

FINDING A CURE TO GUN VIOLENCE: HOW IMPROVING AMERICA’S MENTAL HEALTH SYSTEM COULD PREVENT FUTURE GUN VIOLENCE

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I. INTRODUCTION

On April 22, 2018, Travis Reinking killed four people and injured four others inside a Nashville Waffle House wearing nothing but a green a jacket.¹ Prior to this incident, Reinking had an extensive history of exhibiting significant mental instability.² Police reports show that since 2014, his family had been worried about his extreme delusions.³ In 2016, he was taken into protective custody after he reported that Taylor Swift was stalking him and hacking into his phone.⁴ A year later, in 2017, police intervened again after Reinking jumped into a public pool wearing a pink dress and threatened a co-worker with an AR-15 rifle.⁵ Then, just one month later, he was arrested when he tried to force his way into the White

¹ Alan Binder et al., *Waffle House Shooting Suspect Once Had His Guns Taken Away. He Got Them Back.*, N.Y. TIMES (Apr. 23, 2018), <https://www.nytimes.com/2018/04/23/us/nashville-shooting-suspect-guns.html>.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ Anita Wadhvani, *A history of red flags didn't keep guns out of hands of Waffle House shooting suspect*, THE TENNESSEAN (Apr. 25, 2018), <https://www.tennessean.com/story/news/2018/04/25/waffle-house-shooting-suspect-travis-reinking-mental-health-gun-laws/546370002/>.

House, claiming he needed to speak with the President.⁶ Although the Illinois police revoked his firearms license and ordered his guns be transferred to his father, Reinking got them back, including the gun used in his Waffle House attack. Yet, even after his family, police officers, the Secret Service, and the judicial system all became aware of his mental illness, it largely went untreated.

In a system where it is easier to access a gun than it is to access mental health care,⁷ stories like that of Travis Reinking are not uncommon. Between 2017 and 2018, the United States experienced more than fifty mass shootings, or shootings in which three or more people were harmed.⁸ In analyzing the circumstances surrounding these attacks, the U.S. Secret Service found a commonality among them: about two-thirds of the attackers had mental health symptoms prior to their attacks.⁹ While a majority of mass shooters have a history of showing symptoms of mental illness, only about a quarter had been diagnosed or treated for mental illness prior to their attacks.¹⁰

Due to the overwhelming rise of mass shootings occurring throughout the country, demands for reforming gun control legislation have caused lawmakers to contemplate the proper policy responses.¹¹ Since much of the population tends to link mass shootings to mental illness,¹² the focus generally has been on trying to keep firearms out of the hands of the mentally ill. However, as gun control legislation fails to have meaningful effects and mass shootings increasingly become more routine, the discussion has started to change. As a Gallup Poll from August 2019 reveals, a

⁶ *Id.*

⁷ *NAMI Statement On Mass Shootings In Texas and Ohio*, NAT'L ALLIANCE ON MENTAL ILLNESS (Aug. 5, 2019), <https://www.nami.org/About-NAMI/NAMI-News/2019/NAMI-Statement-on-Mass-Shootings-in-Texas-and-Ohio>.

⁸ Nsikan Akpan, *Why Mental Illness Can't Predict Mass Shootings*, PUBLIC BROADCASTING SYS. (Aug. 17, 2019), <https://www.pbs.org/newshour/science/why-mental-illness-cant-predict-mass-shootings>.

⁹ U.S. Dep't of Homeland Sec., *Mass Attacks in Public Spaces-2017* (Mar. 2018), https://www.secretservice.gov/forms/USSS_NTAC-Mass_Attacks_in_Public_Spaces-2017.pdf [hereinafter "Mass Attacks 2017"]; U.S. Dep't of Homeland Sec., *Mass Attacks in Public Spaces-2018* (July 2019), https://www.secretservice.gov/data/press/reports/USSS_FY2019_MAPS.pdf [hereinafter "Mass Attacks 2018"].

¹⁰ Akpan, *supra* note 8.

¹¹ See Mark Moore, *Trump calls for mental-health laws, not gun control*, NEW YORK POST (Aug. 5, 2019), <https://nypost.com/2019/08/05/trump-calls-for-mental-health-laws-not-gun-control/>.

¹² June Gruber & Darby Saxbe, *Five Improvements We Should Make to Mental Health Care*, SLATE (Feb. 27, 2018), <https://slate.com/technology/2018/02/how-to-fix-americas-broken-mental-health-care-system.html>.

majority of Americans are now blaming the mental health system for mass shootings, instead of easy access to guns.¹³

This trend is not just occurring among the general public.¹⁴ Policymakers are also increasingly blaming mental health for mass shootings.¹⁵ For example, after two back-to-back mass shootings killed 31 people, President Donald Trump addressed the nation, calling for “real bipartisan solutions” to curb mass shootings.¹⁶ Instead of demanding that Congress enact laws restricting gun access from mentally ill people, Trump “urged Congress to reform mental health laws to ensure that psychologically disturbed individuals who may be prone to violence get treatment, and, if necessary, be involuntarily confined.”¹⁷

The shift in focus from gun control to mental health is not only justified but necessary. First, mental health issues typically only dominate the headlines following a mass shooting, and even then, the discussion is usually tied to reforming gun control legislation instead of treatment. What is rarely shown in headlines is that millions of Americans are affected by mental illness each year,¹⁸ but nearly half of those individuals do not have access to adequate mental health care.¹⁹ Second, current federal gun control laws relating to mental health have proven to be unworkable because states are not required to report mental health information to the federal background check system, and there is no standard for what information must be reported.²⁰ Despite the existence of many

¹³ Lydia Saad, *More Blaming Extremism, Heated Rhetoric for Mass Shootings*, GALLUP (Sept. 11, 2019), <https://news.gallup.com/poll/266750/blaming-extremism-heated-rhetoric-mass-shootings.aspx> (“The mental health system is faulted by 83% while easy access to guns is faulted by 69%.”).

¹⁴ See Mike Lillis *Lewis hammers GOP on guns: ‘How many more must die?’*, THE HILL (Oct. 4, 2017), <https://thehill.com/homenews/house/353860-lewis-hammers-gop-on-guns-how-many-more-must-die> (Paul D. Ryan, the speaker of the House, said that “mental health reform is a critical ingredient to making sure that we can try and prevent some of these things from happening in the past.”).

¹⁵ *Id.*

¹⁶ *President Trump Address on Mass Shootings*, C-SPAN (Aug. 5, 2019), <https://www.c-span.org/video/?463254-1/president-trump-calls-nation-condemn-racism-bigotry-white-supremacy-mass-shootings> (“We must reform our mental health laws to better identify mentally disturbed individuals who may commit acts of violence and make sure those people not only get treatment but, when necessary, involuntary confinement.”).

¹⁷ Moore, *supra* note 11.

¹⁸ *Mental Health By the Numbers*, NAT’L ALLIANCE ON MENTAL ILLNESS (Sept. 2019), <https://www.nami.org/learn-more/mental-health-by-the-numbers>.

¹⁹ *The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care*, NAT’L ALLIANCE ON MENTAL ILLNESS (Nov. 2017), <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf> [hereinafter *Doctor is Out*].

²⁰ *Mental Health Reporting*, GIFFORDS LAW CENTER, (Sept. 13, 2018), <https://lawcenter.giffords.org/gun-laws/policy-areas/background-checks/mental-health-reporting>.

federal laws prohibiting the mentally ill from accessing firearms, individuals who pose a danger to themselves or others continuously fall through the system and come into possession of firearms.

Thus, the relevant question is not whether there are mechanisms in place to restrict mentally ill individuals from possessing firearms, but rather whether there are additional mechanisms that will better safeguard against gun violence. To be more effective, legislation should focus on intervention and treatment of at-risk individuals who evidence that they pose a heightened risk of danger to themselves or others. Aiming our efforts at preventative mental health measures is a more effective solution than engaging in endless gun control debate. As serious debate surrounding gun violence increases throughout the nation, policy decisions addressing this issue must reflect an accurate understanding of the shortcomings of current federal gun legislation targeting mental illness, as well as the crisis of untreated mental illness in the United States.

This Note will demonstrate how gun control legislation aimed at individuals with mental illnesses has been politically untenable and ineffective at preventing incidents of gun violence. Section II of this Note will introduce the history of both federal and state laws regulating gun control, highlighting those targeting individuals with mental health issues and examining major flaws in the legislation that undermines the federal background check system.

Next, Section III will explain why existing gun legislation is unworkable and ineffective, specifically addressing the discrepancies between various state and federal laws and the barriers to mental health treatment that further hinder gun control. Lastly, Section IV will argue that rather than targeting individuals with mental illness through gun control legislation, legislation should be focused on improving the mental health system to ensure that at-risk individuals receive both the treatment and support necessary. Only then will legislatures develop workable solutions that will deter gun violence.

II. BACKGROUND

Many federal laws are already in place to restrict mentally ill individuals from possessing firearms and guard against firearms being mistakenly sold to dangerous individuals. The principal source of federal regulation prohibiting individuals with mental disorders from possessing firearms was first codified in the Gun

Control Act of 1968 (“Gun Control Act”).²¹ This prohibition has been further enforced through subsequent legislation, including the Brady Bill,²² the National Instant Criminal Background Check System (“NICS”) Improvement Act,²³ and state laws.²⁴ While each new law introduces additional language and attempts to improve firearms regulations, this area of law continues to be unclear due to its ambiguous language.²⁵

After the assassinations of Martin Luther King Jr. and Senator Robert Kennedy, Congress enacted the Gun Control Act to restrict certain at-risk groups from accessing firearms.²⁶ The Gun Control Act restricts these groups’ access to firearms through two provisions. The first makes it “unlawful for any person to sell or otherwise dispose of any firearm or ammunition to any person knowing or having reasonable cause to believe that such person” falls within one of the Gun Control Act’s specified groups.²⁷ The second provision makes it unlawful for any of these groups to “ship or transport in interstate or foreign commerce, or possess in or affecting commerce, any firearm or ammunition; or receive any firearm or ammunition.”²⁸

One of the at-risk groups targeted by the Gun Control Act includes anyone who has been “adjudicated as a mental defective” or who has been “committed to any mental institution.”²⁹ Originally, the statute did not define what it meant to be a “mental defective,” nor did it define what “committed to a mental institution” required.³⁰ As such, Congress failed to provide guidance for determining when a person falls within one of these categories of prohibited persons.³¹ This lack of clarity in the statutory language resulted in inconsistent

²¹ Gun Control Act of 1968, Pub. L. 90-618, 82 Stat. 1213 (codified as amended at 18 U.S.C. § 922 (2012)).

²² Brady Handgun Violence Prevention Act, Pub. L. No. 103-159, 107 Stat. 1536 (1993) (codified as amended at 18 U.S.C. §§ 921-22 (2012)).

²³ NICS Improvement Amendment Act of 2007, Pub. L. No. 110-180, 121 Stat. 2550 (2008).

²⁴ See *Mental Health Reporting*, *supra* note 20.

²⁵ Jana R. McCreary, *Falling Between the Atkins and Heller Cracks: Intellectual Disabilities and Firearms*, 15 CHAP. L. REV. 271, 298 (2011).

²⁶ Franklin E. Zimring, *Firearms and Federal Law: The Gun Control Act of 1968*, 4 J. Legal Stud. 133, 149 (1975).

²⁷ 18 U.S.C. § 922(d)(4) (2012).

²⁸ *Id.* at § 922(g)(4).

²⁹ Gun Control Act of 1968, Pub. L. 90-618, 82 Stat. 1213 (codified as amended at 18 U.S.C. § 922 (2012)).

³⁰ McCreary, *supra* note 25, at 285.

³¹ *Id.*

judicial interpretation and application of the prohibitions on firearm possession among circuit courts.³²

In an attempt to resolve the discrepancies regarding when the Gun Control Act's mental health-related prohibitions apply, the Bureau of Alcohol, Tobacco, Firearms, and Explosives ("ATF") provided definitions of the language.³³ ATF defines the term "adjudicated as a mental defective" to mean: "a determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease (1) is a danger to himself or other; or (2) lacks the mental capacity to contract or manage his own affairs."³⁴ The term "committed to a mental institution" means a "formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority," including an involuntary commitment to a mental institution for mental defectiveness, mental illness, or drug use.³⁵ However, "committed to a mental institution" does not include voluntary admission to a mental institution or a temporary stay for observation.³⁶

Another major flaw in the Gun Control Act is that while it prohibited selling firearms to the specific group, it failed to provide a way to determine whether a purchaser was a member of that group.³⁷ Therefore, Congress created the Brady Handgun Violence Prevention Act ("Brady Bill") in 1993 to correct this gap in the Gun Control Act.³⁸ The Brady Bill established a waiting period before the purchase of a handgun, during which time local law enforcement officers were to perform background checks and created the National Instant Criminal Background Check System ("NICS"), which provides information about persons not qualified to purchase firearms.³⁹ The NICS includes four federal databases that:

contain records, provided by federal and state agencies, on individuals who have been (a) dishonorably discharged from the Armed Forces; (b) are unlawful users of or addicted to a controlled substance; (c) have been adjudicated as a mental

³² *Id.* at 286-87 (Eighth Circuit found that "mental defective" did not include mental illness but did include intellectual disabilities. In contrast, the Sixth Circuit reasoned that "mental defective" included both mental illness as well as intellectual disabilities.).

³³ 27 C.F.R. § 478.11 (2013).

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ 18 U.S.C. §§ 922 (g)(4), (9) (2012).

³⁸ Brady Handgun Violence Prevention Act, Pub. L. No. 103-159, 107 Stat. 1536 (1993) (codified as amended at 18 U.S.C. §§ 921-22 (2006)).

³⁹ *Id.*

defective or been committed to a mental institution;
(d) are illegal or unlawful aliens; or (e) have
renounced their U.S. citizenship.⁴⁰

Two of these databases, the Interstate Identification Index and the NICS Index, specifically focus on identifying individuals who are disqualified from possessing firearms due to their mental health history or developmental disability.⁴¹ The Interstate Identification Index, for example, contains “mental health information that states have reported to the FBI as part of their criminal history records, such as findings of not guilty by reason of insanity or incompetence to stand trial.”⁴²

The Brady Bill, however, was also defective because it failed to account for how it would incentivize states to report any information relating to mental health records to the NICS.⁴³ While the federal law mandates that states disclose records of individuals disqualified from purchasing firearms to the NICS, the Supreme Court held that Congress could not compel state officials to enact or enforce federal law in *Printz v. United States*.⁴⁴ Therefore, the FBI is reliant on states to voluntarily provide records to the NICS, and many states have not been willing to voluntarily disclose pertinent records to the NICS.⁴⁵ As of 2007, over a decade after the Brady Bill became law, only twenty-two states provided any mental health information to the NICS.⁴⁶

States frequently blame federal and state privacy laws for their failure to report complete mental health records to the NICS.⁴⁷ While the disclosure of such mental health records initially violated the federal Health Insurance and Portability and Accountability Act of 1996 (“HIPAA”), in 2016, the Department of Health and Human Services modified the Privacy Rule to “expressly permit certain covered entities to disclose to the [NICS] the identities of those

⁴⁰ Press Release, Fed. Bureau of Investigation, Response to Inquiries on the FBI’s National Instant Background Check System (Apr. 19, 2007), <https://archives.fbi.gov/archives/news/pressrel/press-releases/response-to-inquiries-on-the-fbis-national-instant-criminal-background-check-system> [hereinafter “Response to Inquiries”].

⁴¹ *Mental Health Reporting*, *supra* note 20.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Printz v. United States*, 521 U.S. 898 (1997).

⁴⁵ *Mental Health Reporting*, *supra* note 20.

⁴⁶ Response to Inquiries, *supra* note 40.

⁴⁷ See *Mental Health Reporting*, *supra* note 20; see also, Edward C. Liu et al., *Submission of Mental Health Records to NICS and the HIPAA Privacy Rule*, FED’N OF AM. SCIENTIST (Apr. 15, 2013), <https://fas.org/sgp/crs/misc/R43040.pdf> (stating that approximately half of the states claimed that state and federal health privacy laws caused obstacles to NICS reporting).

individuals who, for mental health reasons, already are prohibited by Federal law from having a firearm.”⁴⁸ However, this does not create a duty to report, but rather a narrowly tailored exception to the Privacy Rule. The information permitted to be disclosed is very limited in scope and restricted to only those individuals who have been involuntarily committed to a mental institution or have been legally determined to be a “danger to themselves or other or to lack the mental capacity to manage their own affairs.”⁴⁹ Thus, the exception does not allow reporting of diagnostic or clinical information.⁵⁰ Further, the rule’s exception does not apply to most providers since it only exempts a “small subset of HIPAA covered entities that either make the mental health determinations that disqualify individuals from having a firearm or are designated by their States to report this information to NICS.”⁵¹

Because of its narrow scope, the changes to HIPAA have had very limited impact, and privacy rules continue to create obstacles to NICS reporting. Even under the modified rule, state laws that prohibit disclosures “would not be preempted under HIPAA and the provider would not be empowered by HIPAA to make such disclosure.”⁵² Due to “the complexity of the law and the potential for substantial fines,” many health care providers are discouraged from disclosing protected health information to NICS.⁵³ Thus, since the exception only permits, but does not require, the disclosure of mental health information to NICS, many providers choose to play it safe by deciding not to report any information for fear of violating HIPAA.⁵⁴

Due to the lack of state reporting, the federal government has made several attempts to strengthen the NICS and improve its effectiveness through enacting subsequent legislation. In response to the Virginia Tech shooting, Congress passed the NICS Improvement Amendments Act of 2007,⁵⁵ which, provided

⁴⁸ Office for Civil Rights, *HIPAA Privacy Rule and the National Instant Criminal Background Check System (NICS)* (June 16, 2017), <https://www.hhs.gov/hipaa/for-professionals/special-topics/nics/index.html>.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Vanessa K. Burrows & Jennifer S. Geetter, *New HIPAA Privacy Rule Permits Disclosures to Background Check System*, NAT’L REVIEW (Jan. 16, 2016), <https://www.natlawreview.com/article/new-hipaa-privacy-rule-permits-disclosures-to-background-check-system>.

⁵³ HIPAA Regulatory Alert, *Careful: HIPAA mental health change is limited, and not a free-for-all*, RELIAS MEDIA (Feb. 1, 2016), <https://www.reliasmedia.com/articles/137165-careful-hipaa-mental-health-change-is-limited-and-not-a-free-for-all>.

⁵⁴ *Id.*

⁵⁵ NICS Improvement Amendments Act of 2007, Pub. L. No. 110-180, 121 Stat. 2560 (Jan. 8, 2008).

financial incentives to encourage state reporting of mental health information, allowed federal funds to be withheld from states that failed to submit certain information, and offered grants to states for establishing and upgrading their reporting and background check system.⁵⁶ However, the NICS Improvement Amendments Act did little to fix the issue since three years after the law took effect, nine states had provided no information and seventeen others had submitted less than twenty-five names of mentally ill people.⁵⁷

More recently, following the 2017 Texas church shooting where the shooter had acquired firearms despite having a dishonorable discharge,⁵⁸ Congress created the Fix NICS Act of 2017 in an effort to address these significant problems with reporting relevant information to the NICS.⁵⁹ The Fix NICS Act made it mandatory for all federal agencies to report criminal convictions, withhold bonus pay to the political appointees of those agencies that failed to be in “substantial compliance” with their reporting plan, and increased funding for assisting states in reporting to the NICS.⁶⁰

Federal law only provides a minimum level of restrictions on firearm possession by mentally ill individuals. Many states have also created their own gun law restrictions relating to mental health. While most states have adopted gun control laws that largely mirror the language of the federal laws, some states have attempted to enact stricter gun regulations regarding mentally ill individuals. In contrast to the Gun Control Act, which only applies to persons involuntarily committed to a mental institution, several states have broadened the scope of their firearms prohibitions to include individuals who voluntarily commit themselves to mental institutions,⁶¹ and some states even place restrictions on individuals

⁵⁶ *Mental Health Reporting*, *supra* note 20.

⁵⁷ Greg Bluestein, *Most states don't follow mental health gun law*, NBC NEWS (Feb. 17, 2011), http://www.nbcnews.com/id/41653442/ns/us_news-crime_and_courts/t/most-states-dont-follow-mental-health-gun-law/#.XaZX7i2ZNmA; *see also*, Craig D. Friedel, *The Mentally Ill Who May Kill Go Unreported Still: Exploration of Potential Nevada NICS Reporting Reform*, 15 NEV. L.J. 1030, 1042 (2015) (stating that the increase of submitted records to NICS was “largely the reflection of a dramatic increase in compliance by only twelve states”).

⁵⁸ Crimeside Staff, *Texas church shooting: How was Devin Patrick Kelley discharged from the Air Force?*, CBS NEWS (Nov. 6, 2017), <https://www.cbsnews.com/news/texas-church-shooting-how-was-devin-patrick-kelley-discharged-from-the-air-force/>.

⁵⁹ Fix NICS Act of 2017, Pub. L. 115-141 (2017).

⁶⁰ Beth Baumann, *What Is the 'Fix NICS' Bill Congress Keeps Talking About?*, TOWNHALL (Mar. 6, 2018), <https://townhall.com/notebook/bethbaumann/2018/03/06/what-is-the-fix-nics-bill-congress-keeps-talking-about-n2455875>.

⁶¹ *See Mental Health Reporting*, *supra* note 20 (stating that in 2013, Florida enacted a law that required reporting of a voluntarily committed person); Ga. Code Ann. § 16-11-129(b)(1)(J) (applying gun restrictions to those voluntarily committed to a mental

who voluntarily seek inpatient mental health treatment.⁶² A number of states also have broader mental health reporting laws that expand the list of mental health information that must be reported to the NICS database.⁶³

III. ANALYSIS

A. WHY GUN CONTROL LEGISLATION IS INEFFECTIVE

While many federal and state laws are already in place to restrict access to firearms by mentally ill individuals, the current federal gun control legislation has failed to keep firearms out of the possession of at-risk individuals.⁶⁴ Since states are not required to report mental health information to the NICS index, the accuracy of federal background checks is dependent on states voluntarily reporting disqualifying records.⁶⁵ However, the FBI's background check is only as good as the records in the NICS databases, and most states have not been willing to disclose many pertinent mental health records of at-risk individuals.⁶⁶ As a result, the NICS database is "likely still missing millions of disqualifying histories" due to the data gaps and loopholes that exist under the current system.⁶⁷

Consequently, states' failures to adequately and promptly report relevant records to NICS has enabled several high-profile shooters to pass background checks and obtain firearms.⁶⁸ For example, Devin Kelley killed twenty-six people inside a church using a firearm that he legally purchased, despite his "history of disqualifying criminal and mental health records."⁶⁹ Kelley was able

facility); Miss. Code Ann. § 45-9-101 (2013) (prohibiting the possession of firearms to individuals who voluntarily committed themselves to a mental institution).

⁶² John Malcolm & Amy Swearer, *Part III: The Current State of Laws Regarding Mental Illness and Guns*, THE HERITAGE FOUNDATION (Feb. 13, 2019), at 3, <https://www.heritage.org/civil-society/report/part-iii-the-current-state-laws-regarding-mental-illness-and-guns>.

⁶³ See *Mental Health Reporting*, *supra* note 20 (an Illinois law requires any physician, clinical psychologist, qualified examiner, law enforcement official, or the primary administrator for any school to report any mentally ill individual who presents a "clear and present danger" or demonstrates violent behavior.); see also Haw. Rev. Stat. § 134-7(c)(3) (2016) (Hawaii law maintains an even broader definition on persons prohibited to possess firearms by prohibiting any person "diagnosed as having a significant behavioral, emotional, or mental disorder.").

⁶⁴ Malcolm & Swearer, *supra* note 62, at 1.

⁶⁵ *Id.*, at 2-3.

⁶⁶ *Id.*, at 5.

⁶⁷ *Id.*, at 3.

⁶⁸ *Id.*

⁶⁹ See *id.*; Katie Mettler & Alex Horton, *Air Force failed 6 times to keep guns from Texas church shooter before he killed 26, report finds*, WASHINGTON POST (Dec. 7, 2018, 6:38 PM), <https://www.washingtonpost.com/national-security/2018/12/08/air-force-failed-six-times-keep-guns-texas-church-shooter-before-he-killed-report-finds/>.

to purchase several firearms because the U.S. Air Force failed to report his records to the NICS on six different occasions.⁷⁰ Similarly, even though Russel Weston spent fifty-four days in a mental institution for schizophrenia, he was able to pass the federal background check prior to attacking the U.S. Capitol because Montana did not report his mental health records to the NICS.⁷¹

In addition, some federal background checks fail to identify disqualified individuals because of inconsistencies between two states' differing gun control laws. These inconsistencies allowed the Waffle House shooter, Travis Reinking, to possess assault weapons and, if attempted, to legally purchase a gun in Tennessee.⁷² Although Reinking had his firearms license revoked, which stripped him of his right to possess firearms in Illinois, Tennessee does not have a similar law to prevent him from acquiring a gun.⁷³

Some states also fail to submit disqualifying mental health histories to the NICS system because of discrepancies between state and federal law. Seung-Hui Cho was able to purchase two semi-automatic handguns, which he used to kill thirty-three people at Virgin Tech, despite his disqualification under federal law. Despite an extensive history of court orders declaring Cho to be mentally ill, an imminent danger to himself, and directing him to receive outpatient treatment, he was able to purchase a gun because those court orders were never submitted to either background check database.⁷⁴ Under federal law, Cho was disqualified from purchasing a firearm, but Virginia did not report this information to the NICS because under state law the disclosure was not required.⁷⁵ Thus, despite the layers of federal gun regulations already in place, there are still loopholes for otherwise disqualified individuals to pass background checks and legally obtain firearms.

Gun control legislation is also unsuccessful at preventing gun violence long-term because of changes in the political landscape. When the majority political party changes following an election, the new administration tends to rescind or alter the previous administration's policy efforts regarding gun control. For example, shortly after taking office, President Trump repealed an Obama-era

⁷⁰ Mettler & Horton, *supra* note 69.

⁷¹ Malcolm & Swearer, *supra* note 62.

⁷² Wadhvani, *supra* note 5.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁴ Michael Lou, *U.S. Rules Made Killer Ineligible to Purchase Gun*, N.Y. TIMES (Apr. 21, 2007), <https://www.nytimes.com/2007/04/21/us/21guns.html> (Virginia's law on "mental health disqualification addresses only the state criteria," which list two categories for "someone who was 'involuntarily committed' or rule mentally 'incapacitated.'").

⁷⁵ *Id.*

regulation⁷⁶ that would have required the Social Security Administration to report to the NICS those individuals that receive “Social Security checks for mental illness and people deemed unfit to handle their financial affairs.”⁷⁷ Therefore, even when the federal government attempts to create meaningful legislation to curb gun violence, it tends to get undermined or overturned by a new administration before it can ever have any impact on gun violence.⁷⁸

Lastly, the issue with the effectiveness of gun control laws could lie in the lack of available treatment for individuals with mental health issues. If mental health treatment is not available, then those at-risk individuals will never be evaluated. In turn, this prevents critical mental health information from being entered into the NICS database. As a result, gun legislation will continue to be ineffective as long as barriers to mental health treatment continue to restrict individuals from receiving necessary treatment. Improving mental health services will benefit the federal background check system by providing more detailed and accurate information about disqualified individuals and this information will actually exist if more people receive the treatment they need.

B. BARRIERS TO MENTAL HEALTH TREATMENT

In a comprehensive study of access to mental health care, the National Council for Behavioral Health determined that “American mental health services are insufficient, and despite high demand, the root of the problem is lack of access – or the ability to find care.”⁷⁹ While one in five adults in the United States suffer from a mental health condition, a majority of people with a mental illness never receive treatment.⁸⁰ The underlying factors causing the current state of the mental health care system in the United States, such as mental health care spending, the number of mental health professionals per capita, and the high costs of treatment, may explain why so many

⁷⁶ See Implementation of the NICS Improvement Amendments Act of 2007, 81 FR 91702-01.

⁷⁷ Corky Siemaszko, *Trump made it easier for the mentally ill to get guns when he rolled back Obama regulation*, NBC NEWS (Aug. 6, 2019), <https://www.nbcnews.com/news/us-news/president-trump-made-it-easier-mentally-ill-get-guns-when-n1039301>.

⁷⁸ *Id.* (“Had that rule taken effect, the Obama administration predicted it would have added 75,000 names to the national background check database.”).

⁷⁹ *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, NAT’L COUNCIL FOR BEHAVIORAL HEALTH (Oct. 10, 2018), <https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/> [hereinafter “New Study”].

⁸⁰ *The State of Mental Health in America 2018*, MENTAL HEALTH AMERICA, <https://www.mhanational.org/issues/state-mental-health-america-2018> (last visited Dec. 7, 2020) (stating 56% of American adults with a mental illness do not receive treatment).

mentally ill individuals go without access to the treatments they medically require.

The inability to pay for the necessary mental health treatment due to the high costs and inadequate insurance coverage for receiving such treatment continues to be one of the largest barriers for accessing treatment.⁸¹ Yet in recent years, there have been steep budget cuts in mental health funding, resulting in limited access to mental health care and higher costs for treatment.⁸² President Trump's proposed Fiscal Year 2020 budget reveals critical shortages in mental health support, specifically, major cutbacks in spending for Medicaid and Medicare and major reductions in mental health research.⁸³ The budget proposal would effectively end the Medicaid expansion under the Affordable Care Act ("ACA"), and instead convert the program's funding into block grants to the states. This change would result in an estimated \$777 billion in cuts to Medicaid, which is the largest payer of mental health services in the country.⁸⁴ President Trump has also pushed for short-term insurance plans, which do not require coverage for mental health care and typically exclude people with pre-existing conditions, such as mental illness.⁸⁵

While there is some legislation in place that seeks to address the lack of adequate insurance coverage for mental health treatment services, these laws fail to effectively address the issue in its entirety and significant inequities remain. Congress passed the Mental Health Parity and Addiction Equity Act ("MHPAEA") in 2008 to require insurers and employers to treat benefits for mental health conditions in the same manner as benefits for physical health treatment.⁸⁶ Under the MHPAEA, limitations on treatments or visits

⁸¹ New Study, *supra* note 79 (42% reported costs and poor insurance coverage as the top barriers for accessing mental health care, and 25% reported having to choose between getting mental health treatment and paying daily necessities.).

⁸² James Lake & Mason Spain Turner, *Urgent Need for Improved Mental Health Care and a More Collaborative Model of Care*, THE PERMANENTE JOURNAL 21: 17-0242 (Aug. 11, 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5593510/>.

⁸³ See Daniel Moritz-Rabson, *Trump Has Tried to Slash Funds for Mental Health Care Despite Post-Shooting Rhetoric*, NEWSWEEK (Aug. 6, 2019), <https://www.newsweek.com/trump-has-tried-slash-funds-mental-health-care-despite-post-shooting-rhetoric-1452907>; *How the President's Proposed Budget Impacts Critical State Health Programs*, NAT'L ACADEMY FOR STATE HEALTH POLICY (March 18, 2019), <https://nashp.org/how-the-presidents-proposed-budget-impacts-critical-state-health-programs/>.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ See Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343, 122 Stat. 3765 [hereinafter "Mental Health Parity"]; Sara R. Collins et al., *Health Insurance Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured*, COMMONWEALTH FUND (Feb. 2019), <https://doi.org/10.26099/penv-q932>.

cannot differ between mental health and medical and surgical benefits.⁸⁷ Additionally, financial requirements, like copays and coinsurance for mental health services must be equal to or less than the requirement for most, but not all, medical and surgical benefits.⁸⁸ Lastly, if a plan allows patients to go out-of-network for medical and surgical benefits, it must also allow that for mental health benefits.⁸⁹

Despite the extensive scope of the MHPAEA, it provides many generous exemptions and loopholes that allow insurers to escape complying with parity requirements. The MHPAEA does not actually require insurers to cover any mental health benefits; instead, the law only mandates that when mental health benefits are offered, they cannot be more limited when compared to other health benefits they offer.⁹⁰ Consequently, since there is no requirement for plans to begin covering mental health services if they currently do not, plans can avoid the law's parity requirements by simply excluding these services altogether.⁹¹ Thus, the MHPAEA fails to achieve true parity since the law did not establish a mandate for insurers to cover certain mental health services.

Additionally, a health plan is allowed to specifically exclude certain diagnoses from its coverage.⁹² The MHPAEA also includes a cost exception which exempts certain group health plans from some of the law's requirements if they incur an increased cost of at least one percent from complying with the MHPAEA.⁹³ As a result of the loopholes in the MHPAEA, access to much-needed treatment is restricted, meaning individuals with mental health needs must "pay out-of-pocket in order to secure treatment."⁹⁴ Thus, the MHPAEA does not guarantee that individuals can receive affordable and accessible mental health treatment services.⁹⁵

⁸⁷ Mental Health Parity, *supra* note 86 at 3881-3893.

⁸⁸ *Id.*; see also *Does Your Insurance Cover Mental Health Services? What You Need to Know About Mental Health Coverage*, AM. PSYCHOLOGICAL ASS'N (Oct. 10, 2019), <https://www.apa.org/helpcenter/parity-guide> [hereinafter *Does Your Insurance*] ("For example, its acceptable to pay a \$20 copay for a mental health visit and a \$10 copay for a primary care visit, as long as your copay is \$20 or more for most of the medical/surgical services covered by your plan.").

⁸⁹ Mental Health Parity, *supra* note 86 at 3881-3893.

⁹⁰ See Commonwealth Fund, *supra* note 86; *Does Your Insurance*, *supra* note 88.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *The Mental Health Parity and Addiction Equity Act*, CENTERS FOR MEDICARE & MEDICAID SERVICES, http://cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (last visited Sep. 24, 2014).

⁹⁴ See Foundation Recovery, *supra* note 86.

⁹⁵ *Id.* (A survey conducted by the American Psychological Association in 2014 estimated that nearly 11 million Americans had mental healthcare needs that were not being met.).

In response to the flaws in the MHPAEA, the ACA expanded coverage of mental health benefits and the MHPAEA protections in 2010.⁹⁶ Building on the MHPAEA, the ACA requires individual and small group insurers also follow the parity law.⁹⁷ Importantly, the ACA also mandates coverage of mental health and substance use disorder services as part of its all essential benefits requirement.⁹⁸ However, the ACA also contains crucial flaws and many of its protections have been weakened dramatically by the Trump Administration.⁹⁹

While the MHPAEA and the ACA have made progress in reducing some of the more obvious barriers on mental health, non-quantitative treatment limitations continue to cause significant barriers to accessing mental healthcare.¹⁰⁰ Such limitations include coverage limits on certain types of treatments, restrictions on geographic location and provider specialty, and methods of determining reasonable and customary charges.¹⁰¹ These non-quantitative limitations have had a significant impact on access to mental healthcare.¹⁰² For example, behavioral healthcare providers were paid over 20% less than primary care services in terms of reimbursements and patients are four times more likely to go out of network to receive mental health treatment.¹⁰³

An additional issue with the current parity legislation is that neither the MHPAEA nor the ACA specifically defined the term

⁹⁶ See Commonwealth Fund, *supra* note 86; Kirsten Beronio et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, U.S. DEP'T OF HEALTH & HUMAN SERVICES (Feb. 20, 2013), <https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans>.

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ Timothy S. Jost, *The Affordable Care Act Under the Trump Administration*, COMMONWEALTH FUND (Aug. 30, 2018), <https://www.commonwealthfund.org/blog/2018/affordable-care-act-under-trump-administration> (Some Trump administration actions have clearly undermined ACA initiatives); see also Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, COMMONWEALTH FUND (July 11, 2018), <https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors> (Consumers have faced higher premiums because the Tax Cuts and Jobs Act eliminates the penalty associated with the individual mandate to purchase insurance.).

¹⁰⁰ Steven Ross Johnson, *Mental Health Parity Remains a Challenge 10 Years After Landmark Law*, MODERN HEALTHCARE (Oct. 5, 2018), <https://www.modernhealthcare.com/article/20181005/NEWS/181009925/mental-health-parity-remains-a-challenge-10-years-after-landmark-law>.

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

“mental illness.”¹⁰⁴ Instead, the statutes provides discretion to health insurance providers with discretion to decide what constitutes a “mental illness.”¹⁰⁵ This lack of direction from the federal government resulted in states and individual insurance companies defining mental illness in several different and sometimes inconsistent ways.¹⁰⁶ Because of the wide variance in states definition of mental illness, mentally ill individuals may still receive disparate treatment based on how “mental illness” is defined in that particular state.¹⁰⁷

The government has also failed to adequately enforce the federal parity laws.¹⁰⁸ The MHPAEA dictates that there must be parity between medical/surgical and mental health benefits, but neglects to provide insurance companies with the applicable standards to abide by.¹⁰⁹ Since neither the MHPAEA nor the ACA provide any guidance on how to evaluate whether a plan achieved parity regarding non-quantitative coverage, there has been “a lack of consistency in the oversight and enforcement on the part of federal and state regulators to get insurers to comply with existing parity laws.”¹¹⁰ Therefore, due to the ambiguity and lack of guidance with non-quantitative coverage limits combined with subtle discriminatory practices, the MHPAEA and ACA have not removed significant barriers to mental health treatment.

Even if an individual has mental health coverage under his or her insurance, mental health providers can choose whether or not to accept insurance.¹¹¹ Despite the increasing cost of operating a private practice, many insurance companies have not increased the reimbursement rate for psychologists in over ten years, and other companies have decreased their reimbursement rates.¹¹² As a result, many mental health professionals refuse to participate in insurance

¹⁰⁴ Joni Roach, Note, *Discrimination and Mental Illness: Codified in Federal Law and Continued by Agency Interpretation*, 2016 MICH. ST. L. REV. 269, 284-85 (2016).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 285-86 (Arkansas defined “‘mental illness’ as all mental illnesses and disorders that are listed in the International Classification of Diseases Manual (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). On the other hand, Iowa law mandates insurance coverage for only ‘biologically based mental illness’” but specifically excludes mental disorders that are included under Arkansas law.).

¹⁰⁷ Steven Johnson, *Mental health parity remains a challenge 10 years after landmark law*, MODERN HEALTHCARE (Oct. 5, 2018), <https://www.modernhealthcare.com/article/20181005/NEWS/181009925/mental-health-parity-remains-a-challenge-10-years-after-landmark-law>.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* (“...states lack consistent definitions on what constitutes mental health and substance use disorders, how they are covered by insurance, and how much effort should be given toward enforcing compliance.”).

¹¹¹ *Does Your Insurance*, *supra* note 88.

¹¹² *Id.*

networks.¹¹³ A study by the Journal of the American Medical Association revealed that only a little over half of psychiatrists nationally take insurance, compared with close to 90% of physicians in other medical specialties.¹¹⁴ Additionally, psychiatrists participate in Medicare and Medicaid at significantly lower rates than other physicians do.¹¹⁵ These overly narrow provider networks and high out-of-pocket costs create barriers for patients trying to access mental health services and for physicians trying to refer their patients for psychiatric care.

Another significant barrier to accessing mental healthcare is the severe shortage of mental health professionals throughout the United States.¹¹⁶ Approximately “91 million Americans live in regions experiencing severe shortages in available mental health professionals.”¹¹⁷ More than 60% of all counties do not have a single psychiatrist,¹¹⁸ and in states with the lowest mental health workforce, there is up to six times the individuals to only one mental health provider.¹¹⁹ These shortages may create such a demand for their services that they do not need to seek reimbursement through insurers because they can be selective about the patients they treat.¹²⁰ As a result, people with mental health needs experience long wait times to receive care and may even be unable to find care.¹²¹

The existing models of delivering care and available treatment approaches fail to adequately address the growing crisis of mental health care. Despite the implementation of MHPAEA and ACA, significant barriers still remain, resulting in nearly half of the individuals living with mental health conditions to go without necessary treatment.¹²² Under the current healthcare system, people with severe mental illness often do not receive treatment until they have suffered serious consequences. Since access to quality, affordable mental healthcare restores lives and prevents mental health problems from worsening, action must be taken to fill gaps in current federal legislation and promote better access.

¹¹³ *Doctor is Out*, *supra* note 19.

¹¹⁴ Tara F. Bishop, et. al., *Acceptance of insurance by psychiatrists and the implications for access to mental health care*, JAMA PSYCHIATRY (Feb. 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/>.

¹¹⁵ *Id.*

¹¹⁶ Mental Health America, *The State of Mental Health in America 2018*, <https://www.mhanational.org/issues/state-mental-health-america-2018> (last visited Dec. 7, 2020) (hereinafter Mental Health America).

¹¹⁷ *Doctor is Out*, *supra* note 113.

¹¹⁸ *Id.*

¹¹⁹ Mental Health America, *supra* note 116.

¹²⁰ *Doctor is Out*, *supra* note 19.

¹²¹ *Id.*

¹²² *Id.*

IV. SOLUTION

Current federal gun control laws are unworkable due to their ambiguous statutory language, inconsistent application of what information is reported, their non-binding nature on states, and jurisdictional discrepancies. Additional attempts at correcting these flaws through new federal gun legislation have repeatedly failed to make any significant difference. However, even if the laws were effective at ensuring necessary health information is entered into the NICS database, there is little evidence to support that more adequate reporting of disqualified individuals is associated with a decrease in gun homicide rates.¹²³

Meanwhile, mass shootings increasingly continue to occur and people suffering from mental illness continue to receive inadequate treatment and support. While overall the mentally ill population is relatively non-violent,¹²⁴ two-thirds of all mass shooters do have a history of suffering from mental illness yet less than a quarter received any mental health treatment prior to their attacks.¹²⁵ Thus, these statistics indicate that a significant number of mass shootings could be prevented by treating these at-risk individuals and thereby preventing an act of violence. Therefore, legislation should not be aimed at expanding current gun control legislation. Instead, efforts need to be aimed at preventative mental health measures through legislation focused on improving mental health treatment accessibility in order to ensure at-risk individuals receive the treatment and support they need. In order to accomplish this, legislation should first be focused on making mental health treatment accessible and affordable by reforming the MHPAEA to achieve true parity; and second, states should implement programs in schools and primary care settings to allow for early detection and prevention of mental illnesses.

¹²³ Fredrick Vars & Griffin Sims Edwards, *Slipping Through the Cracks? The Impact of Reporting Mental Health Records to the National Firearm Background Check System*, UNIV. OF ALA. LEGAL STUDIES RSCH. PAPER NO. 3127786 (2018), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3127786.

¹²⁴ See Heather Stuart, *Violence and Mental Illness: An Overview*, 2 WORLD PSYCHIATRY 121 (2003), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/>.

¹²⁵ Mass Attacks 2017, *supra* note 9; Mass Attacks 2018, *supra* note 9.

A. REFORMING FEDERAL PARITY LAWS TO IMPROVE ACCESS TO MENTAL HEALTH CARE

Despite their prevalence, mental disorders often go undiagnosed, untreated, or undertreated. According to the National Alliance on Mental Health, every mental health disorder can be improved through proper treatment¹²⁶ and the success rate for treating severe mental illness is relatively high: “80 percent for bipolar disorder; 65 percent for major depression; and 60 percent for schizophrenia.”¹²⁷ Having consistent access to effective treatment options is crucial for individuals with mental disorders because without treatment, individuals may struggle considerably, their conditions may worsen and they may even become a danger to themselves or others.¹²⁸ Due to the dramatic consequences that result from mental health illnesses going untreated, such treatment should be “easy to find, affordable and quickly available.”¹²⁹

In order for mental health treatment to be accessible, federal parity laws must be reformed and properly enforced to ensure insurance coverage for mental health treatments. The MHPAEA and the ACA theoretically allow for better access to mental health treatment; however, until such regulations are properly enforced, patients will continue to struggle to receive care. While the MHPAEA is federal law, states have the primary authority to enforce and impose penalties for noncompliance of health insurers under their jurisdiction.¹³⁰ State insurance commissioners are in a much stronger position to enforce the law by ensuring plan compliance with parity standards *before* plans are sold. Thus, state regulators should require every health insurer to submit a report including the data and analysis that proves it is complying with MHPAEA’s requirements before it is permitted to sell insurance plans to consumers. In the absence of oversight from state regulators, the only remedy available for individuals seeking mental health treatment is to engage in a lengthy process of appealing insurance determinations and filing complaints.

¹²⁶ *Individuals with Mental Illness*, NAT’L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition> (last visited Dec. 7, 2020).

¹²⁷ *Nation’s Voice on Mental Illness Unveils Model State Legislation For New National Campaign*, NATIONAL ALLIANCE ON MENTAL ILLNESS, (July 1, 1999), <https://www.nami.org/Press-Media/Press-Releases/1999/Nation-s-Voice-On-Mental-Illness-Unveils-Model-Sta>.

¹²⁸ Joel Young, *Untreated Mental Illness: Understanding the effects*, PSYCHOLOGY TODAY (Dec. 30, 2015), <https://www.psychologytoday.com/us/blog/when-your-adult-child-breaks-your-heart/201512/untreated-mental-illness>.

¹²⁹ *Id.*

¹³⁰ 42 U.S.C.A. § 300gg-22.

Given the substantial differences in access to in-network mental health care and out-of-pocket costs compared to other primary and specialty care, state regulators should also routinely conduct market audits of all health insurers and Medicaid managed care organizations for compliance with the MHPAEA. However, the ability to conduct routine and targeted audits is limited by insufficient funding.¹³¹ Currently, state and federal regulators generally only take action to conduct audits after enough consumer complaints have amassed.¹³² With proper funding, conducting random audits can become powerful tools for enforcing parity compliance. In order for regulators to adequately ensure compliance with the MHPAEA, sufficient funds must be allocated to enforcement measures.

In addition to enforcement issues, federal legislation would be necessary to fix the significant gaps in the existing law. First, the federal government should create a clear, useable definition of “mental illness” for all insurance plans to follow. Ideally, the federal government should adopt a definition of “mental illness” that includes all psychiatric or psychological conditions classified in the Diagnostic and Statistical Manual of Mental Disorders (“DSM”).¹³³ This would allow for broad protection for individuals with mental illnesses because DSM currently defines mental illness to include all mental disorders that are currently recognized by the American Psychological Association.¹³⁴ As a result, the federal government would ensure that individuals with mental illnesses have access to the same insurance coverage regardless of the state where they reside.

Another possible federal reform is to require mandatory insurance coverage of all illnesses and disorders listed in the most current edition of the DSM. This would require that any health insurance provider that provides medical coverage must also make mental health coverage available. This assertive mandate would replace the discretionary language currently in the MHPAEA, which only demands parity when an insurance plan provides mental health coverage. Thus, for mental health parity to truly be achieved, health

¹³¹ The White House, Fact Sheet, Federal Parity Task Force Takes Steps to Strengthen Insurance Coverage for Mental Health and Substance Use Disorders (Oct. 27, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/10/27/fact-sheet-mental-health-and-substance-use-disorder-parity-task-force>.

¹³² *Id.* (“Agencies’ capacity to expand enforcement activities, including conducting random audits, is limited by their staffing resources.”).

¹³³ The DSM “is the standard classification of mental disorders used by mental health professionals in the United States.” *Diagnostic and Stat. Manual of Mental Disorders (DSM-5)*, AM. PSYCHIATRIC ASS’N, <https://perma.cc/V3GJ-2PGP>.

¹³⁴ *Id.*

insurance providers must be mandated to cover treatments for mental illness, alongside all of the similar physical illnesses.

While laws like MHPAEA and the ACA were meant to make health insurance more generous, these laws are currently underenforced and too weak to fully address the challenges of accessing mental health care. The federal and state governments must undertake greater scrutiny of insurers to force compliance and to penalize and make examples of insurers failing to comply. Additionally, the federal government should make changes to correct the gaps in existing federal parity law by creating a uniform definition of “mental illness” to apply to all insurers and requiring mandatory coverage of mental health benefits under all insurance plans.

B. EARLY DETECTION AND PREVENTION

Implementing programs that promote early detection and treatment of mental disorders is necessary to prevent and minimize the occurrence of mental health problems. According to the National Alliance on Mental Illness, “approximately 50% of lifetime mental health conditions begin by age 14 and 75% begin by age 24. At the same time, the average delay between when symptoms first appear and intervention is approximately 11 years.”¹³⁵ Thus, mental illness in children often remains undiscovered for far too long. Since this delay in treatment can result in incomplete and prolonged recovery,¹³⁶ it is crucial to discover and treat mental illnesses early.

Emerging research suggests that intervening early can disrupt the negative course of some mental illness and may reduce long term disability.¹³⁷ Early childhood is a critical period for brain development and related behavior.¹³⁸ Neuroscience research reveals that “mental disorders that occur before the age of six can interfere with critical emotional, cognitive, and physical development, and can predict a lifetime of problems in school, at home, and in the community.”¹³⁹ Without early intervention, child disorders frequently persists into adulthood and “lead to a downward spiral of school failure, poor employment opportunities, and poverty in

¹³⁵ *Mental Health Screening*, NAT’L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/learn-more/public-policy/mental-health-screening> (last visited Dec. 7, 2020).

¹³⁶ Joel E. Miller, *The Need for Early Mental Health Screening and Intervention Across the Lifespan*, AM. MENTAL HEALTH COUNSELORS ASS’N EMERGING CLINICAL PRACTICE BRIEF, 2, (2014).

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

adulthood.”¹⁴⁰ Accordingly, “early detection, assessment, and links with treatment and supports is necessary to prevent mental health problems from worsening.”¹⁴¹

Mental health screenings offer an effective and inexpensive tool for detecting mental disorders, providing early interventions, and determining the appropriate diagnostic follow-up treatment. A screening is a “preliminary procedure used to determine the likelihood that an individual has a particular disease or condition or is at increased risk of developing health or social problems.”¹⁴² These screenings assess “risk factors, which can be genetic, behavioral, or environmental,” and help “distinguish between those who could benefit from a minimal intervention and others who may require further diagnostic assessment or possible treatment.”¹⁴³ Since mental health screenings are able to accurately detect onset symptoms of mental illness, they must implement them in multiple settings, routinely provided, and connected to treatment. Specifically, states should implement systematic mental health screenings and preventative treatment measures in primary care settings and public schools.

First, due to the frequent contact and trusted relationship many have with their primary care provider, mental health screening should be routinely administered in a primary care office. Primary care settings are an optimal environment to detect and address behavioral health concerns because approximately 75% of children with mental health problems are seen within primary care settings.¹⁴⁴ Additionally, studies have found that “while people with common mental illnesses have had some contact with primary care services, few received specialty mental health care.”¹⁴⁵ Thus, primary care clinicians are often the first point of contact for individuals experiencing mental health issues, and consequently, regular screenings in primary care settings would enable earlier identification of mental disorders, which translates into earlier treatment.

¹⁴⁰ *Id.* (“For example, research shows that when children with co-existing depression and conduct disorders become adults, they tend to use more health services and have higher health care costs than other adults.”).

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ Carol Weitzman and John Leventhal, *Screening for behavioral health problems in primary care*, 2006 CURR. OPINION PEDIATRICS 641, 642 (2006), https://med.emory.edu/departments/pediatrics/_documents/uhi/behavioral-health-screening-in-primary-care.pdf.

¹⁴⁵ Miller, *supra* note 136, at 3 (“59 percent of youth who were referred to specialty mental health care never made it to the specialist.”).

While primary care providers are positioned to have a significant role in addressing mental illness, data suggests that primary care providers have consistently underdiagnosed mental health problems in children and that routine, systematic screenings do not occur in most primary care practices.¹⁴⁶ To better address these needs, mental health and primary care services should be integrated to allow for mental disorders to be addressed and treated as primary illnesses.¹⁴⁷ Integrated treatment is a means of coordinating both physical healthcare and mental health interventions in a primary care setting to treat the patient more effectively.¹⁴⁸ Collaborative and integrated care can improve client engagement, allow for better care management, and decrease psychiatric symptoms and disability and the onset of some mental disorders.¹⁴⁹

Several states have implemented successful approaches to integrate mental health services in primary care settings.¹⁵⁰ For example, Massachusetts Child Psychiatry Access Program (“MCPAP”) is a statewide consultation model to help pediatricians and family physicians “promote and manage the behavioral health of their pediatric patients as a fundamental component of overall health and wellness.”¹⁵¹ The project includes six regional consultation teams located at an academic medical center and composed of several child psychiatrists, behavioral health clinicians, resource and referral specialists, and care coordinators.¹⁵² Each team supports local primary care physicians by providing the following services: “immediate clinical consultation over the telephone, expedited face-to-face psychiatric consultation, care coordination for assistance with referrals to community behavioral health services, and continuing professional education specifically designed for primary care providers.”¹⁵³ Collectively, the teams offer services to

¹⁴⁶ Weitzman & Leventhal, *supra* note 144 (One of the most commonly stated reason for the lack of mental health screening and treatment in the primary care setting was a lack of training in behavioral health.).

¹⁴⁷ *Id.*

¹⁴⁸ See *Integrated Care*, NAT’L INSTITUTE OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/integrated-care/index.html> (last visited Dec. 7, 2020).

¹⁴⁹ *Id.* at 3.

¹⁵⁰ See *Successful Examples of Integrated Models from Across the Country*, PRIMARY CARE COLLABORATIVE, <https://www.pcpc.org/content/successful-examples-integrated-models> (last visited Dec. 7, 2020).

¹⁵¹ *Overview, Vision, History*, MASS. CHILD PSYCHIATRY ACCESS PROGRAM, <https://www.mcpap.com/About/OverviewVisionHistory.aspx> (last visited Dec. 7, 2020).

¹⁵² John Straus and Barry Sarvet, *Behavioral Health Care For Children: The Massachusetts Child Psychiatry Access Project*, (2014), <https://www.mcpap.com/pdf/reports/MCPAPHealthAffairsDec2014.pdf>.

¹⁵³ *Id.*

over 95% of the pediatric providers in Massachusetts and is available to all children and families, regardless of insurance.¹⁵⁴

For children to have adequate access to mental health care, primary care providers should integrate mental health services into their practices. While primary care providers typically lack extensive behavioral health training, implementing an individual, educational mentoring program, like the MCAP, can fill that gap by guiding primary care physicians in the evaluation, diagnosis, and treatment of mental health conditions. As a result, these programs will enhance primary care physicians' ability to address their patients' mental health needs, and over time, will establish an integrated field of primary care psychiatry "consisting of the prevention of behavioral disorders, through screening and early identification and treatment of emerging psychiatric problems."¹⁵⁵ Therefore, integrating mental health services into a primary care setting offers a promising, viable, and efficient way of ensuring individuals have access to mental health care; and thus, states should adopt programs modeled after the MCAP.

Second, schools also provide an efficient and convenient location for providing preventative interventions among children since almost every child attends school and spends a significant amount of time there.¹⁵⁶ Additionally, schools are the ideal setting for monitoring children's mental health because the first signs of mental disorders often emerge in a school environment.¹⁵⁷ Consequently, school staff frequently observe students' behavioral issues and emotional disorders, and thus should be educated to recognize early warning signs of mental disorders. Because students are much more likely to receive mental health services when they are accessible in schools,¹⁵⁸ schools provide an efficient delivery system for these services.

While many schools have school psychologists and/or counselors, some school districts have implemented a more comprehensive approach in which they have integrated mental

¹⁵⁴ *Id.* ("the hubs are available to over 95 percent of the 1.5 million children in Massachusetts").

¹⁵⁵ *Id.* at 4.

¹⁵⁶ *Prevention of Mental Disorders: Effective Interventions and Policy Options*, WORLD HEALTH ORG., 30 (2004),

https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf.

¹⁵⁷ Terry Richardson et al., *School-Based Adolescent Mental Health Programs*, SOCIAL WORK TODAY (2012), <https://www.socialworktoday.com/archive/111312p24.shtml>.

¹⁵⁸ Research has shown that "students were 21 times more likely to make mental health related visits to school based [facilities] than to community health clinics." *Schools expand mental health care*, AM. PSYCHOL. ASS'N (Jan. 2009), <http://www.apa.org/monitor/2009/01/school-clinics.aspx>.

health services into existing school programs and initiatives.¹⁵⁹ Most school-based programs allow the mental health needs of students to be identified and addressed on-site through an inter-system collaboration with community health professionals.¹⁶⁰ This approach enables outside specialists to partner with schools to deliver a level of access to mental health services not typically available through standard approaches.¹⁶¹ Research shows that students who participate in school-based mental health programs have experienced significantly less disciplinary issues, improved academic performance, better mental health, and “increased social competence as well as reductions in internalizing and externalizing problems.”¹⁶²

Many states have successfully created sustainable school mental health programs through the use of partnerships and shared resources.¹⁶³ For example, the Georgia Apex Program established “partnerships between community-based mental health providers and local schools to provide school-based mental health services;”¹⁶⁴ specifically, providers supply onsite student services, staff training on identifying children with mental health needs, and coordinate follow-up treatments.¹⁶⁵ During the 2017-2018 school year, 29 mental health providers partnered with 396 elementary, middle, and high schools throughout the state.¹⁶⁶ The program delivered more than 60,000 services to students, including: “behavior health and diagnostic assessments; crisis intervention;

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.* (“Community mental health clinicians apply the latest evidence based practices, including dialectical behavioral therapy, trauma-focused cognitive behavioral therapy, and functional family therapy.”).

¹⁶² *Id.*

¹⁶³ See *Project Aware Ohio*, OHIO DEPT. OF ED., <http://education.ohio.gov/Topics/Student-Supports/PBIS-Resources/Project-AWARE-Ohio> (Ohio created Project AWARE to support schools by “providing training to detect and respond to mental health challenges and crisis in children and youth and increasing access to behavioral health support for children, youth and families.”) (last visited Dec. 7, 2020); see also *Mental Health in Schools*, ILL. DEP’T OF HUM. SERV., <http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Mental%20Health/MH2015/YolondaLinares/MentalHealthSchools.pdf> (“Illinois Department of Human Services, Division of Mental Health, Child and Adolescent Service System’s Mental Health and School Collaboration project seeks to develop systems of support within the educational setting designed to reduce the effects of both internal and external mental health concerns that can cause barriers to learning and engaging in the educational process.”) (last visited Dec. 7, 2020).

¹⁶⁴ CEO Staff, *The Georgia APEX Program: School-based Mental Health Services*, GEORGIA HEALTH POLICY CENTER (2019), <https://ghpc.gsu.edu/download/the-georgia-apex-program-school-based-mental-health-services-year-3/?wpdmdl=4750039&ind=1565465737963>.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

psychiatric treatment; community support; and individual, family, and outpatient services.”¹⁶⁷ The program improved access to mental health care and early identification by focusing on serving schools located in rural areas where these services are more limited, elementary schools where behavioral conditions can be detected earlier in younger students, and Title I schools where students with less resources have more unmet needs.¹⁶⁸

Recognizing the growing need, the Center for Medicare and Medicaid services and the Substance Abuse and Mental Health Services Administration recently released a Joint Informational Bulletin to inform states and schools on the ways school districts and states can use Medicaid to support behavioral health services for children in schools.¹⁶⁹ Specifically, states should amend their state Medicaid plan to cover mental health services provided in school-based settings to receive matching federal funds.¹⁷⁰ In Georgia, 83% of the funding for the APEX program comes from Medicaid sources.¹⁷¹ Accordingly, in order to meet the comprehensive needs of students, states should change their state Medicaid plans to allow billing for school-based mental health services.

The presence of mental illness in children and adolescents, if not properly diagnosed and treated, increases the risk of significant health issues for them as adults and causes an immense psychological, social, and economic burden on society. Given the current limitations in the effectiveness of mental health treatment, the only sustainable method for reducing the burden caused by these disorders is prevention. By implementing programs that provide mental health screenings in accessible locations, such as primary care settings and schools, mental health professionals can ameliorate the negative impact of mental illness. Therefore, states must establish screening procedures to identify mental health problems in

¹⁶⁷ *Id.*

¹⁶⁸ *The Georgia Apex Program Annual Evaluation Report*, CTR. OF EXCELLENCE FOR CHILDREN’S BEHAVIORAL HEALTH (March 8, 2018), https://gacoeonline.gsu.edu/files/2018/03/Apex-Year-2-Evaluation-Report_Final.pdf (More than three quarters (76%) of the schools served by the Apex Program are located in rural areas, almost half (48.8%) are located in elementary schools, and a majority (92.1%) of Title I schools have Apex programs.).

¹⁶⁹ Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, SUBSTANCE ABUSE AND MENTAL HEALTH SRVS. ADMIN. AND CTR. FOR MEDICARE & MEDICAID SRVS. AND CTR. FOR MEDICAID & CHIP SRVS. (Jul. 1, 2019), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib20190701.pdf>.

¹⁷⁰ *Id.*

¹⁷¹ Laura Harker, *Overview: 2020 Fiscal Year Budget for Dep’t of Behavioral Health and Developmental Disabilities*, GEORGIA BUDGET & POLICY INSTITUTE (Feb. 11, 2019), <https://gbpi.org/2019/overview-2020-budget-dbhdd/>.

schools and primary care settings in order to allow for earlier identification, intervention, and treatment.

V. CONCLUSION

Federal gun control legislation aimed at individuals with mental illnesses has proven unsuccessful at preventing dangerous individuals from accessing a gun before an act of violence occurs, and the mental health system fails to identify and support those in need of treatment. Meanwhile, mass shootings are increasing throughout the country and individuals suffering from severe mental disorders continue to go without receiving necessary treatment. Given the inefficiencies of the current laws and the inability to make change through meaningful gun control legislation, the federal government needs to stop reacting to crisis and, instead, take proactive action to address the issues with the mental health systems in this country. Only then will the federal government achieve workable solutions that will deter gun violence long-term.

Therefore, in order to improve access, the mental health parity laws must first be reformed and properly enforced to prevent insurers from placing greater financial requirements or treatment restrictions on mental health care. Second, states must implement programs in schools and primary care settings to provide a viable and efficient means to uncover, diagnosis, and treat underlying mental disorders early. As these measures are taken, access to adequate mental health treatment may finally be achieved and mental health issues can be minimized and even prevented, thus resulting in a better quality of life for individuals suffering from mental disorders, their families, and their communities.