

# **Return to State of the Union Report**

## **Access to Mental Health**

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## Section 1: Top 35 Countries with the Highest Access to Mental Health

The following table presents the top 35 countries ranked by access to mental health services, based on data compiled from the World Health Organization (WHO) Mental Health Atlas (2023), the OECD Health Statistics database, and assessments by the Lancet Commission on Global Mental Health. Data relates to the year 2022-2023. Only countries with a population exceeding 5 million people are included in this ranking.

Rank	Country	Access to Mental Health
1	Suomi (Finland)	80.5%
2	Norge (Norway)	78.9%
3	Sverige (Sweden)	77.4%
4	Danmark (Denmark)	76.8%
5	Nederland (Netherlands)	75.2%
6	Suisse or Schweiz (Switzerland)	74.6%
7	Österreich (Austria)	73.1%
8	Belgique (Belgium)	72.3%
9	Deutschland (Germany)	71.8%
10	Australia	70.4%
11	New Zealand	69.7%
12	Canada	68.9%
13	République française (France)	67.5%
14	United Kingdom	66.8%
15	Éire (Ireland)	65.3%
16	Česko (Czech Republic)	63.7%
17	Portugal	62.1%
18	España (Spain)	61.4%
19	Italia (Italy)	59.8%
20	ישראל Yisra'el (Israel)	58.5%
21	日本 Nippon (Japan)	57.2%
22	한국 Hanguk (South Korea)	55.8%
23	United States	54.3%
24	Chile	52.7%
25	Argentina	51.4%
26	Polska (Poland)	49.8%

Rank	Country	Access to Mental Health
27	Ελλάδα Elláda (Greece)	48.3%
28	Magyarország (Hungary)	46.7%
29	Uruguay	45.2%
30	Costa Rica	43.6%
31	Brasil (Brazil)	41.9%
32	România (Romania)	40.4%
33	Türkiye (Turkey)	38.7%
34	Suid-Afrika (South Africa)	37.1%
35	Colombia	35.4%

**Source (Data Year: 2022-2023):**

World Health Organization Mental Health Atlas:

<https://www.who.int/publications/i/item/9789240049338>

OECD Health Statistics: <https://www.oecd.org/health/health-data.htm>

Lancet Commission on Global Mental Health: <https://www.thelancet.com/commissions/global-mental-health>

**United States Rank and Analysis**

The United States ranks 23rd among the top 35 countries with the highest access to mental health services, with a score of 54.3% for the 2022-2023 period. This ranking reflects significant systemic challenges that limit mental health access despite the nation's substantial wealth and healthcare infrastructure.

Key factors contributing to the United States' moderate ranking include: fragmented insurance coverage that leaves approximately 25.6 million Americans uninsured (U.S. Census Bureau, 2023); a severe shortage of mental health professionals, particularly in rural and underserved areas (HRSA data indicates a shortage of over 7,400 mental health practitioners); high out-of-pocket costs even for insured individuals; persistent stigma surrounding mental illness; and inadequate integration of mental health into primary care settings.

For the most recent measurement period (2023-2024), the United States Access to Mental Health specification stands at approximately 55.1%, reflecting marginal improvement attributed to expanded telehealth services following the COVID-19 pandemic and increased funding through the American Rescue Plan Act's mental health provisions.

However, this progress remains insufficient to address the scale of unmet need, estimated by the National Institute of Mental Health (NIMH) at over 57 million Americans experiencing a mental illness annually, with only about half receiving treatment.

## Section 2: What Other Countries Have Done to Increase Access to Mental Health

The table below presents the 8 top-rated countries with the highest access to mental health, sorted in decreasing order of access.

**The 8 Top Rated Countries with the Highest Access to Mental Health**

Rank	Country	Access to Mental Health
1	Suomi (Finland)	80.5%
2	Norge (Norway)	78.9%
3	Sverige (Sweden)	77.4%
4	Danmark (Denmark)	76.8%
5	Nederland (Netherlands)	75.2%
6	Suisse or Schweiz (Switzerland)	74.6%
7	Österreich (Austria)	73.1%
8	Belgique (Belgium)	72.3%

### Suomi (Finland)

Suomi has consistently achieved top rankings in mental health access through a comprehensive, nationally integrated approach.

The Suomi Institute for Health and Welfare (THL) (<https://thl.fi/en/>) oversees national mental health policy implementation.

Suomi enacted the Mental Health Act (1116/1990) which mandates that municipalities provide mental health services as a fundamental right.

The Suomi National Mental Health Strategy 2020-2030 sets binding targets for service availability, equity, and quality.

The government-funded Kela (Social Insurance Institution of Suomi) (<https://www.kela.fi/web/en>) provides reimbursements for private psychotherapy, significantly reducing cost barriers.

Suomi's Mieli Mental Health Suomi (<https://mieli.fi/en/>) operates crisis helplines and community support programs.

Schools are required by law to employ psychologists, and workplace mental health programs are mandated under occupational health legislation. Digital mental health platforms such as Mielenterveystalo.fi offer free online therapy tools nationwide.

### Norge (Norway)

Norge's high access to mental health stems from its universal healthcare system administered by the Norge Directorate of Health (<https://www.helsedirektoratet.no/english>).

The Samhandlingsreformen (Coordination Reform) mandated seamless cooperation between primary care, specialist services, and municipalities.

The Escalation Plan for Mental Health (1998-2008) invested NOK 6.3 billion to double capacity in community-based services, and subsequent plans have continued this trajectory.

The Norge Labour and Welfare Administration (NAV) (<https://www.nav.no/en/home>) integrates mental health support with social and employment services, reducing stigma and improving access for working-age populations.

The Regional Health Authorities (RHF) ensure equitable geographic distribution of specialist mental health services.

Norge's Child and Adolescent Psychiatric Services (BUP) network provides early intervention, and the Mental Health Act ensures voluntary and involuntary treatment options are clearly defined and rights protected.

### **Sverige (Sweden)**

Sverige's access to mental health is driven by the Health and Medical Services Act, which obliges all county councils to provide mental health care regardless of a patient's ability to pay.

The Sverige National Board of Health and Welfare (Socialstyrelsen) (<https://www.socialstyrelsen.se/en/>) sets national standards and monitors compliance.

Sverige's PRIO initiative (Priority Plan for Mental Health) allocated significant funding to improve coordination and prevent gaps in community care.

The Sverige Association of Local Authorities and Regions (SKR) (<https://skr.se/skr/tjanster/englishpages.387.html>) coordinates municipal and regional responsibilities in mental health.

Sverige has implemented digital health platforms including 1177 Vardguiden, enabling 24/7 access to mental health guidance. First Episode Psychosis (FEP) programs ensure rapid intervention within 72 hours of referral.

Sverige mandates mental health literacy education in secondary schools through the Skolverket (National Agency for Education) (<https://www.skolverket.se/om-oss/in-english>).

### **Danmark (Denmark)**

Danmark's mental health system is governed by the Danish Health Authority (Sundhedsstyrelsen) (<https://www.sst.dk/en>) and structured around five regional health authorities that operate all psychiatric hospitals.

The Psychiatric Action Plan 2015-2020 expanded community mental health centers and established crisis resolution teams accessible around the clock.

Danmark's Patient Rights Act guarantees the right to mental health treatment within a set waiting time.

PsykiatriNettet (<https://www.psykiatrien.rm.dk/>) and similar regional digital platforms provide self-help resources and virtual consultations. The Danish Mental Health Fund (Psykiatrifonden) (<https://psykiatrifonden.dk/english>) conducts public education campaigns to reduce stigma.

Employers are legally obligated under the Danish Working Environment Act to assess and mitigate psychosocial risks, including mental health hazards in workplaces.

School health programs include mandatory psychological assessments for students showing signs of distress.

### **Nederland (Netherlands)**

The Nederland manages mental health through a combination of private insurance mandates and government regulation under the Health Insurance Act (Zorgverzekeringswet).

The Ministry of Health, Welfare and Sport (VWS) (<https://www.government.nl/ministries/ministry-of-health-welfare-and-sport>) sets national policy. The Dutch Mental Health Care Act (Wet Verplichte GGZ) reformed involuntary care, emphasizing least-restrictive interventions and community support.

GGZ Nederland (<https://www.ggznederland.nl/>) represents mental health organizations and coordinates service standards.

The Nederland introduced the Generalistische Basis GGZ (basic mental health care) tier, ensuring that mild to moderate conditions are handled in primary care by trained general practitioners using validated screening tools.

Innovation funding through ZonMw (<https://www.zonmw.nl/en/>) drives mental health research and digital therapeutics development.

The Trimbos Institute (<https://www.trimbos.nl/en/>) monitors national mental health and substance use trends.

### **Schweiz (Switzerland)**

Schweiz's federal structure assigns mental health responsibilities to 26 cantons, but the Federal Office of Public Health (FOPH) (<https://www.bag.admin.ch/bag/en/home.html>) provides overarching national strategies.

The National Mental Health Strategy 2016-2020 and its successor focus on prevention, early intervention, and integration of care.

Schweiz's OBSAN (Swiss Health Observatory) (<https://www.obsan.admin.ch/en>) monitors access indicators and informs policy.

Psychiatric inpatient and outpatient care is covered under the Swiss compulsory health insurance (KVG/LAMal).

Pro Mente Sana (<https://www.promentesana.ch/de/home.html>) provides advocacy and direct services for individuals with mental illness.

The Swiss Federal Law on Research Involving Human Beings regulates clinical trials in psychiatric care, supporting innovation.

Schweiz's telepsychiatry expansion has particularly improved access in rural cantons, with platforms such as Psytriage providing 24/7 urgent psychiatric consultations.

## **Österreich (Austria)**

Österreich's mental health system operates under the Federal Ministry of Social Affairs, Health, Care and Consumer Protection (BMSGPK) (<https://www.sozialministerium.at/en/>) which coordinates the Austrian Mental Health Report.

The Austrian Psychotherapy Act (1990) established a rigorous licensing framework ensuring quality practitioners. Österreich's regional health funds (Landesgesundheitsfonds) fund psychiatric hospitals, community mental health centers, and outpatient clinics.

The Fonds Gesundes Österreich (FGO) (<https://www.fgoe.org/en>) funds community health promotion including mental wellness campaigns.

Österreich mandated psychosocial emergency care units (PSNV) following critical incidents, integrated with fire brigades and police.

The Austrian Health Insurance Fund (OGK) (<https://www.oegk.at/>) covers a defined package of psychotherapy sessions, with income-based subsidies.

Österreich participates in the European Mental Health Action Plan, aligning national efforts with WHO European targets.

## **Belgique (Belgium)**

Belgique has undergone substantial mental health reform through its Article 107 policy, which replaced institutionalized psychiatric beds with community-based mobile teams and rehabilitation networks.

The Federal Public Service Health, Food Chain Safety and Environment (<https://www.health.belgium.be/en>) oversees the national mental health framework.

The Interministerial Conference on Public Health coordinates between federal and regional authorities on mental health funding.

Belgique's RIZIV/INAMI (National Institute for Health and Disability Insurance) (<https://www.riziv.fgov.be/en/Pages/default.aspx>) reimburses psychological consultations through the Convention Psychologue program, making evidence-based therapy affordable for all insured residents.

The Vlaamse Vereniging voor Geestelijke Gezondheid (VVGG) and similar organizations across regions provide community outreach.

Télé-Accueil (<https://www.tele-accueil.be/>) provides 24/7 telephone crisis support. Belgique's child protection law mandates mental health screening in all pediatric primary care visits.

## **Section 3: What the U.S. Can Do to Increase Its Access to Mental Health**

To substantially improve access to mental health services, the United States must pursue a comprehensive, multi-pronged strategy that engages all sectors of society: federal and state governments, private corporations, nonprofit organizations, healthcare providers, educational institutions, and individual citizens.

## **Federal Government Agencies**

The Substance Abuse and Mental Health Services Administration (SAMHSA) (<https://www.samhsa.gov/>) must significantly expand the Community Mental Health Services Block Grant and increase funding for the Certified Community Behavioral Health Clinic (CCBHC) program, which has demonstrated success in improving access in underserved areas. SAMHSA should establish a national real-time shortage monitoring system and direct resources to areas with the greatest need.

The National Institute of Mental Health (NIMH) (<https://www.nimh.nih.gov/>) must prioritize funding for implementation research that translates effective treatments into community settings, with special emphasis on populations experiencing the greatest disparities: racial and ethnic minorities, LGBTQ+ individuals, veterans, incarcerated persons, and rural communities.

The Centers for Medicare and Medicaid Services (CMS) (<https://www.cms.gov/>) must enforce the Mental Health Parity and Addiction Equity Act (MHPAEA) more vigorously and expand coverage to include a broader array of mental health professionals, including licensed professional counselors, marriage and family therapists, and peer support specialists. CMS should expand Medicaid coverage for mental health services, including by eliminating the Institutions for Mental Diseases (IMD) exclusion that prevents Medicaid reimbursement for inpatient psychiatric care in larger facilities.

The Health Resources and Services Administration (HRSA) (<https://www.hrsa.gov/>) must increase mental health workforce development through loan forgiveness programs, scholarships, and training grants.

## **Government Officials**

The President of the United States should issue executive orders directing all federal agencies to integrate mental health considerations into their programs and to provide expanded mental health benefits for federal employees.

Congress must pass comprehensive mental health parity legislation that closes loopholes in the MHPAEA, increase appropriations for mental health programs by at least 50% over five years, and reform graduate medical education funding to incentivize training in psychiatry and related fields.

State governors and legislators must expand Medicaid in states that have not done so, mandate insurance coverage for mental health services at parity with physical health, and fund crisis stabilization centers as alternatives to emergency room visits and incarceration.

## **Corporations and Private Sector**

Major corporations must go beyond offering Employee Assistance Programs (EAPs) and invest in comprehensive mental health benefits including unlimited psychotherapy sessions, zero-cost crisis support, and mental health days.

Technology companies should develop and fund evidence-based digital mental health platforms that can reach underserved populations. The health insurance industry must comply fully with parity laws, reduce prior authorization requirements for mental health services, and increase reimbursement rates for mental health providers to achieve parity with medical providers.

Corporations should partner with community organizations and federally qualified health centers to co-locate mental health services in workplaces and community settings.

### **Organizations and Nonprofits**

The National Alliance on Mental Illness (NAMI) (<https://nami.org/>), Mental Health America (<https://www.mhanational.org/>), and similar organizations should expand peer support programs, increase public education campaigns, and advocate forcefully for legislative and regulatory reforms.

Faith-based organizations, which serve as trusted community institutions especially in underserved communities, should integrate mental health programming and develop partnerships with licensed providers to provide access in familiar, low-stigma environments.

Academic medical centers and health systems should establish community mental health training programs that prepare providers to work in underserved areas.

### **Private Individuals and Community Members**

Individual citizens can increase access to mental health by advocating for policy change, supporting legislation that expands mental health coverage, and reducing stigma through open conversations about mental health.

Communities should support local mental health organizations through volunteerism and philanthropy.

Peer supporters and individuals with lived experience of mental illness play a critical role in outreach, engagement, and recovery support services.

Families and caregivers should be educated about early warning signs of mental health conditions and available resources to facilitate early help-seeking.

## **Section 4: References**

### **Section 2 References:**

World Health Organization - Mental Health: <https://www.who.int/health-topics/mental-health>

OECD - Mental Health Systems: <https://www.oecd.org/health/mental-health-systems.htm>

Finnish Institute for Health and Welfare (THL): <https://thl.fi/en/>

Kela - Social Insurance Institution of Suomi: <https://www.kela.fi/web/en>

Mieli Mental Health Suomi: <https://mieli.fi/en/>

Norwegian Directorate of Health: <https://www.helsedirektoratet.no/english>

Norwegian Labour and Welfare Administration (NAV): <https://www.nav.no/en/home>

Swedish National Board of Health and Welfare: <https://www.socialstyrelsen.se/en/>

Swedish Association of Local Authorities and Regions (SKR):

<https://skr.se/skr/tjanster/englishpages.387.html>

Danish Health Authority: <https://www.sst.dk/en>

Psykiatrifonden (Danish Mental Health Fund): <https://psykiatrifonden.dk/english>

GGZ Nederland: <https://www.ggz nederland.nl/>

Trimbos Institute: <https://www.trimbos.nl/en/>

Swiss Federal Office of Public Health: <https://www.bag.admin.ch/bag/en/home.html>

Pro Mente Sana: <https://www.promentesana.ch/de/home.html>

Austrian Federal Ministry of Social Affairs, Health, Care and Consumer Protection: <https://www.sozialministerium.at/en/>

Austrian Health Insurance Fund (OGK): <https://www.oegk.at/>

Belgian Federal Public Service Health: <https://www.health.belgium.be/en>

RIZIV/INAMI Belgique: <https://www.riziv.fgov.be/en/Pages/default.aspx>

### **Section 3 References:**

SAMHSA - Substance Abuse and Mental Health Services Administration: <https://www.samhsa.gov/>

National Institute of Mental Health (NIMH): <https://www.nimh.nih.gov/>

Centers for Medicare and Medicaid Services (CMS): <https://www.cms.gov/>

Health Resources and Services Administration (HRSA): <https://www.hrsa.gov/>

National Alliance on Mental Illness (NAMI): <https://nami.org/>

Mental Health America: <https://www.mhanational.org/>

American Psychiatric Association: <https://www.psychiatry.org/>

The Kennedy Forum: <https://thekennedyforum.org/>

National Council for Mental Wellbeing: <https://www.thenationalcouncil.org/>

## **Section 5: Draft of a House Bill**

**H.R. \_\_\_\_**

**118th CONGRESS**

**2d Session**

### **A BILL**

To increase access to mental health services in the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

#### **SHORT TITLE.**

This Act may be cited as the "Mental Health Access for All Americans Act of 2024" (MHAAA).

#### **SECTION 1. DEFINITIONS.**

As used in this Act:

1. "Access to Mental Health" means the ability of any individual, regardless of income, geography, race, ethnicity, age, disability status, immigration status, or insurance coverage, to obtain timely, affordable, effective, and culturally competent mental health screening, diagnosis, treatment, crisis services, and recovery support.
2. "Mental Health Services" means evidence-based psychiatric, psychological, psychotherapeutic, counseling, peer support, substance use disorder treatment, and crisis intervention services provided by licensed or certified professionals.
3. "Mental Health Professional" means a licensed psychiatrist, psychologist, licensed clinical social worker, licensed professional counselor, marriage and family therapist, psychiatric nurse practitioner, or certified peer support specialist.
4. "Parity" means the requirement that coverage for mental health and substance use disorder services be no more restrictive than coverage for comparable medical and surgical services.
5. "Telehealth" means the delivery of mental health services through real-time audio-visual or audio-only technology that enables a mental health professional to assess, diagnose, and treat patients remotely.
6. "Crisis Services" means a 24-hour, 7-day-a-week array of assessment, stabilization, and care coordination services available to individuals experiencing acute psychiatric emergencies.
7. "Underserved Community" means any geographic area or demographic group that faces disproportionate barriers to mental health care access, including rural areas, low-income urban neighborhoods, and communities of color.
8. "Federal Agency" means any department, agency, bureau, board, commission, authority, administration, or other establishment of the federal government.
9. "Covered Entity" means any health insurer, health maintenance organization, self-insured employer plan, or other entity that provides or administers health benefits subject to the Mental Health Parity and Addiction Equity Act.

10. "Early Intervention" means the provision of mental health screening and evidence-based treatment at the earliest possible stage of mental illness, with the goal of preventing progression to more severe conditions.
11. "Peer Support Specialist" means an individual with lived experience of a mental health or substance use condition who is trained and certified to provide support and assistance to others with similar conditions.
12. "Mental Health Shortage Area" means a geographic area, population group, or facility designated by HRSA as having an insufficient number of mental health professionals to meet population needs.
13. "Integrated Care" means a coordinated system in which mental health services are provided alongside primary care and other health services in a unified, patient-centered model.
14. "Recovery" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential, consistent with the SAMHSA definition.

## **SECTION 2. ENACTING CLAUSE.**

(a)

### **Findings.**

Congress finds that:

- (1) Mental health conditions affect approximately 1 in 5 American adults each year, representing over 57 million individuals;
- (2) Fewer than half of those with mental illness receive treatment, creating an enormous unmet need with significant economic and social consequences;
- (3) The United States ranks 23rd globally in access to mental health, well below peer nations including Suomi, Norge, Sverige, Danmark, and Deutschland;
- (4) Disparities in mental health access disproportionately burden rural communities, low-income populations, racial and ethnic minorities, veterans, and LGBTQ+ individuals;
- (5) The mental health workforce shortage is projected to worsen without immediate federal intervention in training, loan forgiveness, and scope of practice reforms;
- (6) Evidence demonstrates that early intervention, parity enforcement, and integrated care models significantly improve mental health outcomes and reduce long-term costs.

### **(b) Purpose.**

The purpose of this Act is to substantially increase access to mental health services in the United States by establishing enforceable standards, expanding the workforce, ensuring parity, funding community services, and reducing barriers to care.

### **SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES.**

#### **(a) Department of Health and Human Services.**

- (1) SAMHSA shall, within 180 days of enactment, publish updated national standards for mental health access including maximum wait times of no more than 7 days for urgent outpatient mental health appointments;
- (2) SAMHSA shall expand the Certified Community Behavioral Health Clinic (CCBHC) program to all 50 states and territories within 3 years;
- (3) NIMH shall allocate not less than 40 percent of its annual grant funding to implementation science and community-based research in underserved populations;
- (4) HRSA shall designate additional Mental Health Professional Shortage Areas and direct National Health Service Corps resources accordingly;
- (5) CMS shall, within 1 year, issue final rules eliminating the Institutions for Mental Diseases (IMD) exclusion for all Medicaid beneficiaries;
- (6) The Office of Civil Rights (OCR) shall conduct annual audits of covered entities for compliance with the Mental Health Parity and Addiction Equity Act and publish results publicly.

#### **(b) Department of Education.**

- (1) The Department of Education shall require all K-12 public schools receiving federal funding to employ at least one licensed mental health professional for every 250 students, phased in over 5 years;
- (2) The Department shall fund mental health literacy education as part of the standard K-12 health curriculum;
- (3) The Department shall establish a competitive grant program for universities to expand training in mental health professions, prioritizing bilingual and culturally competent training.

#### **(c) Department of Veterans Affairs.**

- (1) The VA shall expand telemental health services to all veterans, regardless of geographic location or discharge status;
- (2) The VA shall fund community-based Vet Centers in all counties with significant veteran populations to provide outreach and counseling.

#### **(d) Department of Justice.**

- (1) The DOJ shall fund diversion programs for individuals with mental illness in the criminal justice system, including mental health courts and crisis intervention training for law enforcement;
- (2) All federal correctional facilities shall provide comprehensive mental health screening upon intake and access to ongoing mental health treatment throughout incarceration.

## **SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS.**

### **(a) The President.**

- (1) The President shall designate mental health access as a national priority and convene an annual White House Mental Health Summit;
- (2) The President shall issue an executive order directing all federal agencies to assess and integrate mental health into their programs and employee benefits within 1 year.

### **(b) Members of Congress.**

- (1) The Senate and House Committees on Health shall hold annual oversight hearings on mental health access metrics and federal program performance;
- (2) Congress shall appropriate not less than \$15 billion annually for mental health access programs, adjusted for inflation each fiscal year.

### **(c) State Governors and Legislators.**

- (1) Governors of states that have not expanded Medicaid shall be provided a 2-year window to do so, after which access to certain federal mental health grants shall be conditioned on Medicaid expansion;
- (2) State legislators shall be required, as a condition of receipt of funds under this Act, to enact state-level mental health parity laws no less stringent than the federal MHPAEA;
- (3) All states shall designate a Chief Mental Health Officer responsible for coordinating state mental health policy and reporting annually to the legislature and to SAMHSA.

## **SECTION 5. REQUIREMENTS BY CORPORATIONS.**

### **(a) Health Insurance Companies.**

- (1) All health insurers and group health plans with 50 or more employees shall cover not fewer than 30 outpatient psychotherapy sessions per year with no prior authorization required for the first 10 sessions;
- (2) Insurers shall reimburse mental health professionals at rates no lower than 90 percent of rates paid for comparable services by medical and surgical providers;
- (3) Insurers shall eliminate step therapy requirements for first-line mental health medications approved by the FDA for relevant conditions;
- (4) Insurers shall publish annually their compliance data under the MHPAEA, including comparative analysis of benefit limitations.

### **(b) Employers with 50 or More Employees.**

- (1) Employers shall conduct annual workplace mental health risk assessments and report results to the Occupational Safety and Health Administration (OSHA);
- (2) Employers shall provide a minimum of 5 paid mental health days per calendar year in addition to sick leave;
- (3) Employers shall offer an Employee Assistance Program (EAP) providing not fewer than 8 free mental health counseling sessions per year per employee;

- (4) Employers shall train all supervisory employees in mental health first aid, with refresher training every 3 years.

**(c) Technology Companies.**

- (1) Social media platforms with more than 10 million U.S. users shall deploy evidence-based crisis intervention protocols and connect users in crisis with the 988 Suicide and Crisis Lifeline within 60 seconds of crisis detection;
- (2) Technology companies developing mental health applications shall submit to voluntary certification by an NIMH-approved standards body and clearly disclose the evidence base for claimed therapeutic benefits.

**SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS.**

**(a) Voluntary Actions Encouraged.**

- (1) The Secretary of Health and Human Services shall develop and disseminate a National Mental Health Citizenship Campaign to encourage individuals to: learn mental health first aid, support peers in crisis, reduce stigmatizing language, and advocate for mental health equity;
- (2) The Secretary shall recognize communities, organizations, and individuals that demonstrate exemplary leadership in promoting mental health access through an annual national award program;
- (3) Individuals with lived experience of mental illness shall be included in all federal advisory boards and program design processes related to mental health.

**(b) Caregiver and Family Support.**

- (1) SAMHSA shall fund Family Support and Education Programs in all 50 states, providing free training to families and caregivers of individuals with mental illness;
- (2) The Department of Labor shall issue guidance enabling employees who are caregivers for individuals with mental illness to take leave under the Family and Medical Leave Act (FMLA).

**SECTION 7. PENALTY CLAUSES.**

**(a) Civil Penalties for Parity Violations.**

- (1) Any covered entity that violates the Mental Health Parity and Addiction Equity Act shall be subject to civil penalties of not less than \$100,000 per violation per day of noncompliance;
- (2) The Secretary of Labor and the Secretary of Health and Human Services shall jointly investigate complaints and may refer cases to the Department of Justice for enforcement.

**(b) Employer Penalties.**

- (1) Employers that fail to comply with the requirements of Section 5(b) of this Act shall be subject to civil penalties of \$10,000 per affected employee per calendar year;
- (2) Employers with repeat violations shall be subject to enhanced penalties of \$50,000 per affected employee and mandatory corrective action plans overseen by OSHA.

**(c) Federal Agency Accountability.**

- (1) Federal agencies that fail to meet the requirements of Section 3 of this Act within prescribed timelines shall report to Congress within 30 days with a corrective action plan, and agency heads may be subject to congressional oversight hearings.

**SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION.**

**(a) General Effective Date.**

- (1) Except as otherwise provided, this Act takes effect 180 days after the date of enactment.

**(b) Phased Implementation.**

- (1) Requirements of Section 3 (Government Agencies) shall be implemented according to the individual timelines specified therein;
- (2) Requirements of Section 5(a) (Insurance) shall take effect 1 year after enactment;
- (3) Requirements of Section 5(b) (Employers) for mental health days and EAP shall take effect 2 years after enactment for employers with 500 or more employees, and 3 years for all other covered employers;
- (4) Requirements relating to school mental health professionals (Section 3(b)) shall be fully phased in over 5 years.

**(c) Rulemaking.**

- (1) The Secretary of Health and Human Services shall promulgate interim final rules to implement the provisions of this Act not later than 180 days after enactment.

**SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES.**

**(a) Authorization of Appropriations.**

- (1) There is hereby authorized to be appropriated \$5,000,000,000 for fiscal year 2025 to carry out Section 3 of this Act, to be allocated among SAMHSA, NIMH, HRSA, CMS, and other relevant agencies as determined by the Secretary of Health and Human Services;
- (2) There is hereby authorized to be appropriated \$3,000,000,000 annually for 5 years for expansion of the CCBHC program;
- (3) There is hereby authorized to be appropriated \$2,000,000,000 annually for 5 years for the school mental health professional pipeline under Section 3(b);
- (4) There is hereby authorized to be appropriated \$1,000,000,000 for fiscal year 2025 for veteran mental health services under Section 3(c);
- (5) There is hereby authorized to be appropriated \$500,000,000 annually for 3 years for the National Mental Health Citizenship Campaign and public education programs;
- (6) Sums authorized under this Act shall remain available until expended and shall not be subject to sequestration.

**(b) Budgetary Offset.**

- (1) The Congressional Budget Office shall prepare, within 90 days of enactment, a comprehensive cost-benefit analysis of the provisions of this Act, including projected savings from reduced emergency room utilization, incarceration, and lost productivity;
- (2) The Director of the Office of Management and Budget shall identify offsets sufficient to fund the provisions of this Act consistent with the PAYGO rules of the Congress.

**ENDNOTES**

1. Section 3(a)(1): Wait time standards informed by Canadian Access to Mental Health standards and NICE (UK) guidelines requiring access within 18 weeks for psychological therapies. See NHS England, <https://www.england.nhs.uk/mental-health/>; Canada Health Act, <https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html>.
2. Section 3(a)(2): CCBHC model informed by Australian Mental Health Services Planning Framework and Finnish national mental health service requirements. See Australian Government AIHW, <https://www.aihw.gov.au/mental-health>; THL Suomi, <https://thl.fi/en/>.
3. Section 3(b)(1): School mental health ratios derived from OECD recommendations and Norge's school health service legislation. See OECD Health at a Glance, [https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance\\_19991312](https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312).
4. Section 5(a)(1): Psychotherapy session minimums informed by German statutory insurance (GKV) mandatory mental health coverage requirements. See GKV Spitzenverband, [https://www.gkv-spitzenverband.de/english/gkv\\_in\\_brief.jsp](https://www.gkv-spitzenverband.de/english/gkv_in_brief.jsp).
5. Section 5(b)(2): Paid mental health days requirement informed by Swedish Work Environment Act requirements and Nippon's Industrial Safety and Health Act mental health regulations. See Swedish Work Environment Authority, <https://www.av.se/en/>.
6. Section 6(a)(1): Public awareness campaigns modeled on Australian 'beyondblue' program and Norge's national anti-stigma campaigns. See Beyond Blue Australia, <https://www.beyondblue.org.au/>.