services.

Impact on state law. Most states now have their own parity bills—some of which are more restrictive than the Wellstone-Domenici Act and some more expansive. Although the way that federal and state laws interact in health insurance is complex—and is still being determined by court cases—in general, the weaker state laws will be replaced by the new federal law, while the stronger state laws will remain intact. For instance, the state mental health parity law enacted in Vermont, considered one of the most comprehensive in the country, will trump the new federal law.

Potential advantages and limitations

Dr. Richard G. Frank, a professor of health economics at Harvard Medical School, thinks the most important accomplishment of the 2008 Wellstone-Domenici Act is that it offers new financial protections to the most severely ill patients, who need intensive mental health treatment and inpatient care. Until now, for example, adults with bipolar disorder or schizophrenia might incur $15,000 to $20,000 in medical bills a year for inpatient stays and other intensive treatment—much of which has not been covered by insurance. With the new law, most of those costs will be covered.

The new law also eliminates arbitrary limits on outpatient visits, which will translate into fewer out-of-pocket expenses for patients who see therapists or addiction counselors on a continuing basis.

But Dr. Frank points out that the Wellstone-Domenici Act does not cover the types of services that many patients with the most severe mental illnesses need to support their recovery—but aren't typically included in health insurance policies. These include services such as psychosocial rehabilitation and supportive employment services.

Many of the fears about mental health parity laws—namely, that they would dramatically increase costs for employers and drive up premiums for patients, or result in claims for frivolous services—have not been realized, even with broad parity laws. A dramatic example is the Federal Employees Health Benefits Program (FEHB), which started requiring parity for mental health coverage in 2001, following

***Continued on page 4* (Mental Health Parity)**

MENTAL HEALTH PARITY *(Continued from page 3)*

a directive by President Bill Clinton. An analysis of FEHB claims data found that most reimbursed services were for the treatment of anxiety, attention deficit hyperactivity disorder, depression, bipolar disorder, and schizophrenia.

Medicare mental health parity

Although it received less media attention than the Wellstone-Domenici Act, a law authorizing mental health parity for Medicare beneficiaries will be phased in over several years. Medicare enrolls patients who are 65 and older, as well as younger people who are permanently disabled.

Currently Medicare recipients must pay half of the cost for outpatient psychotherapy and other mental health services. Starting in 2010, the copay will be reduced gradually until it reaches 20% in 2014—equivalent to the current Medicare copay for other outpatient health services. The new law also provides expanded coverage for prescription antidepressants, antipsychotics, and anticonvulsants.

Be prepared; find help

Insurance counselors recommend that purchasers of insurance do the following on an annual basis.

Read the policy. Plans are renewed each year, and provisions may change. Take the time to know which services are covered, and which excluded.

Understand the rules. Identify which services require pre-authorizations or referrals, and which providers are included in a particular network. These rules are a major source of confusion.

Learn how to appeal. Every plan provides information on how to appeal decisions, whether for administrative reasons (such as whether a proper authorization was obtained) or for medical reasons (whether a service meets the criteria for medica1 necessity). Knowing this information in advance may make the appeals process easier.

Barry, C L, et al., "Mental Health and Substance Abuse Insurance Parity for Federal Employees: How Did Health Plans Respond?" *Journal of Policy Analysis and Management* (Winter 2008): Vol. 27, No. 1, pp. 155—70.

For more references, please see www.health.harvard.edu/mentalextra.

Source: Harvard Mental Health Letter
January 2008

The Magic of Believing

(see ad on page 8)

This event is being held on the property of Jo Ann Martin and Saul Kent. Jo Ann is looking forward to seeing as many of you as possible on May 16.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Provisions	Details
Effective date	On or after Jan. 1, 2010, depending on plan renewal date.
Plans affected	Large private group health insurance plans that offer mental health or substance abuse coverage in addition to medical and surgical coverage.
Scope of coverage	"Financial requirements".such as deductibles, copayments, coinsurance, out-of-pcket expenses, and annual and lifetime limits. "Treatment limitations" such as limits on frequency of treatment, number of visits, days of coverage, and duration of treatment.
Conditions covered	Health insurers may determine which mental health and substance abuse conditions they will cover.
Denials	If a health insurer denies a claim, it must provide its criteria for "medical necessity" and explain why the service was not covered.
Out-of-network providers	If a health plan offers out-of-network coverage for medical and surgical services, it must also provide equivalent out-of-network coverage for mental health and substance abuse services.
Cost exemptions	A group health plan can qualify for exemption from the law if it finds that providing mental health and substance abuse coverage increases its costs by 2% or more in the first year, or 1% or more in subsequent years.

Source: U.S. Emergency Economic Stabilization Act of 2008, Subtitle B. Sec. 512

An evolving view of depression

By Carey Goldberg January 19,2009

An occasional column on mental health.

In the world of therapy, Dr. Aaron T. Beck is a rock star.

Considered the father of cognitive behavioral therapy, a form of psychological treatment that has swept the country in recent decades, he has been so famous for so long that some are surprised to find out that he is still, at 87, hard at work.

Beck has recently come out with a new, overarching theory of depression, the mood darkness that in any given year afflicts an estimated 5 percent of Americans (and probably a higher percentage this year).

More than a generation ago, Beck helped overturn the classical idea that depression was "anger turned inward," a form of self-punishment Instead, back then he put forth a cognitive model of depression - that it is a problem of negative bias and habits of thought Any failure means "I am a loser." A rejection means "Nobody loves me."

Now, he has updated his cognitive model with the latest advances in brain science and genetics, and published it in the American Journal of Psychiatry. Beck, a professor of psychiatry at the University of Pennsylvania, cautions that much of the research he cites is still preliminary. But he sketches out a coherent overview of converging psychology and biology that goes roughly like this:

Begin with genes. Beck and others used to speculate about a "blue gene." Researchers are now beginning to identify specific genes that could make the brain "hyperreactive to negative experiences," leading to depression, he writes.

For example, a gene that affects the brain chemical serotonin appears to influence how likely it is that a major stressful event will lead to depression. Studies suggest this serotonin gene is also linked to a tendency toward negative thinking.

How could a gene lead to negative thinking? Well, to continue the example, that serotonin gene appears to make the amygdala, an emotional center of the brain, hyperactive.

Studies have found that a hyperactive amygdala is linked to extra sensitivity to negative stimuli, such as unpleasant images or events. People end up viewing the world negatively - noticing the weeds, not the flowers.

Other studies suggest a biological pathway to depression involving stress hormones that Beck summarizes this way: Stressful events trigger the hypersensitive amygdala to overact, producing a distorted negative reaction~ which prompts excessive stress hormones, leading to depression.

There is also a "top-down" piece of the puzzle: brain scans have found that in depressed people, the prefrontal cortex, known as the seat of rational thought, tends to be underactive.

They are not getting the needed reality check that says "Things are not really so bad." That may help explain how therapy that encourages depressed people to "reappraise" things, to challenge their negative responses, can act to lift mood. Cognitive behavioral therapy aims to help patients by focusing on problems in their thinking and teaching them ways to improve it

There's more. But it seemed the easiest way to sum it up was to ask Beck what he would say these days if a patient asked, "Why am I depressed?"

His answer. "I would say that there is an interplay of genetic, developmental, and stress factors, and the contribution of each of these factors varies from individual to individual. Some individuals, for example, are depressed only if there is overwhelming stress. Others are vulnerable because of their genetic make up and become depressed with minor stressors."

And how does that answer differ from, say, 20 years ago? Back then, he said, he would have emphasized only the psychological factors, and left the genetic and biological factors "up in the air."

He believes, he said, that even a patient who is biologically vulnerable to depression can be helped by effective therapy. For severely depressed patients, he recommends cognitive therapy in conjunction with medication.

Beck's model of depression has evolved admirably, but it does not make the problem of depression simpler, said Philip Levendusky, director of the psychology department at McLean Hospital in Belmont.

The model reflects the fact that depression is complex and has many dimensions, Levendusky said.

Brain science has made amazing advances in recent years, but it is still light years away from understanding mental illness. Beck's theory is a snapshot of the state of the science - it is, Levendusky said, "a quantum jump beyond where we were once upon a time, and probably three quantum jumps from where we'll ultimately be."

Still, Beck ends his August 2008 American Journal of Psychiatry article, which he said brought him a far greater response than anything else he had written, with optimism.

"I have reason to hope that future research will perhaps provide a new paradigm which for the first time can integrate findings from psychological and biological studies to build a new understanding of depression," he wrote

And in the meanwhile, said Michael W. Otto, director of Boston University's Center for Anxiety and Related Disorders, depression can be treated even without a full understanding of its origins.

However it starts, he said, it has a life of its own. "IIs a pattern that needs to be broken," he said, "and the evidence is that it can be broken."

Carey Goldberg can be reached at goldberg@globe.com

Source: The Boston Globe
January 19, 2009

Use Distant Perspective to Cope with Depression, Study Says

New research suggests that processing emotions may facilitate coping but attempts to understand painful feelings may backfire. Processing may perpetuate or even strengthen negative moods and emotions, according to a study conducted at the University of Michigan. Denial and distraction are not solutions, says Ethan *Kross,* a faculty associate at the U-M Institute for Social Research (ISR) and an assistant professor of psychology. Kross's research suggests that the best way to "move on" emotionally is to analyze your feelings from a psychologically distanced perspective.

Kross, alongside Ozlem Ayduk, a colleague from the University of California, Berkeley, conducted several studies providing the first experimental evidence of the benefits of analyzing depressive feelings from a psychologically distanced perspective. The studies received funding from the National Institutes of Health.

"We aren't very good at trying to analyze our feelings to make ourselves feel better," Kross says. "It's an invaluable human ability to think about what we do, but reviewing our mistakes over and over, re-experiencing the same negative emotions we felt the first time around, tends to keep us stuck in negativity. It can be very helpful to take a sort of mental time-out, to sit back and try to review the situation from a distance."

Kross's recent papers show some evidence that self-distancing techniques improve cardiovascular recovery from negative emotions. Another research report shows that the technique may help protect against depression.

In another study published this year in *Psychological Science,* Kross and Ayduk showed that study participants who tried using a self-distanced perspective while analyzing their feelings surrounding a time when they were angry showed a smaller increase in blood pressure than participants who used a self-immersed technique.

For more information, visit www.isr.umich.edu!. •

Source: Joint Commission Advisor for Behavioral Health Care Providers 2008, Vol. 12 No. 11

VNS: An Experimental Treatment for Major Depression

Charles R. Conway, M.D is Washington University associate professor of psychiatry and a 2007 NARSAD Young Investigator, and has been participating in the development of vagus nerve stimulation (VNS) as a treatment for intractable depression. VNS is among several new technologies introduced in recent years that are bringing hope and help to the 5 to 10 percent of people with major depression who fail to respond to any of the standard treatments.

Dr. Charles R. Conway

In VNS, a small electrical-impulse generator is attached to the vagus nerve in the neck, which projects directly into the brain. As Dr. Conway explained, VNS has long been used to treat epilepsy. Many epilepsy patients experience depression, and it was noticed that with VNS treatment, the depression symptoms abated whether or not the epilepsy improved. While VNS is slow to work, Dr. Conway said that research has shown the antidepressant response to be sustained significantly longer than it is with other treatments. Graphing changes in metabolic activity across different time points, he said, the greatest amount of activity with VNS starts around nine months and continues upward.

Noting that VNS treatment appears to work by some long-term, adaptive process, Dr. Conway is applying neuroimaging to learn what this process is, to learn how and in which regions of the brain. Additionally, he wants to determine the optimal electrical signal to induce antidepressant response. Importantly, because VNS treatment is invasive and expensive, he would like to find a way to determine prior to treatment whether or not an individual patient is likely to benefit from it.

Source: NARSAD Research Quarterly Fall/Winter 2008

Mood stabilizers called cornerstone of bipolar disorder treatment

November 1, 2008, BOSTON, MA—A new study has bolstered the role of mood stablizers as the cornerstone of treating bipolar disorder.

Researchers from Tufts Medical Center said that while long-term antidepressant treatment for bipolar is highly prevalent, the benefits and risks of that treatment remain uncertain. So they reviewed studies that looked at treating bipolar with either antidepressants or mood stabilizers to determine risk.

They found that antidepressant add-on therapy was no more effective than stand-alone mood stabilizer therapy, further encouraging reliance on mood stabilizers as the cornerstone of treatment.

The study, which appeared in the journal *Acta Psychiatrica Scandinavica,* was titled "Long-term antidepressant treatment in bipolar disorder: Meta-analyses of benefits and risks."

Source: bp Magazine
Winter 2009

Second-generation antidepressants equally effective as first choice

November 18, 2008, PHILADELPHIA, PA-All second-generation antidepressants are equally effective and should be the first choice for treating depression, according to new guidelines issued by the American College of Physicians.

The college reviewed more than 200 published studies about the benefits and side effects of second-generation antidepressants and found that while they have different adverse effects, they are equally effective.

The guidelines contain several recommendations: that clinicians assess patients' response and side effects regularly, that patients be closely watched for increases in suicidal thoughts or behavior during the first month or two of taking the medication, that treatment be modified if patients don't have an adequate response to drug therapy within six to eight weeks, and that treatment continue for four to nine months after a satisfactory response.

Patients who have had two or more episodes of depression may require an even longer duration of therapy to prevent relapse, the college said.

Source: bp Magazine
Winter 2009

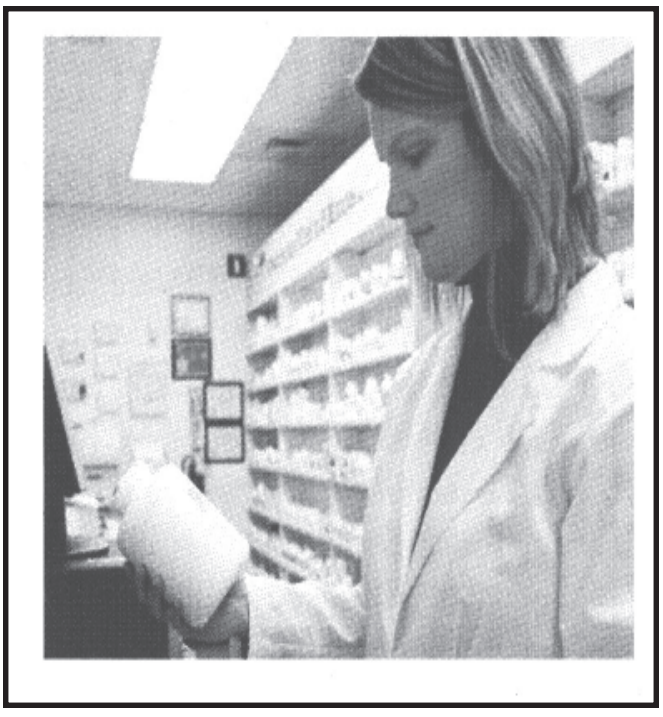
Study: Spanish-speaking Hispanics may need more than depression medication

November 4, 2008, TORRANCE, CA-In a study that could have important implications for the largest population group in the United States, researchers found that Spanish-speaking Hispanics took longer to respond to medication for depression and were less likely to go into remission than English-speaking Hispanics.

In the first study of its kind, researchers at Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center (LA BioMed) found the Spanish-speaking participants in the study were older and were more likely to be women than the English speakers. They also had less education and lower incomes, more medical issues, and were more likely than English speakers to be seen in primary care than psychiatric clinics.

The researchers said the results are important for health care professionals to be aware of, as Spanish-speaking Hispanics who come from lower social economic groups may need more than medication for depression.

Source: Esperanza
Premiere Issue



SOMETHING IS IN THE WORKS!

SAVE THE DATE MAY 16, 2009

4-7PM

MAGIC OF BELIEVING

If you have ever held the hope for yourself or someone you know, please join us to honor Greg Adamson for his longtime commitment to mental health recovery.

GREG ADAMSON, Regional Vice President of Union Bank, graciously serves his community. He has been on the Jefferson Transitional Programs' Board of Directors since the organization's beginnings. And as an accomplished artist, he has been an integral force behind the success of JTP's Art Works program.

Event Honorary Committee Chairperson is **MIKE GARDNER**. Mistress of ceremonies is Channel 4's **MARY PARKS**. The event features a treasure hunt through the sprawling and enchanted gardens of a private home, musical performances, a silent auction, and food by **Outback Steakhouse**. For ticket information please call **951.683.1279**.

This event benefits **ART WORKS @ Jefferson Transitional Programs**. The mission of Art Works is to educate and to empower individuals with chronic mental illness in Riverside County to use creative arts for wellness and recovery.

✂Clip and Keep!

Educational Resources

American Psychiatric Association
202 / 682-6220 • www.psych.org
American Psychological Association
800 / 374-2721 • www.apa.org
Advocacy Center
800 / 342-0823 • www.advocacycenter.com
Child & Adolescent Bipolar Foundation
847 / 256-8525 • www.bpkids.org
DBSA-California
(909) 780-3366
National Alliance for the Mentally Ill (NAMI)
800/ 950-6264 • www.nami.org
National Association for the Dually Diagnosed
800/ 331-5362
National Depression and Bipolar Support Alliance
800 / 826-3632 • DBSAlliance.org
National Family Caregivers Association
301 / 942-6430
National Foundation for Depressive Illnesses
800 / 248-4344
National Institute of Mental Health
800 / 421-4211 • www.nimh.nih.gov
Panic Disorder Line:
800 / 64PANIC (647-2642)
Anxiety Disorder Line:
888 / 826-9438
National Mental Health Association
800 / 989-6642 • www.nmha.org
Confidential depression screening:
www.depression-screening.org

SAVE THE DATE

NAMI - California

Annual Conference

August 21 & 22, 2009

Torrance Marriott Hotel
Torrance, CA

To submit a workshop proposal or to register go to:
www.namicalifornia.org

Medi-Cal Mental Health Ombudsman's Office
1-800-896-4042
Help with Medi-Cal mental health services.

☎

Health Rights Hotline
1-888-354-4474 TDD 916-551-2180
Local calls 916-551-2100 Fax 916-551-2158
http://www/hrh.org
Tells consumers in El Dorado, Placer, Sacramento and Yolo counties about their health care rights, and answers questions about health care coverage and managed care. HRH also has advocacy materials and referrals to other resources. HRH can help with HMOs, PPOs, Medicare, Medi-Cal, and CHAMPUS.

ADA Home Page — USDOJ
800-514-0301 800-514-0383 (TDD)
http://www.usdoj.gov/crt/ada/adahom1.htm
ADA technical assistance, information line, enforcement, settlement information, regulations, mediation, and more.

Zoloft and Cipralex Better Than Other Drugs

LONDON -- Doctors have long assumed that most antidepressants are interchangeable, but according to a new study, Zoloft and Cipralex work slightly better than 10 other popular drugs, and should considered first choice by psychiatrists; for patients with moderate to severe depression.

Source: AP Online
Jan 29, 2009

DBSA–California
16280 Whispering Spur
Riverside, CA 92504