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Mental Health - Nature or Nurture?

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In December 2004, 15-year-old Chelsea Rhoades sat down at Penn High School in Mishawaka, Ind., and answered a questionnaire about her attitudes and behavior. She worked through the questions -- created by a Columbia University program called TeenScreen, which is designed to gauge the behavior and feelings of young people -- and then waited in the hallway.

After a few minutes, according to her subsequent lawsuit, Chelsea was told that she had been diagnosed with "social anxiety disorder" and "obsessive-compulsive disorder." She was told to have her parents take her to a local mental health clinic, whose employees had administered the TeenScreen test.

In tears, Chelsea went home and asked her parents about the diagnoses. Mike and Teresa Rhoades had not signed a consent form for their daughter to be tested, and they were surprised and angry over the results. According to Teresa Rhoades, Chelsea was diagnosed with social anxiety because she had answered "yes" to a test question that asked whether she felt cut off from friends. She felt cut off, she explained to her parents, because she wasn't allowed to go out on school nights. "Her father and I don't think young children should be out every night," said Teresa Rhoades. "We limit their social occasions to keep them out of trouble."

The obsessive-compulsive diagnosis, according to the lawsuit, arose because Chelsea answered that, yes, she did find herself repeatedly doing something she had little or no control over. That "something" turned out to be cleaning her room and doing her daily chores. "That is not a mental illness," said Mrs. Rhoades, who is a quality-control manager at a local company. "That's the way she has been raised."

Indianapolis lawyer John Price filed the lawsuit on behalf of the Rhoades family in September 2005, in partnership with the Rutherford Institute, a right-of-center public-interest law firm based in Charlottesville, Va. Mike and Teresa Rhoades allege that the school and the mental health clinic, the Madison Center, violated their parental rights under the federal and state constitutions, broke federal and state privacy laws, and intentionally inflicted emotional damage on their daughter and family.

The lawyer for Penn High School, Tom Wheeler, said the school instituted the TeenScreen diagnostic program as part of a suicide-prevention effort after a student killed himself in 2003. "The school



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wanted to offer this to as many students as possible," Wheeler said, adding that it sent home forms allowing parents to have their children opt-out of the testing.

Developed by Columbia professor David Shaffer, TeenScreen has been administered in more than 400 communities around the country to identify anxiety, depression, alcohol and drug abuse, and suicidal thoughts in high school students. Advocates say that the vast majority of TeenScreen testing is done with parental permission. Fifty thousand kids took the test in 2005, up from 12,000 in 2003, according to TeenScreen.

The test's effectiveness in curbing suicide can't be easily measured, although the questions do reliably highlight behavior that may lead to suicide, Shaffer said. Results must be followed up by further testing before any diagnosis -- alcohol abuse, anxiety, depression -- can be confirmed, he said.

Opponents argue that TeenScreen's real purpose and effect is to pump the sale of drugs such as Ritalin and Aderall, which stimulate the central nervous system, as well as other pharmaceutical-industry products and professional services for at-risk youth. "They're creating their own marketing to hook kids on these horrible drugs at younger and younger ages," said Karen Effrem, a parent, pediatrician, and activist in Chaska, Minn.

This conflict between parents and mental health experts has erupted in various states. In Minnesota, for example, Effrem has pushed back against a proposal calling for the "early and continuous" screening of babies, infants, and kindergartners to check their "socio-emotional/mental health." That call was part of a plan drafted by the Minnesota Mental Health Action Group, composed of top state officials, mental health professionals, university administrators, company executives, and lobbyists for mental health industry groups. Republican Gov. **Tim Pawlenty** made the plan the foundation of a state budget proposal to boost mental health spending by roughly \$25 million.

Effrem calls Pawlenty's plan "a huge power-grab." In her view, parents are far better at raising their kids than are professionals who have their own agendas. It "is just breathtaking, the scope of what [the mental health sector] wants to do," said Effrem, who works with social-conservative advocates and religious groups to counter the sector's growing role. "The medical experts can't even agree on what constitutes normal mental health."

In various states, parent-rights advocates and their supporters argue that the mental health profession is using labels such as "socio-emotional health" to redefine the normal rules of good character and of parenting. "Who is to say that a handful of psychiatrists can make that definition for a family?" Teresa Rhoades asked.

But psychiatrists, psychologists, social workers, and affiliated professionals argue that their knowledge and experience in dealing with severe mental illness, such as schizophrenia, give them the skills

and science to help boost the emotional health and well-being of children, adults, and older people. "Our society has become so complex and so hard to live in that any decrease in your capacity to handle all the stuff that comes at you becomes a disability," said Kenneth Thompson, a psychiatrist in Pittsburgh.

Even when all parties remain civil, this dispute generates intense passions because it publicly challenges core beliefs on all sides: The belief by parents and many experts that families are the best incubators of character; the belief by mental health professionals that their skills are effective in improving patients' lives; and the belief by millions of Americans that mental health services are vital for their well-being.

Mental Health Boom

Since the 1990s, the mental health sector has greatly expanded services for young children and teenagers. In 1994, 3.4 percent of teenagers' visits to doctors resulted in prescriptions for psychotropic, or brain-related, drugs. By 2001, that proportion had jumped to 8.3 percent, according to a study released in January 2006 by researchers at Brandeis University. The TeenScreen test taken by Chelsea Rhoades is among the more controversial elements in this expansion, especially because it is often a family's first contact with the mental health sector.

Beyond the country's teenage population, millions of adult Americans say they cannot lead productive lives without mental health products and services. The testimonies come from a wide variety of people, including those afflicted with serious ailments like schizophrenia and those who use prescription drugs to help them stay focused on their work or their studies.

One prominent example is offered by Laurie Flynn, the director of TeenScreen, whose daughter was diagnosed at age 17 with bipolar disorder. Aided by drugs and therapy, Flynn said, her daughter graduated from college and later married, although, "it's sad to say, she's an exception."

The demand for mental health services has created an employment boom. The number of psychologists, psychiatrists, substance-abuse counselors, and various support personnel in small clinics exploded from 21,000 in 1972 to 318,000 in 1998, according to "Mental Health, United States, 2002," a report published by the Health and Human Services Department. Major facilities, such as state mental hospitals, employ an additional 360,000 people, a number that has changed little in the past 30 years.

The employment analysis does not include all employees of so-called 12-step groups, such as Alcoholics Anonymous, and the family physicians who prescribe 70 percent of antidepressant drugs.

Also growing is the pharmaceutical industry, whose workers and suppliers produce the psychotropic medications. Sales of such drugs grew 6 percent in 2004 alone, accounting for 8.5 percent of the drug industry's revenues, or \$20 billion, according to the market-research firm IMS Health, which collects data on prescription sales.

Many mental health experts say that these drugs are vital. Shaffer argues, for example, that many young adults will pull themselves out of depression over the course of two or three years, but that in 60 percent of cases drugs can shorten that process to six weeks or so.

Still, medical science has no biological or chemical tests that can determine whether a person is depressed, suicidal, schizophrenic, or afflicted with another mental problem. "There is no laboratory test that establishes a specific diagnosis," said Steven Sharfstein, the 2005 president of the Baltimore-based Sheppard Pratt Health System who heads the 35,000-member American Psychiatric Association.

Sharfstein said, "we'll get there within the next five to 10 years." Thomas Insel, head of the National Institute of Mental Health, said that despite the lack of a biological test, researchers will soon discover why individual patients respond well or poorly to particular drugs. Others are less optimistic. Ronald Levant, who in 2005 was president of the 150,000-member American Psychological Association, said, "Getting a biological marker, I don't think will happen in my lifetime."

Without a definitive test that can link biological factors, such as a chemical imbalance, to a specific malady, psychologists and psychiatrists identify maladies by checking patients' behavior and mood. But humans are so willful and their motivations so complex that diagnoses are prone to error. For example, one-third of kids diagnosed with depression are really afflicted by "bipolar disease," said Henry Nasrallah, an associate dean and a professor of psychiatry at the University of Cincinnati.

To help organize behavioral diagnoses, the psychiatric association publishes the Diagnostic and Statistical Manual of Mental Disorders, known as the DSM. The latest edition, published in 2000, is 943 pages and lists long-recognized serious mental illnesses, such as schizophrenia and obsessive-compulsive disorder. Mental health professionals, often with the aid of drugs, usually treat those who suffer from these illnesses as outpatients. At least one-quarter of federal mental health spending -- roughly \$27 billion in 2004 -- goes for treatment of these illnesses.

A main driver of the mental health sector's growth, however, can be found in a new category of diseases and disorders that has been added to the DSM. This category does not yet have an agreed-upon label, although professionals in the field use such terms as care for the "worried-well," "emotional and social health," "experience impairment," "cosmetic psychopharmacology," or just "well-being."

The category includes acts that society has traditionally classified as bad behavior or as character flaws, such as alcoholism. It also includes behaviors often stigmatized as "sloth," "fidgetiness," or the "winter blues," or those that are understood as simply shyness, excessive pride, or melancholy. But the manual regards these as medical conditions, and provides names such as "depression," "attention-deficit disorder," "social anxiety disorder," and "narcissistic personality disorder." For example, the DSM states that a diagnosis of mild depression, or "dysthymic disorder," can be made when a patient over a two-year period displays two from a range of symptoms that characterize the

condition, which sufferers say can be extremely debilitating. Among the symptoms listed are poor appetite, overeating, low energy, low self-esteem, poor concentration, and feelings of hopelessness.

This "well-being" category continues to grow. Overeating, for example, was once seen as gluttony -- an individual vice. But mental health professionals now label obesity a public problem that requires professional attention because of the high social costs incurred in treating diabetes, heart attack, and other diseases. Although obesity is not included in the DSM, Russ Newman, executive director for professional practice at the psychology association, cited it as an example of how the mental health field is expanding. "Politicians are seeing the sheer cost of not paying attention to lifestyle and behavior," Newman said.

Overall, the growth of the mental health sector has not reduced the prevalence of mental and emotional ailments. The discovery of new drugs in the 1950s did boost the success rate in treating schizophrenia to 48.5 percent from 1955 to 1985, according to a peer-reviewed article in *The American Journal of Psychiatry*, published by the American Psychiatric Association. But after 1985, the success rate dropped to 36.4 percent, barely above the 35.4 percent rate recorded between 1895 and 1955, the article said. The spike resulted mainly from a looser definition of success used by the mental health sector from 1955 to 1985, according to the study's chief author, Dr. James D. Hegarty of Penn State's College of Medicine. The drugs work well, he said, but most patients stop using them because of side effects.

By the mid-1990s, according to a 1999 report on mental health by the Office of the Surgeon General, roughly 22 percent of American adults in any given year had a diagnosable mental disorder, while 21 percent of children and adolescents "had some evidence of distress or impairment associated with a specific [mental health] diagnosis." The report estimated that half of children were not treated for their maladies.

Still, these problems are balanced against the many grateful patients who benefit from the industry's services and products. In 2003, 2.75 million adults were getting federal disability benefits because of mental problems, up 10 percent from 1997. Nationwide, the number of "episodes" treated by mental health organizations for less than 24 hours grew steadily from 1.7 million in 1955 to 10.7 million in 2000, according to the 2002 HHS report on mental health in the U.S. This increase far outpaced the growth of the U.S. population.

Political Fights

The mental health sector's increasing political clout is tied to its marketplace success. That success is somewhat constrained, however, by the public's continuing preference to define behavior according to traditional notions of personal responsibility, family loyalty, and religious obligation.

Many mainstream religious believers, for instance, believe that human character is defined not by the latest version of the diagnostic manual but by making choices between good and evil, and by rejecting or

embracing divine grace. Similarly, American values encourage people to work hard and persevere -- such commandments urge Americans to "pull yourself up by your bootstraps," or to "suck it up." By the early 1900s, Horatio Alger had sold more than 100 million children's books by featuring kids who triumphed over circumstances by dint of pluck, toil, and honesty.

Michael J. Fitzpatrick, the executive director of the National Alliance on Mental Illness, a support and advocacy group for people living with mental illness, offers some data to explain the rivalry between the mental health field and traditional attitudes. When faced with "mental health problems," 51 percent of Americans turn first to family and friends, he said; 17 percent turn first to a doctor, 10 percent to a counselor or therapist, and 9 percent to a cleric. On average, the nation's 350,000 clerics, provide roughly eight hours of counseling per week.

Only 7.6 percent of Americans who seek help turn first to psychiatric specialists, ranking this group somewhat ahead of mental hospitals and nonprescription medicine.

Yet, the demand for mental health services and products is soaring because of changes in religious beliefs, a decline in marriage rates, and other disruptions to the family. "Our society has lost a lot of its infrastructure, like the family and religiosity, which used to be very helpful support networks for people in distress," Nasrallah said. Nearly all child-rearingThe employment analysis in the 1960s was done within marriage, but now roughly 33 percent of children in the U.S. are born into one-parent families.

The mental health sector benefits from the prestige of science as well. Its association with such a respected field enables the sector to attract more clients and to win more funding from politicians. Mental health advocates often argue that their claims and therapies are based on biological science. "We now know these [severe mental] diseases are brain diseases," said Insel, of the NIMH, whose budget of \$1.5 billion mostly goes toward developing new drugs. "The mind isn't anything separate from the brain. It's just the emergent property of the brain.... Right now, biology and psychology are the same; they really have merged."

Still, the public strongly resists this purely biological view of human character and behavior. Some 45 percent of Americans "consider mental illness a matter of moral failure," Fitzpatrick said.

The strongest political pressure against the mental health sector comes from a loose network of medical experts and motivated opponents of the industry. Gayle Ruzicka is an example of the latter. She is president of the Utah Eagle Forum, a leading backer of a twice-defeated state bill to restrict teachers' ability to refer children for mental health checks. Adults are free to choose the drugs offered by mental health experts, Ruzicka said, but that choice "doesn't really work [because the drugs are] masking their problems."

Other activists assemble in conservative and religiously minded

groups, such as Concerned Women for America and the Church of Scientology.

These loose coalitions hardly speak with one voice, however. Some critics argue that the mental health sector should put more effort into treating people who are severely mentally ill, but most of the groups focus on the growth of the mental health sector's "well-being" diagnoses. The Scientologists, for their part, utterly reject the legitimacy of the entire mental health sector.

These groups differ over the role of drugs as well. Vera Sharav, who runs the Alliance for Human Research Protection, based in New York City, is very critical of mental health drugs, while her ally, E. Fuller Torrey, a schizophrenia expert, author, and president of the Treatment Advocacy Center of the Stanley Medical Research Institute, praises the role of pharmaceuticals in treatment.

Amid their differences, these disparate critics tend to find common agreement over studies that show drugs to be too expensive, ineffective, or harmful. For example, critics recently highlighted a May 2006 letter by drugmaker GlaxoSmithKline that said the suicide rate among deeply depressed 18-to-24-year-olds who were prescribed the company's antidepressant, Paxil, jumped from 0.92 percent to 2.19 percent.

One frequently cited set of peer-reviewed studies was published in 1998 and 2002 by the American Psychological Association. Irving Kirsch, a psychologist at the University of Connecticut, reported, "The pharmacological effects of antidepressants are clinically negligible." Kirsch and his colleagues compared improvements between patients given placebos to those given patented drugs. Their study concluded that up to 80 percent of improvements by patients who took the drugs were a function of their faith in the drug's effectiveness, not of the drug itself.

The critics also highlight statements by David Graham, the associate director for science and medicine at the Food and Drug Administration, who argues that the new "atypical" antipsychotic drugs increase annual deaths by at least 12,000 people. Graham estimated the death toll by calculating the percentage of people who die in short-term tests of these drugs, then multiplying the percentage by the total number of people using those drugs, while excluding all possible deaths from longer-term use of the drugs.

Alan Goldhammer, the vice president for regulatory affairs at the Pharmaceutical Research and Manufacturers of America rebutted Graham's criticism by citing another study's conclusion that 14.6 percent of the elderly people taking the newer antipsychotic drugs died within 180 days -- fewer than the 17.9 percent of those who died while taking the older drugs. The study was published last December in *The New England Journal of Medicine*.

The critics' most fundamental charge is that the mental health sector wants "well-being" to displace the traditional social notions of family, religion, and self-help. Those values, the critics say, are the foundation

of good character, of self-control, and of democracy because they reduce the individual's dependency on government. Peter Breggin, a New York City psychiatrist and author, dismissed the biology-centered perspective of mental health as "the religion of intellectuals," because it "is built on a myth that human suffering is biological in origin." Suffering "comes from human experience and human conflict, from life and death," he said, and "drugs undermine the responsibility of parents to parent, teachers to teach, and children to grow up, to learn to take charge of their own behavior as they grow."

To be sure, the conflict between the critics and supporters of the mental health sector can be overdrawn. Many of the critics want better treatment of the severely ill and acknowledge that drug treatment does help some patients. Similarly, many mental health practitioners criticize aspects of their profession and endorse the use of traditional remedies where appropriate.

TeenScreen's Shaffer, for instance, says that government should pay for results, not patient visits, and that "fundamentalist" religious faith reduces the risk of suicide. The easy availability of alcohol -- not biology -- probably is the main driver of youth suicide, he added.

The sharpest criticisms of the mental health field come from full-time political advocates in Washington and in state capitals. Critics such as Effrem not only have won some victories; they have also gotten support from the White House, which reduced the 2007 budget request for HHS's Substance Abuse and Mental Health Administration to \$3.3 billion, slightly below the \$3.4 billion appropriated for 2006.

At the state level, Effrem, Ruzicka, and their allies have successfully lobbied for bills that curb the mental health sector's access to kids, while the Alliance for Human Research Protection has helped prod the FDA into warning doctors about the hazards of some drugs used by children and adults. In February, an FDA advisory panel cited the deaths of 25 people in recommending use of a warning label for drugs prescribed for the treatment of children diagnosed with attention deficit hyperactivity disorder, or ADHD.

Public concern about the mental health sector has also had some effect. The number of children's prescriptions for antidepressants fell 25 percent between 2001 and 2005, according to the market-analysis firm Medco Information Warehouse. Those numbers may shrink further.

But the mental health sector continues to gain other customers, revenues, attention, and market share. Government continues to fund the sector, health insurance executives advertise novel mental health services, TeenScreen continues to test, and Americans continue to buy the products and services. Conservative critics have had little influence over the federal government's mental health agency, which continues to fund projects they dislike, including grants that pay for TeenScreen tests.

In October 2005, the federal government provided \$9.7 million for 14 state anti-suicide programs, four of which were slated to use the TeenScreen test. Federal money also flows to other groups, such as

Massachusetts-based Screening for Mental Health, which got \$1.7 million in 2004. The organization received almost \$1 million in contributions from pharmaceutical companies in 2004, and recently got \$507,000 from the Ronald McDonald House Charities to fund mental health screening in 1,000 middle schools.

"This stuff is pervasive," Effrem complained, citing her recent discovery that Minnesota education officials plan to routinely test kindergartners for "socio-emotional" problems. "It is spreading its tentacles everywhere." Effrem's pessimism matches the guarded optimism of one of her opponents, TeenScreen's Flynn. "We are still very much groping in the dark, but we know more than we did 25 years ago," Flynn said, "and I believe we will continue to increase our knowledge."

Drug Treatments

Antidepressants are the most widely prescribed mental health drugs, but high-priced new anti-psychotics -- used to treat serious maladies -- are generating the fastest revenue growth.

Total U.S. dispensed prescriptions

	Anti-depressants	Anti-psychotics	Analeptics
2001	143,748	29,882	21,636
2002	164,771	34,705	25,013
2003	178,365	38,764	26,246
2004	186,774	41,742	29,087
2005	189,850	43,775	31,851

Total U.S. sales

	Anti-depressants	Anti-psychotics	Analeptics
2001	\$11,421,888	\$5,374,591	\$1,191,512
2002	\$11,622,163	\$6,619,177	\$1,663,275
2003	\$13,170,384	\$8,406,791	\$1,963,100
2004	\$13,389,505	\$9,560,117	\$2,422,268
2005	\$12,501,029	\$10,471,598	\$2,961,596

SOURCE: IMS Health

Teen Suicide

Suicides among teenage boys have dropped in recent years, while the rate for teenage girls remains much lower. The suicide rate for the U.S. population has remained fairly steady.

Suicide rates in the U.S.

	Boys (ages 15-19)	Girls (ages 15-19)	Total population
(per 100,000 residents)			

1950	3.5	1.8	11.4
1960	5.6	1.6	10.6
1970	8.8	2.9	11.6
1980	13.8	3	11.9
1981	13.5	3.5	12
1982	14	3.1	12.2
1983	13.9	3.2	12.1
1984	14.2	3.5	12.4
1985	15.8	3.7	12.4
1986	16.2	3.7	12.9
1987	16	4.1	12.7
1988	17.6	4.3	12.4
1989	17.6	4.2	12.2
1990	18.1	3.7	12.4
1991	17.9	3.7	12.2
1992	17.6	3.4	11.9
1993	17.4	3.8	12
1994	17.9	3.4	11.8
1995	17.1	3.1	11.7
1996	15.4	3.5	11.5
1997	14.9	3.3	11.2
1998	14.3	2.8	11.1
1999	13	2.7	10.5
2000	13	2.7	10.4
2001	12.9	2.7	10.8
2002	12.2	2.4	11
2003	11.6	2.7	10.8

SOURCE: Health and Human Services Department

Booming Sector

The mental health sector has grown since the 1950s by providing more services outside of traditional hospitals. The government tracks the number of individuals who receive care from different services or at different times throughout the year by counting "patient care episodes."

Patient care episodes in U.S. mental health organizations
(in millions)

	Long-term care (Hospital and residential treatment)	Short-term care (Less than 24 hours)
1955	\$1,296,352	\$379,000
1965	\$1,565,525	\$1,071,000
1969	\$1,710,372	\$1,972,082
1971	\$1,755,816	\$2,435,097
1975	\$1,817,108	\$5,040,489
1983	\$1,860,613	\$5,333,425
1986	\$2,055,571	\$5,830,047
1990	\$2,266,022	\$6,354,606
1992	\$2,322,374	\$6,502,307
1994	\$2,502,166	\$7,082,050
1998	\$2,521,175	\$8,028,776
2000	\$2,335,711	\$8,405,532

Number of staff in core mental health organizations

1972: 6% Short-term care workers

Total Workers: 375,984

1986: 7% Short-term care workers

Total Workers: 494,515

1992: 25% Short-term care workers

Total Workers: 585,972

1998: 47% Short-term care workers

Total Workers: 680,310

SOURCES: National Institute of Mental Health; Center for
Mental Health Services

Mental Health Spending

Per capita mental health spending is highest in the Northeast and is expanding in the Midwest, but remains low in the South.

Per capita mental health spending, by state (2003)

0-\$50:

Idaho	\$33.69
New Mexico	\$28.80
Texas	\$39.02
Oklahoma	\$39.43
Arkansas	\$29.57
Florida	\$37.99
Georgia	\$49.88
West Virginia	\$48.74

\$50-\$75:

Oregon	\$56.49
Nevada	\$62.78
Utah	\$70.91
Colorado	\$66.30
South Dakota	\$65.89
Nebraska	\$58.29
Iowa	\$73.70
Missouri	\$67.30
Kentucky	\$51.27
Illinois	\$66.12
Indiana	\$72.37
Ohio	\$62.03
South Carolina	\$67.18
North Carolina	\$50.26
Virginia	\$68.54
Louisiana	\$51.34
Alabama	\$60.95

\$75-\$100:

North Dakota	\$81.06
Washington	\$91.01
Wisconsin	\$90.98
Michigan	\$97.79
Kansas	\$75.22
Tennessee	\$87.22
Mississippi	\$93.49
Rhode Island	\$88.75
Delaware	\$81.40
Alaska	\$85.06

\$100-\$125:	
California	\$109.34
Montana	\$123.41
Wyoming	\$103.27
Minnesota	\$119.07
New Hampshire	\$117.14
Massachusetts	\$106.21

\$125+:	
Arizona	\$126.33
Maine	\$127.92
Vermont	\$152.35
Pennsylvania	\$195.01
New Jersey	\$125.60
Maryland	\$147.08
District of Columbia	\$414.08
Hawaii	\$125.38
New York	\$192.07
Connecticut	\$151.03

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