Confronting Economic, Social, and Legal Obstacles to Mental Health Equity in America

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Abstract

This paper investigates the economic, social, and legal barriers that undermine mental health equity in the United States. Economic challenges include the high and often prohibitive costs of care, inadequate insurance coverage, and insufficient investment in mental health research and pharmaceutical innovation. Social impediments involve disparities in school-based mental health services, cultural stigmas that discourage help-seeking, and language barriers that limit effective communication and treatment. Legal and political factors further restrict access through inconsistent state laws, the use of executive power in shaping mental health policy, and the lasting impact of institutionalization practices. Drawing on diverse perspectives, the authors examine the historical and structural roots of these obstacles and offer evidence-based recommendations to address them. Proposed solutions include strengthening parity enforcement, expanding culturally competent care, improving funding for community-based services, and reforming policies to remove systemic barriers. Together, these approaches aim to advance a more equitable and accessible mental health care system for all.

Introduction

Mental health equity is not simply a matter of increasing the number of therapists or clinics. It is a complex challenge shaped by the ways our economic systems, social structures, and legal frameworks interact to either support or restrict access to care. For many Americans, these forces create barriers that make mental health treatment difficult to get, uneven in quality, or entirely out of reach.

As part of the Teen Think Tank Project, the Mental Health Equity Research Cohort set out to explore these barriers in depth. Our approach was to look at the problem from three critical angles: economic, social, and legal impediments. Economic factors often dictate whether a person can afford treatment, whether through insurance limitations, out-of-pocket costs, or the uneven distribution of mental health resources. Social factors, such as stigma, discrimination, and the way communities talk (or do not talk) about mental health—can determine whether individuals seek help in the first place. Legal issues, from gaps in mental health parity enforcement to policies that unintentionally exclude vulnerable populations, add another layer of restriction.

The ten research papers in this collection each examine a different aspect of these challenges. Some focus on the economic realities that shape access to care, others on the social climate that influences attitudes toward mental health, and still others on the legal frameworks that can both protect and limit patients' rights. While each paper stands alone in its findings and recommendations, together they tell a broader story about the state of mental health equity in America—and about what it will take to make lasting change.

Economic Impediments to Mental Health Equity

Access to mental health care in the United States is often determined less by the severity of a person's condition than by their ability to pay for treatment. While one in five Americans experiences some form of mental illness each year, only about half receive care—and the reasons are deeply rooted in economics, not in a lack of awareness or concern. Mental health treatment is rarely a one-time cost; it is often a lifelong process involving medication, therapy, and ongoing monitoring. For many, this translates into a permanent and usually unaffordable financial burden.

The structure of the U.S. healthcare system compounds these challenges. As mental health care has become entangled in a profit-driven insurance model, coverage gaps, high deductibles, and restrictive provider networks prevent millions from accessing necessary services. Even for those with insurance, limitations such as prior authorization requirements, "fail-first" therapy mandates, and lower reimbursement rates for mental health providers reduce the availability and quality of care.

These economic barriers are reinforced by the high cost of developing new treatments. The pharmaceutical industry, while enormously profitable, invests relatively little in mental health research compared to other medical fields. Innovation has stagnated, with many current psychiatric medications functioning much as they did decades ago. The reluctance to invest in more effective treatments reflects a broader pattern in which financial considerations outweigh patient need.

Understanding these economic realities is critical to building a more equitable mental health system. Without addressing the profit incentives that drive insurance and pharmaceutical practices, millions will continue to be priced out of the care they need, deepening disparities and worsening public health outcomes.

The Profitization of Healthcare Negatively Affects Our Mental Health

Based on a 2022 study, 20% of the US population has some sort of mental illness, but only 10% get treated. (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). The immediate response to hearing this news may be confusion. The statistics might suggest that the treatment does not matter. It can also make it seem like once the diagnosis is gained, some individuals stop caring about their mental health. But, the reason that half of all those who have mental illness has to do with the economics of mental health care, not with a lack of concern or awareness.

There is no magic pill to delete schizophrenia, or depression, or any mental illness. Treatment tends to be lifelong, and recovery is not linear. Some days will be more complex than others, not all medications will be the same, and not all forms of therapy will be effective. With this lifelong illness comes a permanent bill. A bill that not everyone can afford, which makes this confusing statistic a depressing reality.

The consistently high cost of mental health care is a significant reason why many people who seek help are ultimately unable to access the resources they need. This paper explores how the U.S. healthcare system evolved into a profit-driven model, the specific obstacles it creates for those seeking mental health care, and potential reforms that could address these systemic failures.

Historic Background. To gain the best possible insight into how for-profit healthcare models harm people, it is essential to understand how the United States arrived at this position. In 1912, Teddy Roosevelt began advocating for certain types of insurance, including social and health insurance. (Smith, 1)

In 1927, the Committee on the Costs of Medical Care was established to investigate the economic aspects of healthcare. (Smith, 2). They had endorsed ideas of voluntary health insurance, such as dental and life insurance, which were not considered employee benefits at the time. During the Great Depression, FDR worked on multiple policies, including Social Security and employment policies; however, outside of childcare and healthcare, these areas were largely overlooked. In 1938, plans to create a National Health Bill were drafted, but they did not progress far, although early Blue Shield plans were developed.

In 1946, the Hill Burton Act was passed, which “prohibited discrimination of medical services based on race, religion, or national origin. It required hospitals to provide a 'reasonable volume' of charitable care and allowed for 'separate but equal' facilities.” (Smith, 3.) This ensured that anyone, regardless of race, could access proper healthcare. Yet, the separate but equal clause ensured that even though everyone was entitled to treatment, the quality of these separate facilities was significantly different.

In 1956, the military began covering the health insurance of active military members, allowing individuals to join the army and receive coverage for their physical health. Still, too many mental issues can lead to being kicked from the military. So many with mental diseases lose this opportunity for free healthcare.

In the 1960s, private healthcare plans began setting premium rates and basing prices on an individual’s experience with varying health costs. (Smith, 5). This made it difficult for people with disabilities and older people to find coverage they could afford. Medicaid and Medicare were enacted in 1965, providing lower-income families with access to insurance and healthcare.

In 1972, social security reforms allowed those with long-term disabilities and terminal illnesses to start collecting payments. (Smith, 7). Then in 1981, significant Medicaid reforms were put in placeed to curb government spending. This significantly lowered the number of people Medicaid could reach. In turn, this budget cut cost thousands of people their benefits, making it that much harder for people to access mental health support.

By 1987, 31 million people were uninsured. (Smith, 8). HIPAA was formed in 1996, which restricted insurance companies from using preexisting conditions as a basis for denying coverage to patients. The Personal Responsibility and Work Opportunity Act severed the link between cash assistance and Medicaid and prohibited legal immigrants from receiving insurance coverage.

In 2009, $634 billion was allocated to health reform funds, and the following year, the Affordable Care Act was enacted. It also led to the requirement that companies provide employees with health insurance, which ended in 2016. In 2023, 7.7% of the population is uninsured, whether they are in a state that has not expanded Medicaid or cannot qualify for Marketplace subsidies. (Smith, 9). Every budget cut or law that increases the cost of insurance access makes it harder for individuals to get the mental care they may need.

Health insurance is designed to provide comprehensive care for a person's physical and psychological well-being. When insurance companies are given the easy opportunity to ignore claims and refuse treatment plans they deem unnecessary, this leads people into harm's way due to their limited options. With so many mental illnesses being invisible until they become too difficult to live with, it allows companies to ignore claims until they get too severe.

So when insurance stops becoming cheap and the people's health is simply neglected to make a profit, many individuals are forced to deal with high deductibles and less comprehensive plans, which puts those with chronic mental conditions in harm’s way. Many Americans find themselves in an uncomfortable position when trying to prioritize their physical health. So, the question now becomes, how does this affect their mental healthcare?

The Ineffectiveness of Insurance Coverage. The short answer is that a lack of reliable insurance leads to a lot of mental health issues being ignored. Yet it is essential to understand why. It has already been established that 7.7%, or 25 million people, are uninsured. These people are required to pay high prices to be able to receive mental healthcare. This care can be up to $500 for the first visit alone.

For those with health insurance, statistics find that "Roughly two-thirds of Americans with a diagnosed mental health condition were unable to access treatment in 2021, though they had health insurance. Only a third of insured people who visited an emergency department or hospital during a mental health crisis received follow-up care." (Chatterjee, 1). Many private insurance companies simply do not see mental health care as a necessary cost.

Fine print within insurance companies can lead to claims being denied due to specific factors. One significant issue is the lack of an in-network provider nearby. Some plans force you to try cheap drugs and methods of therapy before moving on. These methods can be ineffective and lead to some people's situations becoming significantly worse. It is also possible for people not to meet the requirements for insurance payment. Forcing clients to wait for insurance to change their mind, not get treated, or pay out of pocket.

Another issue is that while some people do pay for insurance, many do not see mental health care as a priority, so they do not get it covered. Often, the realization that care is needed can come too late due to a lack of information and not recognizing the issue immediately. After all, not everyone deals with mental health in the same way, or has the same problems; it is possible to go your whole life suffering, never realizing there is a deeper issue.

So, even with insurance, many aren't truly covered, and even when they are, the cost for constant treatment to keep a person at a constantly manageable level is expensive. As a result, profit-driven insurance companies avoid covering essential mental health services, while those who need care the most are unable to afford it.

Solutions. Acknowledging there are issues is not enough. Without action, this becomes more than just critique; it reflects a system where profit is prioritized over human well-being, leaving vulnerable people behind. Finding solutions is already challenging, but actually put in placeing them nationwide is even more difficult. As this essay has already shown, past efforts at healthcare reform have repeatedly been stalled or reversed due to political resistance and systemic inertia.

One such solution, however, can be found in countries like Sweden, which is regarded as having one of the best mental healthcare systems in the world, alongside other European countries such as Germany and Finland. A key feature of these countries is that they all offer universal healthcare. Sweden, in particular, provides a strong example of how universal access can improve outcomes.

Critics of universal healthcare argue that uniform tax rates are inequitable. Yet, more people actually save money by paying higher taxes than by individually covering healthcare costs. While it may take a little longer for appointments and personal care to be received, wait times can still be considerable even for those who pay for private healthcare. Emergency services, however, remain available at a fast and reliable pace in both systems.

Sweden also offers an incredible work-life balance, along with integrated mental healthcare within its broader healthcare system, with a strong focus on early intervention. By removing profit incentives and focusing more on people, Sweden has developed one of the healthiest populations in terms of mental well-being.

Of course, someone still has to foot the bill. In Sweden's case, the government pays for the care of its people, an idea many in the United States reject as government overreach. But, the U.S. does not need to copy other models outright. Implementing change of any kind will require long-term investments in time and money. Still, even a gradual shift toward a more accessible and equitable system could dramatically improve outcomes. Full-scale reform may take time, but the potential to create a more humane and just healthcare system makes the effort worthwhile.

Conclusion. Conscientious citizens need to understand the history that has led to the current state of affairs. Looking back, lots of improvements have been made to the country's healthcare system. Better yet, there is still room for improvement. People suffering because their income is too low to afford insurance but too high to receive help are being done a disservice, especially in the face of mental health issues.

The invisibility of mental health challenges should not render them irrelevant in policy discussions. Instead of immediately pushing forward into finding a solution, it is essential to understand what is wrong with the economic state of our system. When considering improvements to the healthcare system, it is necessary to understand its evolution to its current state. By learning about the ways the system has evolved over the years, it becomes possible to initiate a discussion on how to improve our system to make it more equitable for all.

Insurance Coverage Limitations Affect Mental Health Service Utilization

Problem debt impacts nearly one in five (18%) individuals living with mental health issues. This type of debt occurs when people are unable to repay what they owe, creating added financial stress that can worsen their mental health challenges (Money and Mental Health Policy Institute, 2024). The Mental Health Parity Act (MHPA) of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 brought significant improvements to the insurance industry's responsibility to help individuals avoid debt related to mental health. But, despite these federal laws, issues like unequal reimbursement rates, limited enforcement, and rising treatment costs continue to prevent many, especially those with severe conditions, from accessing the care they need.

Background. Since the late 1960s, economic inflation has become increasingly more detrimental to our financial situations. This reached a climax in the 1980s, with long-term effects still being felt today. When inflation rises, it increases the prices of all goods and services, including medical care. As a result, insurance companies' prices also go up. The people who were affected by this the most were the people suffering from mental health problems. In addition, many preconceptions questioned whether mental health issues were real. Over the years, individuals suffering from mental health issues have been uninsured. Nearly 40% of working-age adults with severe mental illness were uninsured for at least part of the year, while only 28% of people who do not have severe mental illness have sufficient health insurance to meet their needs (Rowan, 2023). This shows statistically how the individuals who are in need of insurance coverage are at an economic disadvantage and are suffering more.

A Growing Problem. While they show an attempt at fixing the economic issues surrounding mental health coverage, the MHPA and MHPAEA did not go far enough to resolve the entire problem. For example, "MHPA required group health plans with fifty or more employees that offered mental health benefits to apply the same lifetime and annual dollar limits to mental health coverage as those applied to coverage for medical/surgical benefits" (Barry, 2010). Additionally, the MHPEA mandated that all insurance plans must provide the same coverage for mental health illnesses as for surgical ones. But, these laws still did not offer proper reimbursement rates, introduced many limitations, and failed to have adequate enforcement measures in place.

“Insurance companies reimburse mental health providers 22% less on average than physical health providers.” (Charlie Health Editorial Team, 2024). Twenty-two percent may not seem like a lot, but that could mean losing hundreds or even thousands of dollars. Many insurance companies also require authorization to provide more treatment, which can delay the person's access to immediate care and limit the number of therapy visits. Even if the therapists disagree, the insurance company can require a medical necessity review. This review is a process undertaken by healthcare professionals, insurance providers, and regulatory bodies to assess the appropriateness of medical services and procedures. It serves as a critical checkpoint to determine whether a particular treatment or intervention is warranted based on a patient’s clinical condition and established guidelines.” (Navigating medical necessity review, 2023). Additionally, there is a lack of resources to upkeep MHPA and MHPEA, and these are unknown to many.

Solutions. First, the government must more strictly enforce these parity laws to ensure compliance by insurance companies. We can also advocate for more accessible mental health services. Another plausible solution to this would be minimizing the costs of insurance. Between 2021 and 2024, there was a 24% increase in annual insurance rates. We can decrease the rising costs of insurance and reduce the out-of-pocket payments by geting more funding from the government. Federal and state governments should provide more grants to alleviate stress for everyone.

Reducing financial stress on these individuals can lead to a more positive overall outcome for their health. “Half (46%) of people in debt also have a mental health problem…86%

of respondents to a Money and Mental Health survey of nearly 5,500 people with experience of mental health problems said that their financial situation had made their mental health problems worse."(Money and Mental Health, 2024). Suppose mental health care programs and financial assistance programs become more widely available. In that case, people suffering from severe mental illnesses will be able to manage their money more effectively while having access to the support they need.

Conclusion. If everyone works together to address this issue, more lives can be saved and people can be helped. Because people are not informed, insurance companies are able to get away with not following the law and not providing equal access to everyone. Although federal parity laws have improved mental health insurance, issues such as uneven payments, lax enforcement of regulations, and rising costs continue to hinder access to care, particularly for those with severe mental health conditions. Just because someone has a mental illness rather than a physical one does not mean they should not be offered the same amount of care and treatment.

Obstacles to Innovation in the Pharmaceutical Industry

In 2019, only $0.50 per person was spent globally on researching mental health, despite its extensive impact. With the global population in 2019 being 7.7 billion, it was more important than ever to develop working medication for the estimated half of the population that will go on to experience a mental health disorder in their lifetime (McGrath et al., 2023). Nevertheless, between 2015 and 2019, the average annual cost for pharmaceutical research and development was only US$3.7 billion (Woelbert et al., 2020, p. 11). As the years go by, most of the "advanced drugs" that were invented for people with mental illness are now almost a century old. Given the growing mental health crisis and the lack of effective, up-to-date medication, the pharmaceutical industry must significantly increase its global investment in mental health research and development to drive innovation and improve patient outcomes.

Outdated Innovation in Psychopharmacology. Mental health disorders are very complicated, and so is the medicine behind them. Even though two people can be diagnosed under the same mental illness and suffer the same symptoms, the medicine that each person needs may be different from one another due to multiple factors. Benzedrine was first administered in 1937 to combat hyperactivity disorder; decades later, adderall, which targets the same disorder, has no advancement in effectiveness.

This can be said for multiple other drugs and mental health solutions as well. Lithium was introduced in 1949 for the treatment of bipolar disorder, and it is still the “gold standard” for combativeness to this day. As well as Thorazine, the very first antipsychotic, which was invented in the 1950s,that works just the same as Abilify, which was in use by the early 2000s (Higgins, 2017). For what reason has the effectiveness of these drugs remained unchanged for decades?

Payne Whitney Psychiatric Clinic’s lead pharmacology director, Dr. Richard Friedman, explains, “‘The risk-averse pharmaceutical industry takes a known compound with a known mechanism of action and modifies it just slightly to get a ‘new drug.’ So, you have lots and lots of what we call ‘me-too’ drugs that are new, they are patented, but they work on the same targets as the old drugs’” (Rosenberg, 2019, p. 33). The effort is not being made to expand the effectiveness of drugs for a new target audience, which means that more and more people in the world do not have medicine that works for their mental illness.

Unequal Allocation of Research Funds. The pharmaceutical industry makes more than US$1 trillion each year on average, with prescription drugs alone expected to reach the trillion mark in value by the next decade. The entire industry is projected to grow, with the potential to surpass the US$2 trillion mark within a couple of years. To sustain this growth, the industry must invest billions in research and development (R&D) for new products and solutions. In 2019, the pharmaceutical industry spent about US$83 billion on R&D, and as of recent, this number has reached well over a hundred billion annually. But, in the same year, only US$3.44 billion was spent on research and development for mental health, representing just 4% of the total R&D fund (Woelbert et al., 2020, p. 11). This suggests that funding is not the primary barrier to innovation in this case. Then why, despite its vast resources, does the pharmaceutical industry remain hesitant to prioritize mental health R&D?

Obstacles. Although it may seem that the pharmaceutical industry has hundreds of billions of dollars at its disposal, the reality is more complex. Developing a drug that works for its target audience and has minimal side effects is a daunting task. Years of testing and tweaks go into creating a final product. These years of development often carry a high risk of failure, with no guarantee of a successful breakthrough. Research conducted in a 2020 article estimated that approximately US$1.1 billion is spent on R&D for a new drug alone, including expenses related to failures (Wouters et al., 2020). Spending billions per mental health drug when failure is a high chance is a kind of risk the industry is not willing to take. Especially when the revamped old drugs still generate significant profits. The industry is able to create ‘me-too’ drugs for a fraction of drug development costs, and reap billions in revenue annually from them. It is a system that works well for them, but limits treatment options for those with severe mental illness.

A Solution Through Partnership. Although the pharmaceutical industry may not be willing to change its ways, there are people worldwide who want to make a difference. The only difference between the industry and these people who want to make a difference is that the industry has the funds. But, what if the industry collaborated with those who wish to dedicate their time and effort to experiments, research, trials, and the development of new drugs? Dr. Friedman had this in mind, noting, “That is something that basic science researchers in universities are going to do, make discoveries that are interesting about the targets for psychiatric disorders, identify targets, synthesize new drugs, and go to the drug companies and say, ‘Guess what, we found a fascinating new target. We understand something about schizophrenia or depression that we did not before, and now we want to partner with you and we want you to go ahead and make and test this” (Rosenberg, 2019, p. 34). Pharmaceutical companies may even be eligible for tax deductions for funding these R&D costs.

In the United States of America, Internal Revenue Code (I.R.C.) § 174 allows for tax deductions for research or experimental expenses. As outlined by Bloomberg Tax, “The IRS defines qualified research expenses (QREs) as the sum of in-house research expenses and contract research expenses’. In-house research expenses include the costs of: Employee wages for qualified services performed by such employee, Supplies used to conduct qualified research, Computers used to conduct qualified research” (R&D Tax Credits and Deductibles Explained, 2025). These deductions incentivize major pharmaceutical companies to allocate more resources to the R&D field. This small solution has the potential to transform the lives of billions worldwide.

Conclusion. Advancing mental health drug development requires a global commitment to funding innovation, particularly in partnership with academic institutions. Providing these individuals with the necessary funds to study the complex anatomy of the brain would enable them to save many lives. With that in mind, the pharmaceutical industry must allocate more funds to R&D in the mental health field, directly supporting the mission of saving lives and creating stable homes worldwide. Working to fund innovation worldwide will generate a sense of urgency to effect change in the current system, offering new drugs to people who currently have none that work. This is why the pharmaceutical industry must significantly increase its global investment in mental health R&D.

Social Impediments to Mental Health Equity

Social conditions have a significant influence on whether people seek mental health care and how that care is provided. Factors such as community attitudes, the quality of local resources, and the history of interactions between certain groups and the health care system can determine access just as much as the availability of clinics or insurance. For many racial and ethnic minorities, immigrant communities, and families with limited income, obstacles include distrust rooted in past medical abuses, negative stereotypes about mental illness, and a shortage of providers who understand their cultural background. Schools, neighborhoods, and language access also shape opportunities for treatment, with inequities in education and public services often exacerbating these challenges. This section examines how social issues limit access to care and explores strategies to build trust, reduce stigma, and develop services tailored to the needs of diverse communities.

Medical Abuse and Its Impact on Minority Access to Mental Health Care

Access to mental health care is a fundamental human right, yet it remains unequally distributed to all American citizens across racial and ethnic lines. Minority communities, specifically African Americans, continue to face disproportionate barriers to receiving adequate mental health support. One of the reasons for this lies within the lasting impact of historical injustices that have shaped African Americans' relationship with health care systems. One of the most infamous examples is the Tuskegee Experiment, a medical experiment funded by the government that violated the trust of hundreds of African American men. Even though the study ended in 1972, its mental and cultural consequences are still felt today, having a significant impact on how African Americans interact and view semantic systems such as mental health services.

The Tuskegee Syphilis Study: A Breach Of Trust. In a research carried out in Tuskegee, Alabama, between 1932 and 197, the U.S Public Health Service deceived 600 black men , 399 of whom had syphilis and 201 of whom did not , into thinking they were being treated for "bad blood", a non-medical and confusing term. In actuality, even when antibiotics became accessible (Centers for Disease Control and Prevention [CDC], 2022), the men who had syphilis were not given access to appropriate treatment. The study's goal was to trace the untreated spyhills' natural source. Because the men were never given a chance to give their informed consent, many of them experienced serious health issues or passed away.

When the study was made public in 1972, it caused a national uproar and resulted in lawsuits, congressional investigations, and regulatory changes meant to safeguard research participants and patients. The harm to African Americans' trust in the medical system had already been done, and the effects are still being felt today (Brandt, 1978), even though it sparked significant ethical standards in medicine, such as the establishment of Institutional Review Boards (IRBs).

Medical Mistrust and Mental Health Avoidance. African Americans' enduring and pervasive mistrust of the medical system is one of the Tuskegee Study's most significant repercussions. This suspicion is not merely sentimental; it is also logical and supported by history. When it comes to mental health, this embedded skepticism manifests as a hesitancy to seek counseling, therapy, or psychiatric care, even in cases where symptoms are severe.

Treatment for mental health issues frequently necessitates openness and faith in the intentions of a doctor. But, a legitimate worry still exists for many African Americans, particularly those whose families were involved in the Tuskegee era: “What if I am being experimented again?” A psychological barrier caused by this dread deters people from getting help (Gamble, 1977).

Research demonstrates that African Americans are more likely to discontinue treatment early and are much less likely than white Americans to receive outpatient mental health treatments (Snowden, 2001). This disengagement is frequently made worse by stigma, supported by the community memory, and driven by fear.

Intergenerational Trauma Cultural Memory. The trauma of the Tuskegee Study is passed down through generations, despite the fact that it stopped more than fifty years ago. When the psychological scars of one generation are transmitted through family stories, customs, and cultural values, that is referred to as intergenerational trauma. Tales of medical exploitation are passed down as caution in many African American households. In the social memory created by these stories, the health care system is viewed as a place of danger rather than security. As a result, mental illness is typically stigmatized, and seeking help is discouraged (Bailey et al., 2017).

Many people rely on unofficial systems, such as family elders and church congregations, rather than seeking professional help. While these supports are meaningful, they are not alternatives for clinical mental health care, especially when trauma, anxiety, or mood disorders are involved.

Systemic Barriers Reinforced by History. Beyond personal suspicion, Tuskegee’s legacy reinforces structural injustices. According to Williams and Mohamad (2013), African Americans are more likely to reside in underfunded communities with little access to culturally appropriate care, inexpensive insurance, and mental health experts. Even when treatments are available, they are frequently provided by professionals who are not conversant with the historical and cultural context of Black patients' lives.

According to research, even when symptoms are comparable, Black people are less likely than white patients to have a correct diagnosis of mood disorders and more likely to receive a misdiagnosis of schizophrenia (Bell et al., 2015). Unconscious bias and a system that still struggles to provide equitable services are reflected in these inequities. Mental Health crises in African American communities often result in police intervention rather than treatment. This raises the possibility of physical harm, trauma, and criminalization–events that increase mistrust and steer people away from mental health facilities.

A Modern Parallel: COVID-19 Vaccine Hesitancy. During the COVID-19 pandemic, the effects of Tuskegee were evident. African Americans had a significantly greater rate of vaccine reluctance, especially during the early phases of vaccine distribution. The Tuskegee Study was one of the main reasons given by many for their mistrust of the vaccine's safety and motivations (Bogart et al., 2021). This needed to be actively addressed by public health professionals, who emphasized openness and community involvement.

This reluctance stemmed from an existing wound rather than just a new vaccine. It was a very real, generational, and historical fear. Furthermore, it is not surprising that mental health is still a particularly challenging issue to address, given that public health systems find it difficult to gain trust in physical health initiatives.

Solutions. First and foremost, historical injustices must be openly acknowledged by government organizations, medical schools, and mental health facilities. The Tuskegee Study is a component of a larger trend of medical racism rather than a singular instance. Through public forums, educational initiatives, and training for healthcare professionals, open dialogue about these incidents helps validate African Americans' experiences and start the healing process.

Improving mental health providers' cultural competency. When interacting with mental health care systems, many African Americans report feeling misunderstood, stereotyped, or ignored. Continuous training in trauma, systemic racism, Black history, and culturally particular ways of expressing distress should be provided to providers. Clinicians would benefit from this training by being more equipped to offer African American clients treatment that is considerate, pertinent, and sensitive to their lived experiences.

Conclusion. Their historical histories significantly impact minorities' access to mental health care, and the Tuskegee Syphilis Study is among the most glaring instances of how historical injustices cause long-lasting harm. The research represents exploitation, treachery, and the perils of putting one's trust in institutions for African Americans. Intergenerational trauma, attitudes about mental health, and systemic inequities in care and access have all been influenced by this history.

The Impact of Socioeconomic Status on Mental Health Equity Among School-Aged Children

A child's zip code often exerts more influence on their mental health than their genetic code. Despite growing national attention on youth mental health, children from low-income backgrounds remain disproportionately disadvantaged in accessing adequate mental health care. According to the Centers for Disease Control and Prevention (CDC, 2023), over one in five children in the U.S. experience a mental health disorder annually, yet fewer than half receive treatment. These disparities are particularly pronounced in underfunded school districts, where mental health resources are either severely limited or altogether absent.

While awareness of youth mental health challenges has increased, the intersection of socioeconomic status (SES) and accessibility to care remains a critical barrier to equity. SES not only influences the likelihood of developing mental health conditions but also affects the timeliness, quality, and sustainability of care. The failure to address these inequities perpetuates cycles of disadvantage that adversely shape educational attainment, future employment, health, and overall life trajectories.

SES is a primary determinant of mental health equity among school-aged children in the U.S. Historical injustices, policy deficiencies, and systemic barriers continue to prevent many children from receiving the care they need. Equitable access to mental health services is crucial for ensuring the well-being and future success of vulnerable youth, especially those affected by poverty.

Background and Root Causes. SES, commonly defined by income level, educational attainment, and occupational prestige,has long been a structural determinant of health in the United States. Historical policies such as redlining, inequitable school funding, and limited access to affordable health insurance have created entrenched disparities in both health and education. For low-income families, these systemic inequities function as intergenerational barriers to mental health care (McLaughlin et al., 2010).

Children in poverty are disproportionately exposed to adverse childhood experiences (ACEs), including neglect, abuse, food insecurity, and housing instability. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2023) asserts that the cumulative effect of ACEs significantly elevates the risk for depression, anxiety, substance use disorders, and suicidal ideation. Despite elevated risk, these children face considerable obstacles to accessing care—ranging from unaffordable costs and lack of culturally competent providers to stigma and service inaccessibility (Gary, 2005).

Empirical research confirms these disparities. Children in the lowest income quartile were two to three times more likely to have a mental health disorder than their higher-income peers, but significantly less likely to receive treatment. (McLaughlin et al., 2010). Untreated conditions impair academic performance, social integration, and long-term development. Furthermore, childhood mental illnesses that remain unaddressed often evolve into chronic adult conditions, further perpetuating cycles of poverty and health inequality.

Within educational settings, the primary environment for children,access to mental health services is often stratified along SES lines. Title I schools, which predominantly serve low-income students, frequently lack certified mental health professionals. According to the National Center for Education Statistics (2022), the average student-to-counselor ratio in U.S. public schools is approximately 424:1, which exceeds the recommended ratio of 250:1 set by the American School Counselor Association. Funding disparities between affluent and under-resourced districts manifest as unequal access to school-based mental health services (Ali et al., 2019).

In contrast, well-funded districts often provide comprehensive support systems that include full-time psychologists, behavioral intervention teams, and trauma-informed educators. Kenneth Paul Rosenberg's Bedlam: An Intimate Journey into America's Mental Health Crisis (2019) provides a poignant analysis of systemic failure in public mental health infrastructure. Rosenberg highlights how institutional neglect disproportionately affects low-income youth, who are frequently misdiagnosed, criminalized, or institutionalized instead of receiving therapeutic support. The book underscores how fragmented care systems contribute to inequities in mental health outcomes.

Policy Failures and Systemic Gaps. Although federal and state initiatives have sought to address youth mental health, many lack the equity-centered frameworks necessary for sustainable reform. One of the most persistent barriers is the disjointed nature of the U.S. mental health care system. Legislative reforms such as the Mental Health Parity and Addiction Equity Act and the Affordable Care Act (ACA) aimed to broaden access and improve coverage. But, enforcement remains inconsistent, especially for Medicaid-dependent families (CMS, 2022).

Medicaid is the primary health insurer for over 39 million children, the majority of whom come from low-income households (CMS, 2022). But, systemic issues, such as provider shortages, low reimbursement rates, and bureaucratic complexities, limit access to care. Families often endure long wait times or must travel extensive distances to locate an in-network provider. Medicaid beneficiaries frequently receive substandard care relative to their privately insured peers, deepening health inequities.

In education, policy gaps are equally stark. Although most states have adopted Multi-Tiered Systems of Support (MTSS) or Response to Intervention (RTI) frameworks, these are inconsistently put in placeed and under-resourced. Wealthier districts integrate these frameworks with dedicated staff and extensive training, while underfunded schools often lack the resources to provide even basic interventions.

School-based mental health initiatives also suffer from unstable funding. Mental health receives less than 1% of total federal education funding, leaving schools to rely on competitive grants for support. When budget cuts arise, mental health programs are typically among the first to be eliminated.

New York City's ThriveNYC initiative, launched in 2015, exemplifies the pitfalls of insufficient oversight and coordination. Despite a $1 billion investment, the program lacked clear performance metrics and community accountability, resulting in uneven service delivery and unclear outcomes. This example highlights the necessity of robust infrastructure, transparency, and localized engagement in policy put in placeation (Rosenberg, 2019).

Evidence-Based Recommendations. Achieving mental health equity among school-aged children in low-income communities requires comprehensive, systemic reform. The following policy recommendations are grounded in empirical research.

Stabilize and Expand School-Based Mental Health Funding. Federal and state legislatures should allocate sustained funding for hiring full-time counselors, psychologists, and social workers in Title I schools. Programs such as the Mental Health Service Professional Demonstration Grant should be expanded and institutionalized to provide more comprehensive support. Research confirms that increasing the number of school mental health personnel improves both behavioral and academic outcomes (Ali et al., 2019).

Strengthen Medicaid Access and Quality. To improve access to care, Medicaid reimbursement rates must be increased, and administrative barriers must be reduced. States should integrate school-based health centers into Medicaid provider networks. Additionally, strict enforcement of parity laws is essential to ensure mental health is treated on par with physical health (CMS, 2022).

Mandate Universal School-Based Mental Health Screenings. States should put in place universal mental health screenings using validated tools and link results to intervention frameworks. Successful pilot programs in Illinois and Ohio demonstrate that early detection significantly improves care outcomes and reduces stigma.

Advance Community Mental Health Literacy. Culturally and linguistically responsive public education campaigns can reduce stigma and empower families to seek care. Trusted community institutions, such as libraries, places of worship, and local media, can facilitate the dissemination of information (Gary, 2005).

Enhance Cross-Sector Collaboration and Data Systems. States should develop integrated data platforms that connect educational, healthcare, and social service agencies to facilitate seamless information sharing. Interagency task forces, composed of mental health professionals, educators, families, and youth, can tailor services to meet specific community needs and promote accountability.

Promote Trauma-Informed Education. Mandatory training in trauma-informed practices equips educators to support students affected by poverty and ACEs. Research indicates that trauma-informed teaching can reduce disciplinary referrals and enhance academic engagement (SAMHSA, 2023).

Conclusion. Mental health equity should not be a privilege limited by geography or income. As documented by Rosenberg (2019), the current system inadequately serves low-income youth, perpetuating cycles of trauma and neglect. But, with the right policy interventions, this reality can change.

Reforms, ranging from Medicaid expansion to trauma-informed education,are within reach if supported by sustained political will, intersectoral collaboration, and equitable investment. Recognizing mental health as a fundamental right, not a luxury, is essential to safeguarding the future of all children, regardless of socioeconomic background.

Gaps in Educational Inequality Within Pediatric and Youth Mental Healthcare Worsen Disparities for Marginalized Communities

In 2023, about 42% of high school students reported persistent feelings of despair or hopelessness, a striking addition from the preceding decade that disproportionately affected marginalized communities (Centers for Disease Control and Prevention [CDC], 2024). This crisis is not just a matter of statistics; it reflects systemic failures in educational and mental health support, particularly for minority students.

Take the case of Maria (a composite based on CDC data and National Alliance on Mental Illness [NAMI] reports on rural mental health disparities, 2023), a 16-year-old Latina student at a rural Texas school with no resources. While fighting anxiety and depression after a family injury, Maria never talks to a counselor at a learning center about her mental health. Her learning center's trainer oversees over 800 students and lacks specialized mental health education, while the nearest accredited therapist is 45 miles away. Maria's story is not new or unique. It illustrates a broad crisis in American education, which fails to provide adequate support for the mentally ill student who primarily demands it.

The educational disparity in pediatric psychiatric care refers to the systematic imbalance in access, quality, and consequences of psychiatric care provided by academic organizations, particularly affecting underprivileged residents, including racial and cultural minorities, LGBTQ+ youth, low-income students, and students with disabilities.

While School-based Mental Vitality Support, a comprehensive initiative designed to address the increasing needs of students in terms of their mental health, has improved during the Swing Sixties, systemic obstacles are still persistent. For example, 20% of youth and adolescents are aware of a psychiatric condition, only 60% of those in need of treatment, together with significantly lower rates among students of color and those from low-income families (National Institute of Mental Health, 2023). This treatment gap exposes a troubling reality in which the students who are experiencing the most social and economic difficulties are also the least likely to get the mental health support they need.

This difference indicates that the current school-based mental health systems may further contribute to injustice because they do not consider that there are many barriers, cultural stigma, language, and mistrust in institutional systems,keeping marginalized students from accessing help. Also, this trend creates a cycle in which untreated mental health problems compound academic difficulties and educational inequity that extend beyond school.

Enlightening systems further perpetuate a disadvantage in health care for oppressed young people by a lack of support, staffing, and structural barriers to get equal access to school-based support for psychiatric disorders, requiring a complete policy reform to include added federal support, mandated staffing ratio, and commonly lent flexibility to ensure all students receive sufficient psychiatric support.

Background & Root Causes. The present youth mental health crisis is the result of decades of policy choices and social injustices that have harmed marginalized groups disproportionately. Educational mental health support has evolved from basic support to include vocational and case management assistance, as well as family involvement, academic time, penal management, and crisis response, if necessary. Although support became more comprehensive, services were initially designed to support white, middle-class high school-aged students attending well-resourced suburban schools (Adelman & Taylor, 2020). These Social Justice terms and models exemplify how services were never intended to protect equity.

Today's inequities in support systems persist due to chronic underfunding, and schools serving marginalized populations are underfunded at about $1,800 per pupil a year, which directly limits specialized clinical and psychiatric staffing (Gaining Trust, 2022), which shows how state funding formulas hold significant control over practice levels, ultimately creating two support tiers.

Trauma histories and structural discrimination have increased mental health needs while creating barriers to help-seeking, including deep mistrust rooted in medical racism (Williams & Mohammed, 2021). This historical perspective illustrates how past injustices continue to affect current care.

The intersectional nature of multiple oppressive systems means a student experiencing exclusion based on racism, poverty, and instability at home will have higher risks and fewer pathways to intervention (Crenshaw Institute, 2023). It is essential to keep in mind that marginalized students must navigate compound stressors while receiving holistic support.

The COVID-19 pandemic compounded these disadvantages, as marginalized students experienced greater impacts on their mental health, stable housing, and educational progress. Federal policies, such as the IDEA and ESSA, include references to mental health. But, they are not necessarily culturally responsive and have no equity mandates (National Association of Secondary School Principals, 2022), meaning laws have been written that make good faith attempts to help students, but still are missing the requirements for "good care" to be culturally competent. This failure proportionally impacts historically and structurally marginalized students, as their vulnerability is continuously underestimated or ignored, creating a cycle in which the most vulnerable students receive little if any support for their educational outcomes.

Policy Failures & Gaps. The current approaches to school-based mental health services have constantly failed to meet the needs of the marginalized youth, which has created a system that ends instead of reducing existing bias. A study of political mistakes reveals three critical areas where there is an urgent need for improvement: insufficient financial mechanisms, inadequate workforce development, and the absence of shareholder-focused put in placeation standards.

Funding Inequities and Resource Allocation. The primary policy failure lies in the inadequate distribution of mental health resources to education systems. The funding for schools primarily comes through Title I and IDEA; however, these federal programs are not fully addressing the needs of marginalized populations, despite the federal government's well-intentioned efforts (U.S. Education Department, 2023). The ambiguity surrounding how broadly federal-directed programs address the nuanced needs of diverse student populations is often the target of public debate.

An independent analysis revealed that Title I schools receive, on average, $340 per student for mental health service compared to $890 per student for non-Title I schools, which either limits access to mental health professional services, programming or evidence-based intervention (SMHC); accordingly, this demonstrates that funding disproportion directly translates into service inequities for the most vulnerable students.

An additional compounding factor involves state financing formulas, as, in Texas, schools serving primarily Hispanic and Black students receive 17% less education funding than schools serving white students. This severely impacts schools' ability to recruit and retain qualified mental health professionals (Texas Education Agency, 2022), and in short, demonstrates how structural racism has become entrenched in public educational financing.

This trend is seen across the country, where rural and urban schools serving primarily marginalized populations continue to receive funding that is unfair in comparison to suburban populations, consistently demonstrating an exclusion of marginalized populations who are most in need of mental health support.

Critical Staffing Shortages and Training Deficits. The most apparent failure policy is the staggering lack of adequately trained mental health professionals in schools serving marginalized communities. Current data shows 55% of schools nationally do not have enough mental health resources, with schools serving predominantly students of color and low-income students experiencing the worst shortages (National Association of School Psychologists, 2023). Thus, even shortages are not experienced equitably, impacting those who face disadvantage the most and are already in resource-scarce situations.

The recommended ratio of school psychologists to students is 1:500, but the national average is 1:1200 with some high-need schools ballooning to 1:2000 or more, allowing professionalsè' shortages to compound systemic bias. Even with the existing staff, there is a lack of cultural competency training. Of available school counselors, only 34% were trained in culturally responsive mental health intervention, and less than 20% felt prepared to meet the needs of LGBTQ+ students (ASCA, 2022). This reveals how insufficient training leaves available staff unable to serve diverse populations adequately.

Such training deficits result in misdiagnoses, inappropriate interventions, and the reinforcement of biases towards a cultural norm, which further threaten vulnerable populations.

Systemic Barriers and Enforcement Gaps. Federal and state policies lack meaningful enforcement mechanisms to ensure equal access to mental health services. While ESSA requires states to report mental health indicators for students, there are no consequences for persistent differences or requirements for corrective action plans (2023). This absence of accountability allows for continued unchecked behavior.

Additionally, current guidelines are unable to address structural obstacles that prevent marginalized students from accessing available services. These include language barriers, the plan for English-language learning families that prevent participation in programming for mental health, and disciplinary policy as colored students of color are excluded from the school's assisted support services (Civil Rights Data Collection, 2022). Education and health policy create crosses and obstacles.

Medicaid reimbursement for school-based mental health services is limited and varies significantly by state, creating financial constraints for providing extensive mental health programming (Medicare and Medicaid Services Center for Medicare Services, 2023) in schools. Privacy rules, although important, are often misinterpreted by school personnel in ways that share inappropriate information and hinder coordinated care for vulnerable students.

Proposed Solutions. Education systems require wide, multi-level policy interventions to address the gaps in mental health aimed at the causes of inequality when creating permanent support systems. Evidence-based research and successful model programs provide a roadmap for improving policies that can yield meaningful results for marginalized youth.

Federal Policy Interventions. At the federal level, Congress must pass the Excellence in Schools Act, which will provide an annual $1.5 billion to school-based mental health services with precise equity requirements (Mental Health America, 2023). This legislation should include provisions for increased Medicaid reimbursement for school-based mental health services and remove the current obstacles that prevent permanent funding for extensive programming.

The Department of Education should establish compulsory requirements for equity in mental health under ESSA, requiring states to track and report the use of mental health care and satisfaction among demographic groups. Technical assistance and further federal support will be necessary for schools that consistently demonstrate discrimination to develop corrective action plans.

Federal policy should also make the minimum staffing degree mandatory for mental health professionals in schools, with the necessary conditions for schools serving a high percentage of marginalized students. This is supported by research from the National Association of School Psychologists, which shows that school meetings lead to significant improvements in students' mental health outcomes and a reduction in disciplinary events (NASP, 2023).

State-Level Reforms. State educational agencies should require compulsory cultural qualification training for all mental health professionals, with regular requirements for relapse prevention. States such as California and Oregon have groundbreaking, extensive training programs that integrate trauma-informed practice, cultural responsibility, and LGBTQ+ positive attitudes, resulting in improvements in the use of services and outcomes among marginalized students.

State funding sources should include weighted funds for students at high risk of mental health challenges, including colored students of color, LGBTQ+ youth, students in special care, and homeless students. The weighted memorial method of Minnesota has shown success in reducing inequalities in mental health by improving the overall student results (Minnesota Department of Education, 2023).

States should also establish schools for mental health, including social representatives, mental health professionals, and young voters who guide policy development and put in placeation, to monitor efficiency. These commissions will ensure that politics is responsible for social needs and cultural contexts.

Local Implementation Strategies. The school districts should use a community participation model that leverages local mental health organizations, community centers, and trust-based organizations to deliver culturally responsive services. The Wraparound Milwaukee program demonstrates how school districts, such as the University of Wisconsin-Madison (2022), can enhance access and outcomes for marginalized youth, ultimately reducing the costs to the districts (University of Wisconsin-Madison, 2022).

The districts should put in place colleague aid programs that train students to provide mental health care to classmates, with a particular emphasis on recruiting employees from marginalized communities who can offer support. Research suggests that colleagues increase support programs and improve mental health skills among the student population (Journal of School Mental Health, 2023).

Addressing Implementation Challenges. Critics of expanded school mental health services often cite cost concerns and questions about the appropriate scope of educational responsibilities. But, economic analyses consistently demonstrate positive returns on investment for school mental health interventions.

Every dollar invested in school-based mental health programming yields $7 in reduced special education costs, decreased juvenile justice involvement, and improved academic outcomes (RAND Corporation, 2022). To address capacity concerns, put in placeation should follow a phased approach, starting with schools that serve the highest percentages of marginalized students. Public-private partnerships can leverage community resources and expertise while maintaining accountability for equitable service delivery.

Privacy concerns can be addressed through comprehensive training for school personnel and clear protocols for information sharing that prioritize student safety while respecting confidentiality. States should develop model policies that strike a balance between protection and the need for coordinated care.

Conclusion. The failure of the education system to provide mental health services equally to all students entrenches inequalities for marginalized youth and the education system. We must prioritize policy action, including proper funding, workforce development, and structural changes for equity, to serve vulnerable students who are unlikely to achieve success in both academic and personal development without it.

If we do not intervene decisively, the outcomes will escalate from generation to generation; students like Maria will remain silent and unheard while we watch their potential go unrealized, perhaps even while hoping their trauma resolves on its own. The prevalence of social costs will escalate too, including school dropout rates, youth justice involvement, and adults with mental health crises that the system could have prevented with youth intervention, proper support, and educational resources.

To shift the inequity that exists in this system will require decision-makers to be brave—federally they need to put equity into the funding that they provide, state legislators need to require training standards that encompass mental health education training, and locally, decision-makers need to focus on championing equitable and culturally responsive practices that ensure mental health care for all students that accepts their identity and responds to their needs.

The Role of Cultural Stigmas and Language in Mental Health Access to Care in the U.S.

Awareness of mental health has increased over the past few years across the United States, but access to adequate mental health care remains highly unequal. Perhaps the most overlooked and influential barriers are cultural stigmas and language, which most profoundly affect racial, ethnic, and immigrant groups. These problems not only affect people's willingness to seek care but also how providers interpret and respond to their symptoms, often leading to misdiagnosis and ineffective treatment plans. Acknowledging these challenges is essential to closing the gap in mental health access and creating an expanded and responsive health care system.

Cultural Stigmas: Invisible Yet Powerful. Cultural stigma is conceived as the negative beliefs, attitudes, and social norms of an artistic community that surround mental illness. Mental illness in most communities is seen not as a medical disorder but as a personal failure, a moral failure, or a spiritual affliction (CHOC Health, 2023). This deeply rooted stigma prevents open discussion and impedes seeking help.

For instance, in African American populations, historical distrust of medical systems as well as cultural values of hardness and self-sufficiency are likely to result in the underuse of mental health services. Latinx individuals may prefer to seek advice from spiritual leaders or family members rather than professionals if their symptoms are somatic or amorphous. In many Asian and Middle Eastern cultures, mental illness is associated with shame or dishonor not only for the patient but for their entire family (CHOC Health, 2023).

The impacts of cultural stigma are staggering. People with mental health conditions will postpone treatment, and as a result, symptoms escalate and could have been managed. They will retreat socially to avoid judgment, further perpetuating feelings of loneliness and desperation. Even when individuals do seek help on a professional level, stigma prevents them from being willing to commit to treatment or medication. In some cases, these conditions perpetuate further dependence upon crisis intervention or law enforcement, solidifying cycles of institutionalization and crisis (CHOC Health, 2023).

Language Barriers. Language capacity is a significant yet undervalued aspect of accessing quality mental health care. According to the Kaiser Family Foundation (2023), over 26 million U.S. residents have limited English proficiency. These individuals span immigrant and low-income populations, and language becomes a decisive factor in determining whether a person can access timely, culturally sensitive care. Mental health discussions are subtle and emotionally nuanced; when patients and providers lack a common language, subtlety is lost.

Limited English speakers may struggle to describe their emotions, follow medical directions, or understand their diagnosis and treatment options. In some instances, they rely on untrained staff or family members to convey sensitive information, which raises concerns about confidentiality and accuracy (Kaiser Family Foundation, 2023). The shortage of bilingual providers, specifically those trained in culturally competent care,results in many individuals never having a provider who can both speak their language and relate to their cultural experience.

Studies published in Psychiatric Services affirm this connection, showing that patients with limited English report lower satisfaction and higher dropout rates from mental health care (Psychiatric Services, 2016). Language is also responsible for misdiagnosis when cultural idioms are not appropriately interpreted or when symptoms are described physically rather than psychologically (Psychiatric Services, 2016).

The Intersection of Both. Cultural stigma and linguistic barriers are not independent of one another—they reinforce each other. When individuals are fearful of being stigmatized as “mentally ill” and lack linguistic resources to articulate their experience, they are more likely to suffer silently. Consider a Latinx teenager who is anxious but cannot distinguish between feeling nervous and experiencing clinical anxiety due to inadequate Spanish-language resources and health education (Relief Mental Health, 2024).

Or imagine an older Asian immigrant who views depression as a sign of personal failure and has no access to a Mandarin-speaking therapist (Relief Mental Health, 2024). In either case, the result is the same: untreated illness, deteriorating mental health, and increased risk of crisis.

These intertwined barriers create a context where millions remain underserved and where mental health disparities persist generation after generation. Without reform, they can undercut even the most well-funded interventions by reducing participation and trust (Kaiser Family Foundation, 2023).

What Should We Do About It? Systemic reform at the levels of policy, education, and practice is required to counteract stigmas and language barriers. Programs that incorporate culturally responsive care, where professionals are trained in both clinical methods and cultural sensitivity,have shown promise in building trust among marginalized populations. Bilingual therapy programs, such as those advocated by Relief Mental Health (2024), enable clients to communicate openly without apprehension about being misunderstood. Telemedicine and translation services can also bridge communication gaps, especially in underserved rural communities (Relief Mental Health, 2024).

Policy reform must also play a central role. Enacting the Mental Health Parity Act to mandate equal insurance coverage for mental health treatment is a crucial first step in addressing this issue. But, more must be done. Expanding access to language services, funding community outreach, and partnering with religious organizations, cultural centers, and schools are effective strategies for shifting public perception and promoting early intervention (CHOC Health, 2023).

Conclusion. Cultural stigma and language differences are two of the most enduring obstacles to mental health care in America. They are structural problems grounded in history, power, and inequality. Meeting this complexity is the first step toward true reform. Solutions must go beyond curing illness—they must meet people where they are, linguistically, emotionally, and culturally.

Creating a mental health system that truly serves all communities requires us to rethink what care looks like. It calls on healthcare professionals to listen deeply and respond with empathy. It urges policymakers to prioritize equity over efficiency. And it invites all of us to replace judgment with curiosity, stigma with solidarity, and silence with compassion. The path forward may be difficult, but it begins with understanding—and we are already on our way.

Legal Impediments to Mental Health Care

Laws and regulations have a direct impact on who can get mental health treatment and what kind of help they receive. While measures such as the Mental Health Parity and Addiction Equity Act were designed to make coverage fairer, many rules are poorly enforced or vary so much by state that their protections are uneven. Legal gaps still affect how insurance companies handle mental health claims, how crises are managed, and how disability protections are applied. In some situations, outdated policies or inconsistent application of the law leave people without the support they need. This section reviews the current legal landscape, explains where it fails to meet the needs of those with mental health conditions, and discusses reforms that could make access to care fairer and consistent.

The Impact of Institutionalization Laws on Access to Mental Health Care

Mental health affects millions of people daily (Mental Illness, n.d.). But, it has historically been shrouded in deep stigma, particularly concerning institutionalization, which was once deemed a cure-all by administrations and lawmakers. The evolution of laws governing mental health treatment, especially regarding institutionalization, reveals a profound shift from lax oversight to stringent regulation of patient care.

From the mid-20th-century era of mass confinement to today's more community-focused, yet still imperfect systems, legislation has consistently shaped how individuals access mental health care. Legislation about institutionalization has always been a primary determinant of access to mental health care, fundamentally influencing regulation, funding, and public awareness.

Background & Root Causes. The mid-20th century was an age of mass institutionalization in America. At this time, mental illness was broadly misunderstood, and public sentiment frequently kept those with mental health issues excluded from mainstream society. The general perception, powerfully reinforced by the absence of extensive legislation, was that large state-funded institutions were a convenient solution to a multifaceted issue. It was this attitude that prompted states to increasingly provide funding for these institutions, which reached a high of about 500,000 inpatients nationwide in America (U.S. National Library of Medicine, n.d.).

The reality was that these institutions were far from therapeutic and often bordered on dystopian. Patients, regardless of their varied needs, were subjected to a "uniform routine." Treatments routinely consisted of coercive practices such as "restraint, sedation with drugs, such as bromides and chloral hydrate, or experimental treatment with opium, camphor, and cathartics," with little government audit or oversight (Morrissey & Goldman, 1986). This bleak reality was made all the more alarming by the extreme shortage of qualified staff in relation to the massive patient population, and it highlighted a systemic failure.

The lack of significant federal investment in mental health research only served to exacerbate these problems; in 1955, national spending on mental health research accounted for a mere 0.0167% of the overall federal budget (Gorman, 1956). The result was that clinical practice routinely depended on unproven and antiquated techniques, directly stifling the creation of effective treatments and knowledge about mental illness.

Public outcry and professional concerns ultimately led to significant policy reforms, including initiatives such as the Joint Commission on Mental Illness and Health and the landmark Community Mental Health Centers Act of 1963. This act aimed to undo mass institutionalization by promoting a "system of community mental health centers," providing the foundation for a fundamental shift toward localized care.

Policy Gaps & Failures. Despite the Community Mental Health Centers Act's visionary intention, its put in placeation manifested serious policy breakdowns and gaps that still affect mental health care access today. The act, though landmark, did not establish comprehensive structures for the smaller, locally oriented mental health centers it initially envisioned. This led to an irregular and often incomplete rollout, which created a lingering demand for the extensive state-sponsored facilities of the earlier era, even with their well-documented failings. The promise of deinstitutionalization was not entirely fulfilled, leaving many individuals without sufficient community support.

Additionally, government regulation of mental health institutions and services was a significant shortcoming for many decades. Before 1992, regulation was primarily a state-by-state matter, resulting in substantial variations in the safety and quality of institutions, which depended on individual state resources and priorities. This patchwork system contributed to uneven standards, allowing substandard care environments to continue unchecked. Despite subsequent legislation aimed at promoting mental health parity, such as the landmark Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, key gaps in enforcement persist. Existing policies do not necessarily require health plans to perform and submit detailed comparative analyses of their non-quantitative treatment limitations (NQTLs), for example, prior authorization requirements or network adequacy,to federal and state regulators.

Without adequate resources and authority for regulators to actively audit these analyses, instead of merely accepting self-reports, unfair access barriers continue to restrict care. The early absence of federal investment in research, as reflected in the pre-NIMH period, is also a key policy failure; without a solid evidence base, practical and accessible treatments were unable to emerge, forcing patients to rely on substandard or even harmful practices.

Solutions. Solving the ongoing problems in access to mental health care demands complex, research-driven policy prescriptions targeting strengthened regulation, higher funding, and active awareness. First, to address shortcomings in governmental oversight, legislation needs to equip federal and state regulators with adequate resources and authority to audit health plans' NQTLs proactively (Fulfilling the Promise of a Right to Adequate Mental Health Care, n.d.). That would mean going beyond self-reporting to actively examine prior authorization hurdles, network adequacy, and other non-financial obstacles, while also assessing the potential for high fines for failure to comply.

An example of such a law is the Consolidated Appropriations Act, 2021: “the law requires Issuers to make their NQTL comparative analyses available to the Secretary of Health and Human Services (HHS) or applicable state authorities upon request” (New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Plans and Issuers, n.d.). Legislators and administrative agencies are crucial players in ensuring that mental health parity is not just a legal theory, but a functional reality.

Second, enhancing access requires a significant boost in federal and state investments in mental health research and community-based services (O’Connor & Moran, 2025). This means allocating a greater proportion of the federal budget to the National Institute of Mental Health and its affiliated agencies, thereby driving innovation in prevention and treatment.

At the same time, funds must be expressly directed to build and fortify community mental health centers as detailed in the Community Mental Health Services Block Grant (Community Mental Health Services Block Grant, n.d.), ensuring they are well-staffed with a range of professionals and provide a comprehensive range of services, from crisis intervention and outpatient treatment to supportive housing.

This would address the long-standing issue of understaffing and provide alternatives to mass institutionalization. Legislators and federal agencies, through appropriations and grant programs, respectively, have the authority to enact these funding expansions.

Lastly, federally and state-funded awareness campaigns are essential to destigmatize mental illness and propel the use of modernized mental health systems. These campaigns, which public health agencies can oversee, should inform the public about the availability of services, encourage early intervention, and broadcast successful recovery stories.

In tandem with this, systematic surveying of mental health patients by government and nonprofit organizations can yield precious data. This feedback can directly translate into legislative action, demonstrating real-world obstacles to care and informing policy changes in funding, regulation, and service delivery to more effectively address patient needs. Such cooperation between state legislators, federal agencies, and community stakeholders is necessary to create a truly accessible, comprehensive, and compassionate mental health care system.

Conclusion. From the darkness of mass institutionalization to the current, albeit imperfect, quest for community-based care, legislative policies have decisively molded the contours of mental health services. Though significant progress has been achieved in ending abusive institutional practices and promoting mental health parity, the path toward equal access is incomplete.

The continued deficiencies, stemming from historic underfunding, fragmented oversight, and gaps in put in placeation,emphasize the imperative for ongoing legislative action. Policy reform for mental health care is not a goal; it is an urgent necessity to guarantee that each person receives timely and effective access to the compassionate care they deserve. Reform starts with strong oversight, continued investment, and a commitment to learning and serving the needs of individuals living with mental illness.

State Legislation vs. Federal Law: Its Impact on Mental Health Accessibility

Today, we are facing a dangerous epidemic that continues to be prevalent within our country-and even the world. As a matter of fact, 9 in 10 Americans believe that the United States is experiencing a mental health crisis (CSG, 2023). Further research reveals that a central challenge within the crisis is the inconsistent put in placeation of mental health resources and federal law across states.

According to Mental Health America (MHA), there are significant discrepancies in reports of mental health access by state, with states like New York and Massachusetts scoring higher for mental health prevention and aid, while states like Texas and Arizona score substantially lower (MHA, 2024). These geographical discrepancies, along with inconsistent state legislation and inequitable enforcement of federal laws, make it difficult to fully and consistently address mental health nationwide. These variations between state laws and federal enforcement highlight the primary causes of modern issues surrounding mental health services: the lack of state put in placeation and weak legal structures.

A Series of Gaps. Incorporating necessary and consistent legislation within both state and federal governments to effectively monitor and care for those facing a mental health crisis is essential to the general welfare of America. But, as we will see, gaps in funding, insurance, programming, and services make it clear that consistency is not occurring.

Funding and Insurance Policy Gaps. Despite Americans wanting to receive mental health care, the expense and lack of insurance coverage are major deterrents that cause them to neglect their need for treatment. More precisely, 35.7% of those who did not get treatment claimed that their inability to get mental health treatment was because their insurance did not cover it, and 59.8% believed that treatment would cost too much (SAMHSA, 2023).

Even with federal government funds, states have the freedom to fund national programs to whatever extent they deem fit. So, even if programs such as Medicaid and Medicare are enacted, nationwide access would vary by state due to the varied amounts of funding, which may cause certain people to be uninsured and unable to afford mental health treatment (MHA, n.d.).

Federal parity laws and coverage laws aim to ensure that financial disparities do not hinder access to mental healthcare. For example, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires coverage for mental and substance use disorders to be as non-restrictive as coverage for medical health care (NIH, n.d.). Still, the law is rendered ineffective if it can not be administered properly.

State Program Gaps. 911 used to be the primary calling source for those experiencing a mental health crisis, whether they were encountering it firsthand or witnessing someone else experience it. But, this often resulted in detainment and violence from law enforcement, causing severe trauma and fear of receiving help. Through multiple unfortunate incidents, it has become clear that law enforcement should not be the primary force involved in mental health emergencies. (Rosenberg, 2019). So, the National Suicide Hotline Designation Act of 2020 was established for such emergencies, creating a new national line for mental health crises—988. (988lifeline, n.d.).

Despite specific barriers, states can put in place important programs and legislation that end up being a valuable resource to those experiencing mental illness. The Marcus Alert is a system from Virginia that requires collaboration between 911, crisis call centers, behavioral health agencies, and law enforcement (Arlington, VA, n.d.).

Gillian Gmitter, Licensed Professional Counselor and Assistant Program Manager at the Community Service Board, shared her insights on the Marcus Alert and the national 988 helpline with us on Teen Think Tank. While the 988 lifeline was established nationally, Gillian notes that, unlike other states, the State of Virginia uses the Marcus Alert to better coordinate responses between 911 calls and 988 calls, depending on the emergency and circumstances.

Additionally, depending on the issue at hand, they use a variety of ‘levels’ and collaborate with multiple experts to help resolve the matter efficiently. Even though all US states have individual programs and response protocols concerning 988 and mental health crises, she expressed that, through her experience, other states lack similar coordinated response systems, which results in unnecessary or fragmented care (G. Gmitter, personal communication, July 23, 2025).

On top of the Marcus Alert Legislation, the State of New York established Kendra’s Law. Along with establishing requirements and accessibility for services, so that people in need of care can live safely within their communities, we created AOT (Assisted Outpatient Treatment) programs in each county within the state. This program entailed a prescription from a physician and a court order mandating the treatment for an individual. This additionally required collaboration between the AOT programs, OMH (New York's Office of Mental Health), and local mental health authorities (New York State Office of Mental Health, n.d.). But, Dr. Rosenberg also notes that, despite judges approving treatment and medication for 25,000 individuals through the program from 1999 to 2019, many more were unaware of its existence.

While AOT is available in some states, it is less effective and used less often than New York's system (Bedlam, 2019). Psychiatry Online supports this with a research study that examined the effectiveness of AOT programs in other states. Although it has been issued in 47 states, research has found that it is not as widely put in placeed in many of them due to a lack of resources, enforcement, and inconsistent monitoring (Psychiatry Online, 2016).

Rural Policy Gaps. Where you live in the United States should not become a barrier to treatment; however, it is clear that it does. As previously mentioned, rural states have less access to mental health services than more urban and suburban states. As specified in multiple sources, many of these geographical and environmental barriers include stigma, travel distance, lack of public transportation, and lack of insurance coverage (NAMI, 2022; RHIHub, 2025). Particularly, Rural Minds communicates that there is a common self-imposed fear of receiving help due to a strong belief in self-reliance, negative judgment from peers, as well as unreliable or nonexistent access to the internet, which restricts access to telehealth services. They quantitatively specify that 65% of rural counties lack a psychiatrist, and 28% do not have access to broadband (Rural Minds, 2023). So, it is also essential to address these geographical challenges so that all rural states feel both comfortable and can receive the care they need.

Solutions. This epidemic does not have to be permanent; despite there being a mental health crisis, it is clear that our government is taking action in an attempt to minimize the problem. Nevertheless, there are still improvements the state government can make to increase mental health accessibility in the United States substantially. By further honing in on what needs to be done, considering different circumstances, we can drastically turn around the mental health crisis, so long as we change how the government responds to it. So, to ensure mental health access, we must combat significant discrepancies in laws and mental health access within states by ensuring that the federal government is more involved in promoting a higher standard for mental health access.

Improve the process for data collection. For state legislatures to adequately enforce laws, they must first gather information on issues within the status quo and how government regulation lacks influence. For instance, when we discussed the issue of parity laws, it became clear that many sources illustrated how states had found it difficult to enforce them among agencies due to limited or unreliable data collection, specifically for non-quantitative treatment limits (NQTLS).

Currently, states rely on comparative analysis for data, which involves insurance companies explaining why certain limits are placed. But, the issue lies in the fact that these comparative analyses often end up being unreliable, specifically because insurers provide vague explanations. Some regulators have specified that more regulations, specifically those from the federal government,would be helpful. (The Commonwealth Fund, 2024)
So, it is necessary to improve methods of collection and require more specific reports from states about compliance among agencies. In doing so, states can accordingly target core issues and alternatively enforce legislation to improve coverage for mental health treatment and resources.

Increase in Collaboration. Many successful state programs mentioned in this article featured effective collaboration between multiple agencies and professionals, primarily involving connections between mental health professionals, law enforcement, and federal agencies and groups. Namely, the Marcus Alert and 988 calling system involved participation between professionals and involvement from other departments. Additionally, Kendra's Law and AOT involved professionals from multiple fields and enforcement from various government departments. In fact, enforcement of 'Collaborative care models' is also maintained in a few other states. Economically, the NCSL states that New Jersey, Wyoming, Massachusetts, and Louisiana require insurers to reimburse services provided by these models (NCSL 2023).

If we continue to use such models and create newer models that require expertise and collaboration between multiple fields, it would result in more effective and improved treatment for those facing mental health issues and emergencies.

Rural and Digital Access Adaptation. As mentioned before, states in more rural areas have a harder time accessing services and help for mental conditions. So, federal and state regulations must ensure that individuals in rural areas have the same access as those in more urban or suburban areas. For example, federal law could mandate the creation of multiple facilities in every county and region to ensure easier access to care.

Additionally, to address the specific stigma that has arisen in rural areas, states should ensure that there are programs put in placeed in schools and on social media to inform the public on the necessity of getting mental health care. RHI also proposes the alternate solution of put in placeing legislation so that there are more areas that 'house' both mental health specialists and primary care professionals in the same building (RHI 2020). This way, there would be more areas where rural Americans can access care, and they could also maintain a level of privacy and avoid discrimination from others.

Conclusion. As is clear with the majority of the American population, mental health is an issue quite prevalent in the country, affecting the lives of many people. Mental illness and mental health are unintentional obstacles that many Americans face in their lives, affecting the general welfare and community of the United States.

The struggle intensifies when there are no effective systems in place to help those in need. In a situation where the health of the population is in danger, every other aspect of the nation ultimately suffers. Without federal and state cooperation on change, the status quo, which harms many by preventing them from accessing needed care,will persist. Ultimately, the system that we all rely on to ensure a stable, healthy, and prosperous society is our government. So, state and federal governments must put in place more effective programs and legislation that call for intervention before the majority of the population suffers in silence or pain. This epidemic does not have to be permanent; however, to improve, we need help.

Executive Power and the Fight for Mental Health Equity

Nearly 1 in 5 adults in the U.S. lives with a mental illness, and government leadership plays a critical role in their care (Kenneth Paul Rosenberg, 2019). In response to this growing issue, our government offers various solutions for its citizens. In our government, there are three distinct branches: the legislative, executive, and judicial branches. Each branch has a different role in serving the public. It begins at the legislative branch, where the Senate and House of Representatives create laws. Then, the laws are passed down to the executive branch, where the president can either veto or sign the law.

Once the law is signed, it is enforced through executive power, whether it is exercised directly by the president or through various departments, allowing the act to be put into action. But, if someone sues the law, the responsibility falls to the judicial branch, where the Supreme Court will decide whether the law is constitutional or not (United States Courts, n.d.). With these steps, the acts can be ensured to help with the ongoing inequalities in mental health care. Our executive branch can use its power to help pass and enforce various mental health care acts that address unfairness.

Historical Context. President John F. Kennedy passed the Community Mental Health Act in 1963. This act allowed people to be treated in a location closer to home, rather than in an asylum located far away (Erickson, 2021). This is just the start of the many acts that presidents have passed in hopes of helping those in need of mental health care.

The Americans with Disabilities Act (ADA), which was passed in 1990 by President George H. W. Bush, prevented discrimination against those who had mental health disabilities and illnesses (NAMI 2024). Furthermore, this act also ensures that people with mental health issues are accommodated accordingly, depending on whether it is for a job, school, or transportation (ADA National Network, n.d.). For example, if a person with a mental health disability starts working at an office, the office would accommodate them, whether by providing at-home work options or a flexible schedule.

The following two acts, the Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act (MHPAEA), are related to each other, despite being signed by different presidents. According to NAMI (2024), President Bill Clinton signed the MHPA in 1996 to address disparities in mental health care costs, and in 2008, President George W. Bush signed the MHPAEA to strengthen those protections.

While the MHPA discusses the differences in mental health care as a whole, the MHPAEA focuses on the insurance portion. The MHPAEA “requires insurance coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions” (Mental Health Parity, n.d.-b). This act helped support the MHPA by further ensuring that mental health care costs were equal. It also helps make insurance coverage for mental health care equal, as though it were any other medical condition.

Finally, the American Rescue Plan Act. This act was signed by President Biden in 2021 and provided funding to support efforts to combat the COVID-19 pandemic (National Association of Counties, 2021). It helped fund many programs during this crisis, in the hope of aiding the country's recovery. President Biden allocated $1.9 trillion to be distributed among several programs, with around $86.24 billion towards mental health resources (American Rescue Plan Act Funding Breakdown, 2021a). According to the National Association of Counties (2021), one of the services that received funding was the Community Mental Health Services Block Grant, which allowed counties to establish local mental health services for both adults and children. Although all of these acts have helped improve mental health care, there is still considerable room for improvement.

The Need for Enforcement. Passing acts is only the beginning; effective enforcement is the real challenge. According to USAFacts (n.d.), the Department of Health and Human Services (HHS), which is under the executive branch, oversees programs that involve the public's health, including mental health services. They also ensure that states and providers comply with these federal laws and help fund these programs, ensuring that they are all properly funded.

Within the HHS, there are several branches, all focused on different areas of health. One of these branches is the Substance Abuse and Mental Health Services Administration (SAMHSA). The SAMHSA focuses on promoting mental health, preventing substance misuse, and providing treatments (Our Mission and Vision, n.d.). In addition to these services, SAMHSA also helps enforce laws such as the Mental Health Parity and Addiction Equity Act by providing funding through block grants and overseeing whether states are following them.

With block grants, the federal government provides funding to state governments, allowing them to allocate the funds as they see fit. For SAMHSA, these grants are offered to "organizations providing substance use and mental health services, research, technical assistance, and training to advance the behavioral health and to improve the lives of individuals living with mental and substance use disorders, and their families" (Grants for Mental Health and Substance Use, n.d.). These grants enable SAMHSA to expand its access to care, enhance community services, and ensure compliance with federal mental health laws.

Even though there are plenty of different ways for the executive branch to ensure that the acts are followed, there are still challenges that occur. There could be a lack of funding or insufficient funds, which may disrupt the entire funding system. If one organization misuses its budget, then one area that might have needed the budget will not be able to perform its job accurately.

Additionally, problems could arise during the put in placeation process. Something can occur that causes the act to be misunderstood and put in placeed incorrectly.

Possible Solutions. To resolve these issues, organizations or key departments, such as HHS or SAMHSA, can help strategically allocate funding. For example, if a specific area within a program requires additional funding, it could receive the funding first, and then the budget can be allocated based on urgency. Additionally, federal agencies, such as HHS, can continue to develop various resources, including webinars, that assist in understanding the acts (Training and Technical Assistance Center, 2025) to ensure that both acts are enforced correctly and funds are distributed efficiently. Finally, HHS and SAMHSA can be directed to expand their oversight through the executive branch, allowing them to monitor and report back on whether states are utilizing the laws as intended.

Conclusion. In conclusion, executive power has had several impacts on mental health care, particularly in terms of the financial budget and ensuring equal cost coverage for insurance. Although the executive branch does not enforce the laws itself, it relies on departments such as the Department of Health and Human Services (HHS) to put in place them. The HHS is divided into many different sub-departments, one of which is the Substance Abuse and Mental Health Services Administration (SAMHSA). These two agencies work hand in hand, with the HHS overseeing and funding the SAMHSA. As a result, the SAMHSA can provide treatment, conduct research, and help ensure that best practices are being put in placeed.

Although there are many setbacks in these mental health acts, such as financial budget, misinterpretation, and insufficient enforcement, there are still solutions to these problems. Each of these problems could be solved through careful financial budgeting, allocating various resources for understanding the issue, and empowering agencies like SAMHSA and HHS. But, these solutions may require time to be beneficial, but with the help of agencies tackling each of these problems one by one, mental health care continues to improve.

Summary

Mental health care in the United States faces significant challenges that go far beyond just finding a doctor or therapist. For many people, the real obstacles are rooted in how our health system is built, how our society views mental illness, and how our laws and policies work—or fail to work. Economic barriers, such as high costs and inadequate insurance coverage, keep treatment out of reach for millions. Social issues such as stigma, cultural misunderstandings, and language differences make it even harder for people to seek help. Legal and policy gaps add another layer of difficulty by allowing uneven access, weak enforcement of protections, and a lack of investment in better care. Understanding these economic, social, and legal impediments is the first step toward creating a system that works for everyone, not just a lucky few.

Economic Impediments

Money is one of the biggest reasons people cannot get the mental health care they need. Therapy can cost hundreds of dollars for a single visit, and medications can be expensive too, especially if they are required for years. Even people who have insurance often end up with high deductibles, small provider networks, or rules that don't cover specific treatments. In low-income areas, fewer people get insurance from their jobs, and many states haven't expanded Medicaid, so finding affordable care is even harder. The way the U.S. health system is set up means that companies often focus on saving money instead of making sure people get the help they need. Without making changes to lower costs, improve insurance coverage, and fund more public mental health programs, many people will continue to be left without treatment.

Social Impediments

Social problems also stop people from getting help. In some communities, mental illness is seen as something to be ashamed of, which makes people hide their struggles instead of getting treatment early. Language barriers make it even harder for some people to find the proper care, especially if there are no providers who speak their language or understand their culture. For many African Americans, past events like the Tuskegee Syphilis Study created a lasting mistrust of the health system, and that mistrust is still felt today. These issues lead to people waiting until their situation is dire before seeking help or avoiding treatment altogether. To fix this, there needs to be more culturally aware care, more interpreters, education to fight stigma, and stronger connections between health providers and local communities.

Legal Impediments

Laws and policies also play a significant role in determining who receives care and who does not. In the past, weak oversight meant people could be kept in unsafe institutions with little to no treatment. Later, when the government attempted to transition to community-based care, the plans were never fully put in placeed, resulting in gaps in the system. Even though there are now laws like the Mental Health Parity and Addiction Equity Act, they are not consistently enforced. Insurance companies can still make it hard for people to get help by requiring special approvals or having too few in-network providers. Different states have different rules and levels of funding, which means the kind of care you get can depend on where you live. Furthermore, insufficient funds have been allocated to research for developing new treatments. To change this, the government would need to enforce the laws it already has, ensure equal access in every state, and allocate more funding to research and community services.

Conclusion

Economic, social, and legal issues all combine to make it much harder for people in the U.S. to get the mental health care they need. Each of these problems feeds into the others, creating barriers that can seem impossible to overcome. The only way to make real progress is to work on all of them at once—lowering costs, ending stigma, making services culturally respectful, and enforcing laws that protect access to care. If these changes are made, the mental health system could move closer to treating people with the fairness, understanding, and urgency they deserve.

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Editor's Note

This document compiles ten student research papers on mental health equity in the order they were submitted. Minor formatting adjustments were made to ensure APA 7 compliance, including consistent fonts, spacing, margins, and citation formatting. Each paper retains its original tone and structure, preserving the authenticity of the authors' work.

The cohort’s work was presented live via webinar and can be found here.