Economic Impediments to Mental Health Equity

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Abstract

This paper examines the economic, structural, and systemic barriers that prevent equitable access to mental health care in the United States. Despite legislative reforms such as the Mental Health Parity and Addiction Equity Act, chronic underfunding, restrictive insurance practices, and insufficient pharmaceutical investment continue to exacerbate inequities, particularly for low-income, rural, and marginalized populations. Historical trends, including deinstitutionalization and insurer bias toward physical health, have left mental health systems fragmented and under-resourced. The analysis highlights the consequences of underfunding, clinician burnout, workforce shortages, and high denial rates for care, as well as disparities in reimbursement and pharmaceutical research. International models of stepped-care delivery, rural workforce incentives, telepsychiatry, and transparent clinical trial systems are explored as potential solutions. By addressing financial, policy, and industry shortcomings, the paper argues for a restructured system that values prevention, access, and human dignity, ensuring that mental health equity becomes a realized right rather than an unmet aspiration.

Introduction

In the United States, the Declaration of Independence guarantees us the right to life, liberty, and the pursuit of happiness. To achieve these rights, the United States has a responsibility to protect the health and well-being of its people, because without good health, freedom, and happiness cannot truly exist. When someone breaks a bone, they are immediately taken to a hospital and treated; however, half of the adults in the U.S. with a mental illness do not receive the care they need (National Institute of Mental Health, n.d.).

By denying or limiting access to mental healthcare, the nation is effectively stripping these individuals of their fundamental rights, as their ability to live freely, pursue happiness, and participate fully in society is directly compromised. This chronic public underfunding of mental health services, inefficiencies within the insurance system, and the pharmaceutical industry's failure to prioritize the research and development of psychiatric medications collectively create a systemic inequity in mental healthcare, disproportionately harming low-income, rural, and marginalized populations.

Brief Historical Context

Historically, there have been many inefficiencies in addressing mental healthcare. In the 1960s, the deinstitutionalization movement took place to provide more community-based care for people suffering from mental illnesses. Unfortunately, these community-based facilities were never actually built because the government did not fund them, leaving many individuals with mental illness homeless or incarcerated (Ryan, 2021). The outcome of deinstitutionalization was merely the relocation of the problem from one institution to another that was equally ill-equipped. Throughout history, insurers often prioritized physical health over mental health, making access to mental healthcare difficult.

To address this issue, the Mental Health Parity and Addiction Equity Act, or MHPAEA, was passed in 2008 to equalize financial requirements and treatment limitations for mental healthcare with those for physical healthcare (Centers for Medicare & Medicaid Services, 2024). Despite this legislation, insurers still deny mental health coverage more often than physical health coverage.

Denial rates frequently exceed 90% for intensive treatments like residential programs or home-based therapy (Lasswell, 2022). These alarmingly high denial rates reveal that, despite legal protections, systemic barriers continue to prevent individuals from receiving the care they need. This shows that mental healthcare inequities are deeply entrenched, shaped by historical neglect, insurance practices, and policy shortcomings, which makes it clear that addressing mental health is not just a matter of treatment, but of ensuring equity and upholding fundamental rights.

Another historical barrier to mental healthcare is the fact that, since the 1980s, with the creation of Clozapine (a medication used to treat severe mental health conditions), there have been no new effective antipsychotic medications (Rosenberg, K. P., & DuLong, J., 2019). Due to a pattern of longer development times and higher costs compared to other areas of drug discovery, many pharmaceutical companies left the mental healthcare domain (Loiodice et al., 2024).

Underfunding

Public underfunding leads to overwhelmed, understaffed community mental health services, resulting in limited access and long waits for vulnerable populations. Community mental health centers serving low-income individuals often lack funding, forcing staff reductions and limiting treatment options. In some cases, clinics have shut down altogether, exacerbating access issues (Omiyefa, 2025). This is important because it shows that systemic neglect disproportionately affects the most vulnerable populations.

An Overwhelmed System

Due to inadequate funding, many facilities are overwhelmed, resulting in patients waiting weeks or months—delays that can lead to symptom worsening and crises (Omiyefa, 2025). Underfunding does not just create inconvenience; it has harmful consequences for patients' mental health. In rural Western Colorado, the counselor-to-patient ratio in 2022 was 470:1, far exceeding recommended levels (Phillips, 2023). For context, the American School Counselor Association (ASCA) recommends a student-to-counselor ratio of 250:1 to ensure effective service delivery (Student-To-Counselor Ratio: Striking the Right Balance for Student Support, 2023). While this guideline primarily applies to schools, it highlights the importance of manageable caseloads in any mental health context; similar ratios are often recommended for community mental health services to ensure timely and effective care.

With nearly double the recommended counselor-to-patient ratio, counselors are unable to provide individualized support to each of their patients. When clinicians are responsible for too many patients, they often experience burnout, which in turn reduces access to care. Supporting this, a survey by Bain & Company, in collaboration with the Medical Group Management Association, found that roughly 25% of U.S. clinicians are considering leaving healthcare due to burnout, with excessive workload and a lack of support as major contributors (Landi, 2022). Importantly, clinician burnout directly reduces the availability and quality of care for patients.

Mental Healthcare Deserts

Along with clinician burnout, public underinvestment contributes to a growing shortage of the behavioral health workforce. Many professionals avoid underserved or rural areas due to poor pay and a lack of support. (Phillips, 2023). In particular, 160 million Americans live in mental healthcare deserts, or areas that lack proper mental healthcare. To ensure a sufficient supply of mental healthcare in these “deserts”, over 8,000 more professionals would be needed, as of March 2023 (Counts, 2023). The fact that nearly half of Americans live in mental healthcare deserts underscores a systemic shortage of providers, which not only limits timely access to treatment but also deepens existing health inequities by leaving millions without the basic support needed to maintain stability and well-being.

Despite similar training lengths, psychologists earn a mean annual wage of $256,930, while cardiologists earn an average of $421,330 per year in the US (Psychiatrists, 2023). Knowing this, why would an individual choose to become a psychiatrist when, with the same level of education, they could earn about double the salary of a psychiatrist by being a cardiologist? This inequality in pay makes mental health professions less desirable, and that is why, especially in rural areas, there are not enough providers.

Insurance

Even in areas where providers are available, insurance systems make it difficult to access care. Insurance systems continue to impose financial and administrative barriers, like high cost-sharing, restrictive parity enforcement, and low reimbursement, that limit access to mental health care despite coverage. Although the Mental Health Parity and Addiction Equity Act mandates equal treatment limits for mental health care, many insurers still charge higher copayments, limit visit frequency, and use stricter prior authorization for mental health services (Hassanein, 2023). This gap between legislation and practice highlights how insurers exploit regulatory loopholes and weak enforcement mechanisms, ultimately creating barriers to access.

Hidden Costs to Patients

By imposing hidden restrictions, insurance companies shift costs and responsibilities onto patients, undermining the very intent of parity laws. This indicates that formal legal protections alone are insufficient without stronger oversight, standardized enforcement, and penalties to deter discriminatory practices. Cherlette McCullough, an Orlando, Florida-based mental health counselor who recently began accepting insurance, shared that one client's plan only covered five sessions of psychotherapy (Hassanein, 2023).

Research indicates that, on average, 15 to 20 sessions are required for patients to recover from psychological difficulties, but depending on severity, the number of therapy sessions needed could exceed 30 (American Psychological Association, 2017). This discrepancy highlights how insurance limitations often prioritize cost containment over clinical best practices, leaving patients without the continuity of care necessary for a meaningful recovery. As a result, individuals may drop out of treatment prematurely or face steep out-of-pocket costs, exacerbating inequities in access.

These restrictive coverage policies not only undermine treatment effectiveness but also increase the risk of relapse, which can drive up long-term healthcare costs—ironically counteracting insurers' cost-saving intentions. Let us say an individual suffering from a mental illness requires 30 therapy sessions. Since each therapy session costs approximately $200 and insurance only covers five of them, that individual would have to pay $ 5,000 out of pocket (Hassanein, 2023). A low-income family of four is defined as one with an annual income of less than $30,000 (Legal Services Corporation, 2022). If this family has to pay $5000 out of pocket for therapy, that is 17% of their annual income. This is why many low-income families have no choice but to opt out of mental healthcare treatment.

Reimbursement Disparities

Reimbursement rates also impact access to mental healthcare. Behavioral health visits receive, on average, 22% lower reimbursement than medical visits. This discourages providers from accepting insurance, reducing in-network availability (New Policies Affecting Access to Mental Health Care, 2022). As a result, only about 55% of psychiatrists accept private non-capitated insurance, compared to nearly 89% of other physicians, reflecting a systemic reluctance within the field to participate in insurance networks (Bishop et al., 2014). This payment disparity reinforces a two-tiered system where wealthier patients can afford out-of-network care while lower-income individuals face long wait times or go untreated.

By devaluing mental health services relative to physical healthcare, insurers worsen structural inequities and indirectly contribute to provider shortages. This not only limits patient choice but also deepens the mental health crisis by straining the few providers who remain accessible through insurance networks. At the same time, patients seeking behavioral health care are approximately 3.5 times more likely to be forced out-of-network than those seeking medical or surgical care (Gonzales, 2024).

In particular, services such as psychiatry and psychology face out-of-network rates that are 8.9 times and 10.6 times higher, respectively (Grossi, 2024). In other words, even when patients have insurance, they often face long delays while searching for providers that have a contract with their insurance plan.

This problem is even more severe in rural counties, 65% of which have no psychiatrist at all, because low reimbursement makes it financially unsustainable for practitioners to practice there (Modi et al., 2022). With smaller patient pools, longer travel times, and fewer professional supports, providers are often discouraged from working in these areas, leading to relocation to urban centers where pay is higher. As a result, rural residents are left with limited or no specialized care, creating a cycle where geographic and financial barriers intersect, deepening inequities and worsening mental health outcomes in underserved communities.

Lack of Access to Care

Although insured, many adults, especially those with behavioral health needs, still do not receive care. In 2019, 36% of insured adults with moderate to severe symptoms did not access treatment (Kaye Pestaina, 2022). Health insurance is supposed to be “a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium (Health Insurance - Glossary, 2025). Therefore, “having insurance” is supposed to ensure access, yet over a third of adults who are promised this “insurance” do not receive it.

If a third of insured patients with diabetes or cancer could not access care, the system would be seen as intolerable. Since insufficient insurance blocks access to mental healthcare, patients are unable to receive timely treatment. As a result, crises escalate until the ER becomes the only viable option. A large population study in Ontario showed that 45.4% of psychiatric ED visits were the first mental health care contact for individuals (Kurdyak et al., 2021). In other words, many people who need mental healthcare wait until their situation escalates into a crisis before getting help, highlighting how the system could not actually “ensure” them the protection and care they need.

Lack of Pharmaceutical Development

While insurance barriers prevent individuals from seeking and receiving care, the pharmaceutical industry has been slow to develop new treatments. Pharmaceutical R&D underinvestment in mental health disorders, including uneven development priorities and limited innovation, undermines the creation and accessibility of effective treatments.

Mental illnesses impose an enormous societal and economic burden, yet they receive a fraction of the research funding allocated to other diseases. Schizophrenia, for example, receives only $3.1 per $1,000 of disease burden, major depression $1.8, and bipolar disorder just $0.4, compared with $75.5 for cancer (MacEwan et al., 2016). Despite causing 835 disability-adjusted life years (DALYs), vastly more than sexually transmitted diseases (50 DALYs) or dental/oral diseases (565 DALYs), schizophrenia receives roughly the same or even less research funding. Schizophrenia receives $286 million, while sexually transmitted diseases receive $275 million, and dental/oral diseases receive $516 million (MacEwan et al., 2016). There are significant consequences for these disparities.

A recent cross-sectional study found that Indiana incurred $4.2 billion in direct, indirect, and societal costs—roughly 1% of the state's GDP (New Policies Affecting Access to Mental Health Care, 2022). In other words, not only do mental illnesses impact individuals and communities, but they also impact a state's economy. This unbalanced allocation of research funding directly slows the development of effective treatments, prolongs suffering, and increases long-term costs.

Along with the unbalanced allocation of funds, there is also a disconnect between industry priorities and the actual needs of patients; only 12% of mental health patient groups believe pharmaceutical companies are effective at engaging patients in research and development (Taylor, 2023). 1 in 5 Americans—over 66 million people—take at least one psychiatric medication (Hyman, 2013). In other words, millions rely on drugs whose development may never have incorporated patient perspectives on what matters most: which symptoms are most debilitating, which side effects are intolerable, or which treatment goals are priorities. The result is a system where medications are designed more around market potential than patient experience, leaving many individuals struggling with treatments that may be partially effective, poorly tolerated, or misaligned with their needs. When engagement is so low and usage so widespread, the consequences are tangible: delayed recovery, frequent medication changes, and avoidable suffering for millions of patients.

Concerns about the reliability of psychiatric drug trials are also significant. Manufacturer-funded trials often report approximately 50% greater efficacy than independent trials (Grabmeier, 2024), a phenomenon known as the “sponsorship effect.” Studies comparing trials that test identical drug pairs, but differ only in funding source, show that removing the sponsorship effect would reduce reported efficacy differences by roughly half. Even with current preregistration requirements, only one-quarter of all preregistered trials actually report results (Grabmeier, 2024), meaning the majority of studies remain unpublished or selectively reported.

This creates a system where manufacturers can choose to publish only trials showing their drugs in a favorable light, leaving patients, clinicians, and policymakers with an incomplete or biased understanding of a drug’s actual therapeutic value. The result is not just academic: overestimation of drug efficacy can lead to inappropriate prescriptions, patient exposure to unnecessary side effects, and misallocation of healthcare resources.

Solutions for Underfunding

Building a community-based, stepped-care system and enhancing workforce incentives can help address the issue of underfunding.

Stepped-care

England’s IAPT (Improving Access to Psychological Therapies) is an excellent example of this framework: it scaled a stepped-care model, trained a large cohort of low-intensity CBT (Cognitive Behavioral Therapy) practitioners, and made its outcomes public. Evaluations indicate a recovery rate of around 40–50% among treated patients, accompanied by strong monitoring of outcomes, which demonstrates clinical effectiveness at scale (Clark, 2018). In particular, 40.3% of patients had reliably recovered at the post-treatment stage, and 63.7% showed a reliable improvement (Gyani et al., 2013).

The U.S. could adopt a framework similar to England's IAPT program by scaling stepped-care services nationwide, creating a network of community-based mental health centers that provide low-intensity interventions, such as guided self-help, digital CBT, or group therapy, for mild-to-moderate cases, while reserving specialist care for severe or treatment-resistant patients. To replicate IAPT's success, the U.S. could train a large cohort of low-intensity mental health practitioners, including social workers, psychologists, and supervised non-specialists such as lay counselors or care navigators, to deliver standardized evidence-based therapies. Transparent outcome monitoring should also be implemented, publishing recovery and improvement rates to ensure accountability and continuous quality improvement.

Additionally, integrating stepped-care into primary care and community settings would allow patients to access initial interventions close to home, reducing barriers such as travel or stigma. Given that approximately 59.3 million adults in the U.S. experience mental illness (NIMH, 2025), a stepped-care model could realistically provide effective, evidence-based care to tens of millions of people, with roughly 40% of patients achieving full recovery and over 60% experiencing meaningful improvement if outcomes mirrored IAPT, significantly reducing the national mental health treatment gap (Gyani et al., 2013).

Workforce incentives

To effectively address mental health workforce shortages in underserved areas, implementing targeted financial and professional incentives is crucial. Australia's Rural Health

Workforce Strategy provides a compelling model. This strategy includes initiatives such as the Rural Health Workforce Support Activity (RHWSA), which helps recruit and retain health professionals in rural and remote areas. The RHWSA offers support for relocation, integration into communities, and access to necessary infrastructure and training (Rural Health Workforce Support Activity, 2025).

Evaluations of similar programs have shown promising outcomes. For instance, the Rural Health Multidisciplinary Training (RHMT) program, which provides clinical placements for health students in rural areas, has increased placements from approximately 3,000 in 2004 to over 13,000 in 2018. Graduates with extensive experience in rural clinical placements are more likely to work in regional, rural, and remote areas of Australia (Kolt, 2025).

Furthermore, financial incentives have proven effective in attracting professionals to underserved areas. For example, the Medical Rural Bonded Scholarship Scheme, which offers scholarships to medical students in exchange for service in rural areas, has supported around 2,500 rural students since its inception (Wikipedia Contributors, 2025).

The United States could adopt a model inspired by Australia's Rural Health Workforce Strategy by combining financial incentives, training opportunities, and community support programs. For example, the federal government could expand loan forgiveness or scholarship programs specifically for mental health professionals who commit to serving in underserved urban and rural areas. Additionally, partnerships with medical and graduate schools could create mandatory rural or community mental health rotations, similar to Australia's RHMT program, ensuring trainees gain experience in high-need settings.

Finally, providing relocation support, mentorship, and professional development for clinicians would help retain providers in the long term, thereby increasing access and reducing regional inequities in mental health care.

Proposed Solutions

Addressing Insurance Barriers

Tightening parity enforcement, expanding reimbursement for integrated behavioral health, and subsidizing telepsychiatry could significantly reduce insurance barriers to mental health equity.

Stronger Enforcement. More vigorous enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) is essential. Currently, only two states (Massachusetts and Illinois) conduct routine audits of insurer compliance, and federal enforcement remains limited (Office, 2019). However, where oversight has increased, access has measurably improved. In Massachusetts, the Division of Insurance reported that all 21 major carriers submitted certifications for parity compliance in their 2022 annual submissions, and none identified areas of deficiency or required corrective actions—demonstrating how active oversight and mandatory reporting foster more robust enforcement (Massachusetts Division of Insurance, 2023). Implementing this nationwide could yield similar positive results.

At the federal level, the Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Treasury should move beyond just requiring insurers to submit paperwork on parity compliance. They should finalize outcomes-based standards for nonquantitative treatment limitations (NQTLs) (such as prior authorization, medical necessity reviews, or provider network adequacy). This means compliance would be judged by actual access outcomes—like whether patients are denied care at higher rates for mental health than for medical care—rather than just on insurers' internal policies.

To ensure enforcement consistency, insurers should be required to use a uniform federal reporting template and submit annual reports on their parity compliance. Regulators could then conduct risk-based audits (targeting insurers with suspicious patterns of denials, delays, or narrow networks).

At the state level, regulators would receive federal parity enforcement grants to strengthen oversight. States could conduct market-conduct exams (formal reviews of insurance practices), utilize secret shopper audits (to assess whether patients can actually access providers listed in networks), and apply escalating penalties for noncompliance, ranging from corrective action plans to substantial fines.

To keep both insurers and regulators accountable, public dashboards should be published (modeled on Massachusetts' annual parity reports). These dashboards would list, at the plan level, metrics like denial rates, average wait times, and network adequacy, allowing consumers, providers, and policymakers to compare performance transparently.

Finally, enforcement should be tied directly to federal program participation. Insurers that want to sell plans on the ACA Marketplace, or participate in Medicare Advantage or Medicaid managed care, should be required to submit complete parity analyses and meet access benchmarks. If they fail, regulators could withhold a portion of their payments until corrective actions are taken, creating substantial financial incentives for compliance.

Expanding Reimbursement. Reimbursing integrated behavioral health services in primary care at the same rate as medical visits has proven effective in other countries. In the Netherlands, the 2006 Health Insurance Act expanded access to primary care mental health services within a system where 100% of the population was covered through a mandatory universal health insurance scheme operated by private insurers (European Commission, 2019). This broad, equitable access, supported by subsidies for lower-income households, facilitated widespread uptake of integrated care and helped contain costs. By contrast, in the U.S., integrated care codes (e.g., Collaborative Care Model CPT codes) are reimbursed inconsistently, which limits their adoption.

Aligning reimbursement with medical parity would encourage broader use of integrated models, especially for common conditions like depression and anxiety, which can often be effectively managed in primary care settings through brief interventions, behavioral activation, and medication management. Making these services readily accessible in primary care would reduce barriers to timely treatment, improve outcomes, and prevent the need for escalation to more intensive specialist care.

Implementing integrated behavioral health services in the U.S. would require action at multiple levels. Medicare already allows doctors and other providers to bill for Collaborative Care Model (CoCM) services using CPT codes 99492–99494, which cover care management for patients with mental health conditions like depression and anxiety. However, the payment rates are relatively low and the billing rules are complicated.

To improve access, Medicare could increase these reimbursement rates to match those for regular medical visits of similar complexity and simplify documentation, including allowing nurse practitioners and physician assistants to bill directly for their services. Medicaid, which covers many patients with behavioral health needs, could require states to reimburse integrated services at the same rate as primary care visits and offer additional federal funding to encourage their adoption.

Private insurers and Marketplace plans could also be required to pay at parity with medical care, supported by more explicit federal rules and certification standards. Primary care practices could receive startup grants or higher payments for the first few years to hire behavioral health staff and set up integrated workflows, similar to how the Netherlands funded implementation. Value-based care contracts could reward practices for reducing referrals to specialists and ER visits by managing mental health in-house.

Finally, monitoring would track whether patients can actually access these services, report outcomes like depression and anxiety improvement, and measure cost savings. Altogether, this approach would make integrated behavioral health care widely accessible in the U.S., modeled after successful systems abroad.

Subsidizing Telepsychiatry. Telepsychiatry in Dutch emergency departments integrates remote psychiatric consultations directly into hospital care, allowing psychiatrists to evaluate patients via secure video conferencing rather than requiring in-person visits. This approach has become an integral component of mental health care in the Netherlands, particularly in emergency settings.

A pilot study conducted in Dutch emergency departments found that all telepsychiatry consultations were completed successfully, with only minor technical issues. Patient satisfaction was high, with 78% of patients expressing satisfaction with wait times and 67% reporting overall satisfaction with the care received (International Journal of Emergency Medicine, n.d.). Both psychiatrists and emergency department staff rated the consultations as effective and efficient.

Notably, the average time from consultation request to disposition decision was reduced by approximately one hour during the telepsychiatry phase compared to the baseline phase (Jorn

Eerhard et al., 2025), highlighting the potential of telepsychiatry to enhance service efficiency and patient outcomes.

Adopting the Dutch telepsychiatry model in the United States could significantly improve access to mental health services, especially in underserved areas. To facilitate this, federal policies could mandate that telepsychiatry services be reimbursed at parity with in-person psychiatric consultations under Medicare and Medicaid.

Additionally, private insurers and Marketplace plans could be required to cover telepsychiatry services equivalently to in-person visits, ensuring broader access. Primary care practices could receive grants or enhanced reimbursements to integrate telepsychiatry into their services.

Furthermore, establishing clear guidelines for telepsychiatry practice, including licensure requirements and standards for the use of technology, would ensure the delivery of high-quality care. By implementing these measures, the U.S. could emulate the Netherlands' success in utilizing telepsychiatry to meet the growing demand for mental health services.

Solutions for Pharmaceutical R&D Gaps

Addressing pharmaceutical R&D gaps and trial bias would involve implementing a public funding model, implementing transparency reforms, and prioritizing patient-led initiatives.

Public Funding Model. The UK’s MQ, along with other philanthropic organizations, provides targeted grants to accelerate psychiatric research and translation. This model can be scaled domestically to fill market gaps (Mental Health Research Charity | MQ, 2019). Targeted funding for mental health research delivers strong returns when focused on high-need, under-resourced areas. UK data shows that every $1 invested in scaling up treatment for depression and anxiety yields a $4 return through improved health and workplace productivity (World Health Organization, 2016).

Meanwhile, workplace mental health interventions in the UK generate £5 in benefits for every £1 invested (Mental Health Foundation, 2023). To replicate this in the U.S., a federal mental-health R&D fund—paired with state matching and philanthropic contributions—could prioritize conditions like treatment-resistant depression or schizophrenia by linking grants to disability-adjusted life-year (DALY) metrics. This model ensures that scarce resources drive both equity in research attention and demonstrable societal return on investment.

Trial Transparency. The EMA's revised Clinical Trials Information System (CTIS) transparency rules (2023), in conjunction with the EU Clinical Trials Regulation (2022), enhance public access to clinical trial protocols and results, thereby reducing selective reporting and publication bias and limiting the so-called "sponsorship effect" (EMA, 2023).

Industry-funded trials often report approximately 32% greater efficacy than independent studies of the same drugs, highlighting the importance of transparency and unbiased reporting (Turner et al., 2008). Europe's response has been robust: under these regulations, trial protocols and results must be publicly posted within 12 months.

Since the mandatory use of CTIS began on January 31, 2023, the number of initial clinical trial submissions increased by 51% in March 2023 compared to February 2023, demonstrating that transparency reforms encourage broader trial registration and reporting (EMA, 2023). The U.S. can replicate this approach by linking federal research funding and regulatory approvals to mandatory trial preregistration and the timely publication of results, creating a transparent repository that holds both public and private developers accountable and strengthens trust in clinical findings.

Patient-Led Priorities. Incorporating patient perspectives into research ensures that studies address outcomes that matter most to those affected, enhancing relevance and engagement. A systematic review found that patient and public involvement (PPI) in research led to improved recruitment and retention rates in clinical trials, as well as studies that were more relevant and appropriate for users (Staley & Barron, 2020).

For instance, the UK's National Institute for Health Research (NIHR) INVOLVE program mandates that funded studies include patient and public advisory panels from study design through outcome selection. This approach has been shown to increase trial enrollment by approximately 14% and improve adherence to interventions, while also prioritizing outcomes such as quality of life and functional improvement over solely clinical endpoints (Crocker et al., 2018). Implementing a similar framework in the U.S. could involve requiring federal and state-funded mental health research to include patient advisory boards, mandate patient-prioritized outcome measures, and publicly report how patient input influenced study design.

Such policies would ensure that research addresses real-world needs, enhancing both the ethical integrity and practical impact of U.S. psychiatric research.

Conclusion

Chronic underfunding, insurance barriers, and pharmaceutical neglect create systemic inequities in mental healthcare, undermining Americans' ability to fully exercise their rights to life, liberty, and the pursuit of happiness. While history shows that policy reforms, such as deinstitutionalization and parity laws, have fallen short without adequate funding and enforcement, evidence from other countries demonstrates that scalable solutions—such as stepped-care models, targeted workforce incentives, stronger insurance regulation, telepsychiatry, and patient-centered research—can meaningfully close gaps in access and equity. Addressing these impediments is not just a matter of healthcare policy but of social justice, as the failure to provide timely and effective mental healthcare disproportionately harms low-income, rural, and marginalized populations. Suppose the United States is to live up to its founding promises. In that case, it must invest in a mental health system that values prevention as much as treatment, equity as much as access, and human dignity above profit. Only then can the nation begin to ensure that mental health equity is not an aspiration, but a reality.

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