2022

The Grass is Greener on the Other Side of the Ocean: Adopting Foreign Reforms to Improve Mental Health Care in the United States

Sydney Schubert

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INTRODUCTION

The mental health care system in the United States lacks accessibility, affordability, and adequacy. Access to mental health care is restricted by the high costs and low insurance coverage, limited options and accessibility, lack of awareness of options, and negative associated social stigmas. Mental health disparities are displayed across a broad range of illnesses, socioeconomic statuses and regulations. The limitations and disparities that normally confront the American mental health care system, have been heightened in the wake of COVID-19. Negative mental health, suicide, and substance abuse rates have seen a significant increase since lockdowns began in 2020 and present a serious public health issue that requires redress. Despite the negative consequences of COVID-19, the virus has shed a necessary light on the shortcomings of the mental health care system in the United States.

This paper argues that the mental healthcare system in America must be updated and expanded, with a particular focus on community-based interventions, as seen in other countries. Community-based services will improve crucial areas of healthcare, including accessibility, affordability, quality, and social acceptability. These community-based services include community health centers and building stronger mental health care networks. Combating the issues in our mental healthcare system will require creative solutions that are more than just legal-based, but combine prioritization, education, availability, and affordability. Luxembourg is making waves in the global mental healthcare community with its positive education approach, and Germany is consistently a leader in mental healthcare practices providing financial support, access, outreach programs, and awareness campaigns.[1] Looking to the systems of foreign

[1] Sarah Fielding, *What America Can Learn from the Mental Health Care Systems of Other Countries*, Talk Space (Apr. 2020), https://www.talkspace.com/blog/america-mental-health-care-systems/.

countries will provide us with the creative solutions that are needed to have a genuine impact on mental health in our country.

The National Alliance on Mental Illness has reported that 20% of US adults experience mental illness each year.[2] Despite this number, only 46.2% of adults with mental illness received treatment in 2020.[3] Even more concerning, in 2020, 11% of adults with mental illness had no insurance coverage, 55% of US counties do not have any practicing psychiatrists, and 134 million people live in a designated Mental Health Professional Shortage area.[4] With suicide being the tenth leading cause of death in the US, and 46% of people who commit suicide being diagnosed with a mental health condition, the need for an effective mental healthcare system becomes apparent.

According to psychological autopsies taken of those who commit suicide, 90% of people had shown symptoms of a mental health condition prior to their death.[5] Since the current mental healthcare system is unable to curtail these suicides, despite the appearance of symptoms, changes to the system must be made. The first step in making these changes, is to normalize having conversations about mental health. Once we begin having these conversations, we can begin effectuating change in our own lives, and turn to our elected representatives to make those changes statewide, and even nationwide.

Part I of this paper will discuss the current mental healthcare system in the United States and elaborate on the importance of changing the system in the wake of COVID-19. Part I will also discuss the rise of telehealth as a mental health care service, government regulations that

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[2] National Alliance on Mental Illness (NAMI), *Mental Health by the Numbers* (Feb. 2022), https://www.nami.org/mhstats.
[3] *Id.*
[4] *Id.*
[5] *Id.*

attempt to address the issue of parity and coverage, and the role of mental health treatment in educational institutions. Part II of the paper will discuss the issues in our current system and analyze potential reforms to make our system more effective, by looking at the efficacy of systems in other countries.

I. Current US Mental Healthcare System

The US mental healthcare system has seen numerous reforms since the use of asylums to contain mental illness.[6] The National Mental Health Act in 1946 led the charge for deinstitutionalization by creating the National Institute of Mental Health and encouraging community care and use of psychotropic medications.[7] In 1954, New York passed the Community Mental Health Act, providing funding to outpatient clinics for patient therapy and medication, and other states followed suit.[8] In 1963, President Kennedy signed the Community Mental Health Act, offering $150 million in grants for states to build community mental health centers to provide inpatient and outpatient services, partial hospitalization, emergency services, and educational work.[9] However, due to the funding structure, many centers sent more serious patients back to the hospitals, and states focused on developing aftercare and clinics.[10] Finally, in 1981, President Regan signed the Omnibus Budget Reconciliation Act, repealing federal funding to the community mental health centers.[11]

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[6] Zeb Larson, *America's Long-Suffering Mental Health System*, Origins: Current Events in Historical Perspective (Apr. 2018), https://origins.osu.edu/article/americas-long-suffering-mental-health-system?language_content_entity=en.
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*

The community health centers in the US have failed to fulfill the promise of improving mental health care across the country. The Commonwealth Fund published results from a Commonwealth Fund National Survey of Federally Qualified Health Centers studying the challenges faced by community health centers.[12] The survey indicated that centers face staffing shortages, competition with retail clinics, and decreased funding.[13] Centers reported vacancies in budgeted positions for primary care physicians, registered nurses, and mental health providers.[14] The survey indicated that main center concerns included an increase in uncompensated care, a decrease in Medicaid funding, financial instability, continued staffing shortages, and stifled innovation.[15] The Robert Graham Center published a study reporting that 95% of health centers have at least one staff vacancy and highlighting a need for policy makers to support federal programs that create incentives and provide community-based care training.[16]

Despite the setback of President Regan's repeal, the mental healthcare system has made some rebounds. The Affordable Care Act of 2008 required insurance providers to treat mental and physical illness similarly, where patients can get healthcare coverage through insurance plans. However, different insurance carriers vary considerably in their coverage, the types of care offered, how many providers are in-network, and whether telehealth is covered. Congress also passed the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 in an attempt to

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[12] Corinne Lewis, et al., *Changes at Community Health Centers and How Patients are Benefiting*, The Commonwealth Fund, (Aug. 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/changes-at-community-health-centers-how-patients-are-benefiting.

[13] *Id*.

[14] *Id*.

[15] *Id*.

[16] Caitlin Crowley, et al., *High Demand, Low Supply: Health Centers and the Recruitment of Family Physicians*, Robert Graham Center (Jul. 2018), https://www.graham-center.org/publications-reports/publications/one-pagers/health-centers-recruitment-2018.html.

resolve the issue of parity between mental health care and physical health care. The Affordable Care Act and the MHPAEA are both discussed in further detail in the sections below.

Just as insurance carriers differ, so do mental healthcare providers and settings. Mental healthcare providers can range from mental health specialists to volunteer support group leaders.[17] Providers generally fall into the categories: highly trained providers, including psychiatrists, psychologists, and psychiatric nurses; generalists, such as family practitioners and nurse practitioners; social service providers; and informal volunteers.[18] Mental healthcare settings include hospitals, outpatient clinics, or informal venues.[19] Unfortunately, as previously discussed, in 2020, 11% of adults with mental illness had no insurance coverage and 134 million people live in a designated Mental Health Professional Shortage Area. [20] Mental Health Professional Shortage Areas are areas and population groups within the US that experience a shortage of health professionals.[21] The primary factor used to determine the shortage are designation is the number of health professionals relative to the population with consideration of high need.[22] In order to be considered a Mental Health Professional Shortage Area, the population-to-provider ratio must be at least 30,000 to 1.[23]

a. Mental Health and COVID-19

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[17] Ramya Sundararaman, *The U.S. Mental Health Delivery System Infrastructure: A Primer*, Congressional Research Service, Apr. 2009, at 5, https://sgp.fas.org/crs/misc/R40536.pdf.
[18] *Id.* at 6.
[19] *Id*.
[20] *See* NAMI, *supra* note 2.
[21] Kaiser Family Foundation, *Mental Health Care Health Professional Shortage Areas* (Sept. 30, 2021), https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[22] *Id*.
[23] *Id*.

In the world of COVID-19, an already significant lack of adequate mental healthcare is further exacerbated by the increase in those with mental health conditions and the decrease in access to proper care. The CDC reported that during June 24-30, 2020, there were significant increases in negative mental health, substance abuse, and suicidal ideation.[24] The report found that 40% of adults were experiencing mental health or substance abuse issues, 31% of adults were experiencing anxiety or depression, 13% of adults were experiencing new or increased substance use, and 11% of adults seriously considering suicide.[25] Statistics indicate that the prevalence of anxiety disorders in 2020 was 3 times that of 2019, depression was 4 times more prevalent in 2020 than in 2019, and suicidal ideation was 2 times more prevalent in 2020 than in 2019.[26] Young adults, essential workers, those with job loss, and those with preexisting psychiatric conditions were disproportionately affected by the pandemic, reporting larger increases in negative mental health, substance use, and suicidal ideation.[27] At the end of the report, the CDC recognized the significance and prevalence of this public health issue and called for increased intervention and prevention efforts.[28]

The World Psychiatric Association published a study that dug further into the increased suicide rates and hypothesized that excess suicide is attributable to the economic impact of the pandemic, based on projected unemployment rates.[29] In 2018, the annual suicide rate in the US

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[24] Mark E. Czeisler et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – United States, June 24-30, 2020*, Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report: Vol. 69: Iss. 32, 1049 (2020). https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] McIntyre & Lee, *Preventing Suicide in the Context of the COVID-19 Pandemic*, World Psychiatry Journal: Vol. 19: Iss. 2, 250 (2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7214950/.

was 14.8 per 100,000 people, making it a critical public health priority.[30] Suicide rates across the globe have been linked with rises in unemployment, and the rapid rise in unemployment and economic insecurity occurring during this pandemic will likely significantly increase the risk for suicide.[31] The study found that the major contributing factors to the rise in suicide rates are extreme and genuine uncertainty about the labor markets, financial uncertainty, decrease in consumer sentiment, and social isolation.[32] These contributing factors are extremely prevalent during this pandemic.

A multitude of studies have focused on the pandemic's impact on substance use and the implications for prevention and treatment. One study found substantial increase in substance abuse through the pandemic as an anxiety coping strategy.[33] Another study found that although social distance, isolation and quarantine are essential to prevent COVID-19 transmission, these strategies have been associated with negative emotions that are known to trigger relapse or intensify drug consumption.[34] Further, since the majority of medical efforts are aimed at battling COVID-19, assistance and treatment resources for substance abuse are limited.[35]

The pandemic has affected mental healthcare in settings that include outpatient, emergency room, inpatient units, consultation services, and the community.[36] As discussed

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[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] Steven Taylor et al., *Substance Use and Abuse, COVID-19-Related Distress, and Disregard for Social Distancing: A Network Analysis,* Addictive Behaviors Journal: Vol. 114: 106754 (2021). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8164919/.
[34] Felipe Ornell et al., *The COVID-19 Pandemic and its Impact on Substance Use: Implications for Prevention and Treatment,* Journal of Psychiatric Research: Vol. 289: 113096 (2020).
[35] *Id.*
[36] Ermal Bojdani et al., *COVID-19 Pandemic: Impact on Psychiatric Care in the United* States, Journal of Psychiatric Research: Vol. 289: 113069 (2020). https://www.sciencedirect.com/science/article/pii/S0165178120312269?via%3Dihub.

further below, in outpatient settings, there has been a temporary waiver of regulations around telehealth, allowing platforms to be used across state lines.[37] Community hospitals have embraced the telehealth method.[38] In emergency departments, psychiatric physicians are adapting to telehealth communications or in-person care using personal protective equipment.[39] The in-patient setting has proven difficult, as patients are normally exposed to other people and often participate in group activities.[40] Some facilities have banned visitors and group activities, or tightened admission criteria, particularly for those with substance use disorders.[41] Consultation services and those in the community have adopted hybrid processes with a focus on telehealth.[42]

b. Telehealth

COVID-19 has led to the prominence of telehealth as a major way of getting mental health care. Mandatory lockdowns, positive Covid tests, and fear have kept those in need of mental health care from having access to physical care. Telehealth has provided a way for those with mental health conditions to continue receiving help and treatment, despite the pandemic. Telehealth has become more common, particularly in community-based groups such as Alcoholics Anonymous and Opioid Treatment Program providers, offering patients take-home methadone for more frequent maintenance through the pandemic.[43] Telehealth psychological

[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] Ashley Abramson, *Substance Use During the Pandemic: Opioid and Stimulant Use is on the Rise – How can Psychologists and other Clinicians Help a Greater Number of Patients Struggling with Drug Use?*, American Psychological Association: Vol. 52: No. 2, 22 (2021), https://www.apa.org/monitor/2021/03/substance-use-pandemic.

treatment can assist those with substance abuse disorders adhere to medication schedules, identify and respond to stressors, and address pain, stress, anxiety, and depression.[44]

The Centers for Medicare & Medicaid Services (CMS) issued temporary measures for patients in federally funded plans to allow for greater use of telehealth through the pandemic, including conducting telehealth with patients located in their homes, practicing remote care across state lines, delivering care to both established and new patients through telehealth, and billing for telehealth services as if they were provided in person.[45] CMS expanded telehealth services to Federally Qualified Health Centers and Rural Health Clinics, emergency department visits, home visits, and therapy services.[46] CMS has encouraged health insurance issuers to increase coverage of telehealth services by expanding access to telehealth without cost sharing, including mental health and substance abuse disorder telehealth services, and informing beneficiaries of the availability and accessibility.[47]

The Department of Health & Human Services (HHS) has also taken steps to make it easier to provide telehealth services – using technology for two-way communications for health care services.[48] HHS has encouraged telehealth for routine health care, wellness visits, medication consultation, nutrition counseling, and mental health counseling.[49] HIPAA-covered health care providers may provide telehealth services using application that may not fully

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[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] Centers for Medicare & Medicaid Services, *FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19)* (Mar. 2020), https://www.cms.gov/files/document/faqs-telehealth-covid-19.pdf.
[48] U.S. Department of Health & Human Services, *Telehealth: Delivering Care Safely During COVID-19* (Dec. 2021), https://www.hhs.gov/coronavirus/telehealth/index.html.
[49] *Id.*

comply with HIPAA rules.[50] Although privacy concerns are increased when using technology to receive health care services, these concerns do not diminish the importance of utilizing the telehealth system during a time where access to typical health care services is so limited. Videoconferencing, text-messaging, and e-mails have proven to be beneficial communication approaches for delivering mental health services to those with stress, depression, anxiety, and post-traumatic stress disorder.[51] Although telehealth became crucial during the pandemic, telehealth should continue to expand post-pandemic. It is imperative that telehealth is normalized, adapted, and perfected to best serve those with mental health conditions who struggle to access physical care.

c. Further Government Regulations

One of the most cited problems with the US mental healthcare system is the issue of parity, with commentators arguing that insurance coverage for mental health conditions and substance abuse disorders should be covered equally to any other medical condition. In an attempt to regulate the disparity, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, preventing group health plans and insurance issuers from imposing less favorable benefit limitations on mental health and substance disorders (MH/SUD) than medical and surgical benefits.[52] The MHPAEA applies to group health plans, group health insurance coverage, and individual health insurance coverage.[53] The Act provides that issuers cannot

[50] *Id*.
[51] Mehran Idris Khan et al., *Novel Coronavirus and Emerging Mental Health Issues – A Timely Analysis of Potential Consequences and Legal Policies Perspective,* Fudan Journal of the Humanities and Social Sciences: Vol. 14, 87 (2021), https://link.springer.com/article/10.1007/s40647-020-00313-3#citeas.
[52] Centers for Medicare & Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (Nov. 2013), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.
[53] *Id*.

impose dollar limits on MH/SUD benefits that are lower than medical benefit limitations and that financial requirements and treatment limitations must match those for medical benefits. The Act also provides that benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to the MH/SUD benefits and that out-of-network benefits must be the same for MH/SUD and medical benefits. The Act further provides that the standards for medical necessity determinations and reasons for any denial of benefits must be disclosed upon request.[54]

The MHPAEA has limitations that prevent the law from truly resolving the parity issue. The Act provides for numerous exceptions, does not require large group health plans or insurance issuers to cover MH/SUD benefits, and applies only to those who choose to cover those benefits.[55] In 2019, Milliman released a study evaluating whether true parity had been reached, concluding that it had not.[56] The study found significant disparities in 2017, where behavioral health care providers were 5.2 times more likely than their medical counterparts to see a patient who was out of network. These out-of-network behavioral health office visits were 5.4 times more likely compared to metical or primary care visits, and reimbursement rates for primary care office visits were more than 50% higher than those for behavioral health visits in 11 states and 30%-49% higher in an additional 13 states.[57] These statistics indicate that despite the legislation, parity between MH/SUD healthcare and medical healthcare does not truly exist and must further be addressed.

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[54] *Id*.
[55] *Id*.
[56] Davenport, Gray, & Melek, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, Milliman (Nov. 2019), https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p.
[57] *Id*.

The Affordable Care Act built on the MHPAEA by requiring coverage of mental health and substance use disorder services as one of ten Essential Health Benefit categories.[58] Essential Health Benefits are items and services in listed categories that are based on state-specific benchmark plans.[59] The Affordable Care Act resulted in 20 million people gaining insurance coverage, decreasing the number of people living without mental healthcare by about one third.[60] The Affordable Care Act expanded eligibility for Medicaid, provided some limits on deductibles and co-pays, required marketplace plans to cover those with mental health conditions and substance use disorders, required individual and small group plans to cover these services and prescription drugs, and expanded the MHPAEA to individual and small group plans.[61]

The expanded Medicaid eligibility is a large step towards increasing coverage for those with mental health conditions, a crucial aspect of having an effective mental healthcare system. Medicaid is the single largest payer for mental health services in the US and is required to comply with MHPAEA requirements.[62] Medicare Part B helps pay for outpatient mental health services, including group psychotherapy, family counseling, testing, psychiatric evaluation, medication management, partial hospitalization, and a yearly wellness visit.[63] Medicare covers

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[58] National Alliance on Mental Illness (NAMI), *What the Affordable Care Act has Meant for People with Mental Health Conditions – And What Could be Lost*, (Nov. 2020), at 4, https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/What-the-Affordable-Care-Act-Has-Meant-for-People-with-Mental-Health-Conditions-What-Could-Be-Lost/NAMI_IssueBrief_ACA_11-10-20.

[59] Centers for Medicare & Medicaid Services, *Information on Essential Health Benefits Benchmark Plans*, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb#overview.

[60] *See* NAMI, *supra* note 58, at 2.

[61] *Id*. at 2-4.

[62] Medicaid, *Behavioral Health Services*, https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

[63] Medicare, *Mental Health Care (Outpatient)*, https://www.medicare.gov/coverage/mental-health-care-outpatient.

the cost for yearly depression screenings and 80% of costs for diagnostic visits.[64] However, participants may have a co-payment for outpatient clinics or hospital departments.[65]

Further legislation has been passed since the beginning of the pandemic focusing on increasing monetary spending on improving mental health care. In March 2020, the Coronavirus Aid Relief and Economic Security Act (CARES) included $425 million for the Substance Abuse and Mental Health Services Administration, indicating that $250 million should go to Certified Community Behavioral Health Clinics, $50 million for suicide prevention programs, $100 million for emergency-response spending, and $15 million for tribal communities.[66] Further, in December 2020, the Consolidated Appropriations Act included $4.25 billion for mental health and substance abuse disorders, which increased to $6 billion in 2021, with $35 million for a crisis care initiative, $179 million expanding services for mental health in children, $45 million for suicide prevention, $3.8 billion for substance abuse treatment, and $208 million for substance abuse prevention.[67] The CARES Act also included $19.6 billion to the Department of Veterans Affairs, including expanding mental health services delivered via telehealth for case managers and homeless veterans.[68] These regulations are steps in the right direction, but reform must continue.

d. Mental Health and Education

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[64] *Id*.
[65] *Id*.
[66] National Alliance on Mental Illness (NAMI), *Information on the CARES Act for People with Mental Illness* (Mar. 2020), https://www.nami.org/About-NAMI/NAMI-News/2020/Information-on-the-CARES-Act-for-People-with-Mental-Illness.
[67] Consolidated Appropriations Act, *Health and Human Services Appropriations Provisions Summary* (2021), https://www.ncsl.org/Portals/1/Documents/Health/Health_and_Human_Services_Appropriations_Provisions_Summary_FINAL.pdf.
[68] *Id*.

According to the National alliance on Mental Illness (NAMI), 1in 6 youth aged 6-17 experience a mental health disorder each year.[69] NAMI also reports that 50% of all mental health conditions begin by age 14 and 75% of all mental health conditions begin by age 24.[70] Despite these significant percentages, only about 50% of youth with mental health conditions receive any kind of treatment each year.[71] In 2019, 15% of adolescents aged 12-17 reported receiving mental health services at school.[72] Delays in treatment can lead to worsened conditions that are harder and costlier to treat, indicating the importance of early intervention.[73] Schools can play a key role in identifying and helping youth early on, due to a unique setting for early identification, prevention, and interventions that serve students where they already are.[74] Mental health care in schools can remove significant barriers to seeking treatment, such as transportation, scheduling, and social stigma.[75] It is important that school policies reduce these barriers and increase equitable access to effective treatment.[76]

It has been well documented that the child mental health system does not fully address the mental health needs of children and adolescents in the US, pointing to a need to reconsider current policy and practice.[77] An important article published by Psychiatry Online argued that a lack of clear direction to guide reforms contributes to the inadequacy of youth mental health

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[69] National Alliance on Mental Illness, *Mental Health in Schools,* https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-in-Schools.
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] Sharon Hoover Stephan et al., *Transformation of Children's Mental Health Services: The Role of School Mental Health*, Psychiatric Services: Vol. 58: Iss. 10, 1330 (2007), https://ps.psychiatryonline.org/doi/full/10.1176/ps.2007.58.10.1330.

care.[78] In 2002, President Bush established the President's New Freedom Commission on Mental Health to analyze the state of the country's mental health system and make reform recommendations.[79] The article addressed the commission's recommendations and how those recommendations align with school goals for improving mental health care systems.[80] The Commission recognized that mental health services in schools are a critical component in rebuilding the mental health system for youths and the goals of the Commission were consistent with the goals of most school mental health programs.[81] The American Academy of Pediatrics released a statement recognizing the importance of school mental health systems, and advocates for effective collaboration between educators, primary health care providers, and mental health professionals in implementing high-quality school-based mental health services.[82]

The President's Commission concluded that there are barriers to care, including gaps in care and lack of a national priority, and articulated recommendations for the improvement of mental health systems.[83] These recommendations included addressing mental health with the same urgency as physical health, developing an individualized plan of care for every child with a serious emotional disturbance, promoting the mental health of young children, and improving and expanding school mental health programs.[84] The Commission's report specified four recommendations that would have the most proximal connection to school mental health: reduce stigma, prevent suicide, screen and treat comorbid mental and substance use disorders, and

[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*

improve and expand school mental health programs.[85] These four recommendations are discussed in further detail in subsequent paragraphs.

The first Commission recommendation was to reduce social stigma in schools.[86] The Commission advocated for implementation of a national campaign to reduce stigmas surrounding seeking care for mental health conditions.[87] The report argued that integration of mental health awareness into education curricula would also help to reduce stigma.[88] The Commission further argued that with appropriate training and community support, school staff would be able to normalize mental illness, convey positive messaging about mental health, and encourage students to engage in activities that promote mental wellbeing.[89] The article argues that schools should implement programs on social and emotional learning, prevention programs, and specialized interventions.[90] Schools offer a natural environment to reduce stigma because of their ties to children, families, and communities and can be a great source of information about mental health and available community services.[91]

The second Commission recommendation was for schools to increase focus on preventing suicide, arguing that schools are a critical venue for developing and executing both formal and informal suicide prevention strategies.[92] A 2003 Youth Risk Behavior Survey of over 15,000 high-school students indicated that in the year preceding the survey, 16.9% of high-school students had seriously considered attempting suicide, 16.5% of high-school students had

[85] *Id.*
[86] *Id.*
[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *Id.*

made a plan to commit suicide, 8.5% of high-school students had attempted suicide at least once, and 2.9% of high-school students had made a suicide attempt that required medical attention.[93] It has been reported that over 60% of adolescents that committed suicide had a mental health condition that existed for a year or more before the suicide.[94] The US Department of Health and Human Services issued the National Strategy for Suicide Prevention and called on schools to play a significant role in attempting to prevent suicide.[95] Schools were encouraged to collaborate with other agencies, increase prevention programs, train key school personnel to identify at-risk students, and develop effective screening programs.[96]

The third Commission recommendation was to screen and treat comorbid mental conditions and substance abuse disorders.[97] 50% of adolescents have tried an illicit drug by the time they graduate from high-school and of youth identified as having substance use disorders, it is estimate that up to 75% may have comorbid mental health disorders.[98] Substance use services are often not well integrated into the mental health service programs in schools.[99] Similarly, most communities do not have the capacity to address youth substance abuse due to stigma, lack of resources, and limited evidence-based approaches. Many school and community providers are unprepared to address comorbid mental health conditions and substance use disorders due to a lack of training and support.[100] Schools have the potential to implement effective screening programs for comorbid health problems due to providers' ability to easily reach students.[101] It

[93] *Id.*
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] *Id.*
[100] *Id.*
[101] *Id.*

has been shown that when substance abuse prevention activities are implemented in schools, positive outcomes include delayed initiation of use, decreased frequency of use, and slowed or arrested progression to the use of more extreme substances.[102]

The fourth Commission recommendation was to improve and expand mental health programs in schools.[103] The Commission argued that when detection, prevention, and early intervention services for youths are provided in school contexts, negative consequences such as school failure and comorbid substance abuse can be prevented.[104] The report encouraged coordinating school service approaches that integrate assessment, on-campus prevention services, early intervention programs, and more intensive services.[105] According to the National Institute of Mental Health, research advances in the development of effective mental health treatments for children have made minimal translation into community and school settings.[106] Lack of federal funding has been named as a significant factor in schools lacking resources to offer quality mental health services and address individual students' needs.[107] The majority of schools offer some level of mental health services, but these services are not sufficient to meet the needs of students.[108]

The Psychiatry Online article encouraged collaboration between school mental health providers and the community and argued that more research is needed for effective reform.[109] Most educational reform focuses on test score and grades, with no attention to mental health.[110]

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[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] *Id.*
[108] *Id.*
[109] *Id.*
[110] *Id.*

Although the Commission identified important issues that required change, it did not detail how those changes should be implemented or how those changes would be funded.[111] Systemic change is challenging due to limited resources and a common resistance to change, but reforms are necessary. The youth mental health system is inadequate and must be improved through reforms with clear goals and detailed procedures.

II. Potential Reforms

The current US mental healthcare system has evolved significantly throughout the years and has made important progress towards true parity and accessibility for those with mental health conditions and substance abuse disorders. However, the system requires further evolution before it can be considered effective. Mental healthcare must be made more available, accessible, and affordable. There needs to be a focus on expanding coverage, as well as parity between mental health care and physical health care; mental health services should be as affordable and accessible as medical services. Current regulations have attempted to resolve coverage and affordability issues but should be expanded to fill the gaps that have arisen. The main issues facing the mental healthcare system are properly distributing funds, lack of accessibility, high costs, and social stigmas.

A study by the National Council for Mental Wellbeing and the Cohen Veterans Network found that lack of access is the primary cause for the mental health crisis in the US.[112] The study revealed that the high cost of health care and insufficient insurance coverage played a key role in

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[111] *Id.*

[112] Paul Wood et al., *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, National Council for Mental Wellbeing (Oct. 2018), https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/.

people choosing not to seek care.[113] Those who sought treatment reported having limited options and long waits, with some waiting longer than a week and driving over an hour for treatment.[114] Despite the rise of telehealth, many have a lack of awareness of this option.[115] Finally, many people who chose not to seek mental health care also reported being deterred from seeking care due to the social stigma behind mental health.[116]

Another study looked at the reasons behind inaccessibility of mental health care and found that there is a significant shortage of human resources for mental health.[117] Evidence suggests that mental health care can be delivered effectively in primary health-care settings, through community-based programs, and task-shifting approaches.[118] Task-shifting refers to delegating tasks to those with less or narrowly tailored training, including employing health care providers in different sectors and intersectoral collaboration.[119] This task-shifting provides more resources for the help needed, as well as allows for lowering costs that would be associated with using specialists for all aspects of mental health care.[120] The study also encourages self-help and mutual aid initiatives as support for those using mental health services.[121] Essential to the strengthening of human resources is the development and education of the workforce, by increasing training for both specialized and non-specialized workers.[122] By looking at successful

[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] Ditsuko Kakuma et al., *Human Resources for Mental Health Care: Current Situation and Strategies for Action*, The Lancet: Vol. 378: Iss. 9803, 5 (2011), https://www.sciencedirect.com/science/article/pii/S0140673611610933.
[118] *Id.*
[119] *Id.*
[120] *Id.*
[121] *Id.*
[122] *Id.*

reforms in other countries, the US can adopt such reforms and improve its own mental healthcare system.

a. Foreign Reforms

Many countries focus on community-based services and evidence-based interventions, and these systems can be incorporated more heavily in the US to expand access to mental health care services. The World Health Organization has proposed community-based care and integrating mental health services into primary health care.[123] A study focusing on community-based interventions in Africa found that a critical component of success under this model is the appropriate supervision and continuing education for primary care workers.[124] The study discusses the success of community-based services, including, down-sizing mental hospitals, establishing psychiatric units in general hospitals and formation of community-based mental health teams composed of psychiatrists, nurses, social workers, and others.[125]

Latin American and Caribbean countries have also successfully shifted towards community-based mental health care systems. In 1990, at the Regional Conference for the restructuring of Psychiatric Care in Latin America, the Pan American Health Organization issued the Caracas Declaration.[126] The Caracas Declaration is a reform process in this region that calls for integration of mental health into primary care, shifting from hospital-based care to

[123] Atalay Alem et al., *Community-Based Mental Health Care in Africa: Mental Health Workers' Views*, World Psychiatry: Vol. 7: Iss. 1, 54 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2327237/.
[124] *Id.*
[125] *Id.*
[126] Caldas de Almeida & Horvitz-Lennon, *Mental Health Care Reforms in Latin America: An Overview of Mental Health Care Reforms in Latin America and the Caribbean*, Psychiatric Services: Vol. 61: Iss. 3, 218 (2010), https://ps.psychiatryonline.org/doi/full/10.1176/ps.2010.61.3.218.

community-based care, and protection of the human rights of people with mental disabilities.[127] Countries, including Brazil, Cuba, Chile, El Salvador, Nicaragua, Guatemala, and Panama have developed community-based services focusing on downsizing hospital services, integrating primary care, and promoting health and prevention.[128]

Cuban reform integrated mental health and primary health care at a national level and determined that a critical factor in successful integration was the existence of a detailed plan that assisted in the development of new community facilities, creation of specific mental health programs, and training of mental health professionals.[129] Chilean reform expanded access to mental care through the development of mental health expertise at the primary care level, creating a national network of community mental health centers staffed with teams of mental health professionals.[130] Argentina made reforms at the state level, replacing psychiatric hospitals with psychiatric beds in general hospitals and a network of community-based services that include mental health centers and psychosocial rehabilitation programs.[131] The above reforms have led to important progress in the mental health care systems in these countries, but more reforms must be done to increase the quality of mental health care and to ensure equitable distribution.[132]

Switzerland provides one of the strongest and most comprehensive mental health care systems in the world, utilizing a universal healthcare system. In Switzerland, independent health insurance companies compete on price and services covered but abide by a comprehensive

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[127] *Id.*
[128] *Id.*
[129] *Id.*
[130] *Id.*
[131] *Id.*
[132] *Id.*

package of essential minimum benefits, including mental health and substance abuse services.[133] The government uses a collective bargaining power and national reimbursement schedule to keep costs in check while providing coverage to all citizens.[134] Residents can choose from a multitude of insurance companies that are all regulating by the government, who negotiates reimbursement rates with the companies.[135] The Swiss model involves a high density of psychiatric inpatient facilities and mental health care providers, while maintaining affordable health care.[136]

Mental health education is another key aspect of improving the mental health care system. Focusing on mental health in schools provides both a natural and formal opportunity for reducing stigmas surrounding mental health.[137] Through training and community support, school programs on mental health can lead to normalization of mental health discussions and shift the focus from reducing mental illness to promoting mental well-being.[138] An article published by the American Psychiatric Association suggests that schools should improve and expand mental health programs to integrate assessments with on-campus prevention services, early intervention programs, and systems of care.[139] The shared family-school-community agenda is evidence by strong family and youth leadership, and collaboration between the education system and the child mental health system should be used in creating school programs aimed at mental health education.[140]

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[133] Schneeberger & Schwartz, *The Swiss Mental Health Care System*, Psychiatry Services: Vol. 69: Iss. 2, 126 (2018), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700412.
[134] *Id.*
[135] *Id.*
[136] *Id.*
[137] *See* Hoover Stephan, *supra* note 77.
[138] *Id.*
[139] *Id.*
[140] *Id.*

Luxembourg provides a strong example of successful school programs surrounding mental health. Luxembourg encourages mental health awareness through an educational approach called Positive Education.[141] Positive Education combines well-being with achievement skills and life skills by providing adolescents with psychosocial support in school and community settings.[142] The programs are delivered in schools as a preventative strategy against depression and anxiety, while supporting self-esteem, emotion regulation, empathy, and self-efficacy.[143] Positive Education combines academic learning, character building, and well-being by teaching skills such as grit, optimism, resilience, growth mindset, engagement, and mindfulness.[144] Although interpretations of Positive Education vary amongst schools and countries, these programs have seen overwhelming success in countries like Luxembourg, Australia, Singapore, and South Korea.[145]

b. Proposed Solutions

In analyzing the above reforms, I have narrowed in on four key aspects to improving the mental health care system in the United States. The first step in making effective reform is to increase prioritization of mental health care. Political leaders, mental health practitioners, and the community at large must encourage policy makers to continue the legislative path towards parity between mental health and physical health. One significant aspect of improving policies is to adopt the Swiss method and regulate private insurance, regulate reimbursement rates, and require

[141] David Bott et al., *The State of Positive Education*, World Government Summit (2017), https://www.worldgovernmentsummit.org/api/publications/document/8f647dc4-e97c-6578-b2f8-ff0000a7ddb6.
[142] *Id.*
[143] *Id.*
[144] *Id.*
[145] *Id.*

minimum services to be covered by every policy.[146] Although the Affordable Care act largely ensures insurability, it does not close the disparities in the quality of policies. The Swiss method of regulation and minimal requirements would close the parity gap between not just mental health and physical health, but also among different mental healthcare options.[147]

The second step in making effective reform is to increase education on mental health and to begin this education as early as possible. Through school programs, such as the Positive Education in Luxembourg, adolescents can normalize talking about and seeking mental health care, as well as learn about available options for support and treatment.[148] The reforms suggested by the President's Commission provide insight into the specific issues that educational reforms should address.[149] Education must also continue into the training of primary practitioners and continuing education for both specialists and general healthcare workers. As seen in Africa and Latin America, educating general practitioners on mental health care is crucial for increasing the quality and availability of mental health care.[150]

The third step in making effective reform is to make mental health care more available through task-shifting, collaboration with primary care, building community centers, and telehealth. Task-shifting and collaboration with primary care practitioners creates availability by increasing the number of providers available to provide mental health care services. Collaborating with primary care facilities also increases availability by increasing the settings available to seek mental health care services. Argentina provides an example of reducing

[146] *See* Schneeberger & Schwartz, *supra* note 133.
[147] *Id.*
[148] *See* Bott, *supra* note 141.
[149] *See* Hoover Stephan, *supra* note 77.
[150] *See* Alem, *supra* note 123; *See* Caldas de Almeida & Horvitz-Lennon, *supra* note 126.

psychiatric hospitals to psychiatric beds in general hospitals.[151] Community-based mental health care is perhaps the most important reform to implement in our current system. The countries discussed above found that building more community centers and programs provided greater access to mental health care while also improving the quality of the care.[152] Building community mental health care centers should be a prime focus in mental health care reforms. Telehealth is an emerging method for increasing availability to mental health care and should continue to be a common and accessible resource for those seeking mental health care.

The final step in making effective reform is to make mental health care more affordable, through regulating reimbursement rates and utilizing sliding-scale payments. Although not discussed above, sliding-scale payments are commonplace in other aspects of business, and would allow providers to offer services at different costs based on income, to ensure that everyone can afford the care that they need. Providers would be able to modify the costs of their services to make mental health care more affordable to all who are in need. The Swiss method of regulating private insurance serves as an example of successfully regulating reimbursement rates to align health care costs with the cost of the actual services provided and make costs more consistent.[153] Similarly, by requiring coverage of certain minimal services, insurance beneficiaries can be sure that those services will be covered by their insurance and their out-of-pocket costs will be reduced.[154]

The four key aspects of reform discussed above provide a system of mental health care that utilizes knowledge and experience from other countries to create a more comprehensive,

[151] *See* Caldas de Almeida & Horvitz-Lennon, *supra* note 126.
[152] *Id.*
[153] *See* Schneeberget & Schwartz, *supra* note 133.
[154] *Id.*

accessible, affordable, and effective mental health care system in our country. A system that incorporates these lessons will both address and redress the stated barriers to seeking mental health care services by those in need.

CONCLUSION

The current mental health care system in the United States suffers from lack of availability, accessibility, affordability, and effectiveness. Those in need of mental health care have cited high costs or care and insufficient insurance coverage, limited options and long waits, lack of awareness of care options, and social stigmas as deterrent factors in seeking mental health care services. I propose that the solutions to these problems lie in increasing prioritization of legislative action furthering mental health care parity and regulating private insurance; increasing education through Positive Education in adolescents and continuing education in both mental health and general practitioners; increasing availability of mental health care services through primary care collaboration and building community centers, as well as the continued utilization of telehealth; and increasing affordability through regulating reimbursement rates and using sliding-scale payments. Using these four goals to guide reforms, we can greatly improve the mental health care system in the United States.