Mental Health of America- Augusta

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Below are four recommendations for mental health funding priorities. In the subsequent pages, each priority is justified utilizing position statements from the National Mental Health of America parent organization.

1. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund programs and services to divert and prevent individuals from entering the criminal justice system. We also encourage the funding of mental health services within the jails. Approximately 35% of the population at Middle River Regional Jail report having mental health problems. The Male and Female mental health pods at the Middle River Regional Jail have a capacity to serve a total of 30 inmates. While the daily census changes, there are approximately 700 inmates in the jail. This means that only a small portion of the population who have mental health needs, receive intensive services. MHAA challenges the Legislators to not only fund the clearly needed services within the jail system, but also to fund programs that will prevent those with Substance Abuse and Mental Health Disorders from entering the system. Defunding the Club house program and the substance abuse programs has left the seriously mentally ill and those in need of substance abuse treatment without local services. The societal cost to incarcerate individuals, far exceeds the societal cost of prevention and diversion.**

2. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund Mental Health Specialists at the Virginia community colleges. Through partnerships with the community services boards, Virginia's community college students could obtain needed services. Currently, there is a mental health crisis among the college students. Unfortunately, the community college system is not funded to address this problem.**

3. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund services directed towards the mental health needs of young people. There is a critical shortage of professionals who are qualified to provide psychiatric services, individual and family therapy and school-based interventions to children and youth. It is vital that funding marked to alleviate the shortage and address the needs be provided.**

4. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund increased salaries for the State Hospitals and Commonwealth Center for Children and Adolescents direct care staff. There is a critical shortage of direct care workers at the state hospitals. These shortages are due to low pay and harsh working conditions. Direct care staff salaries are lower than McDonalds. Direct care staff need training to work effectively in these intense environments. Hiring low skill workers does not encourage retention. Locally, the Mental Health two-year degree program at BRCC could impact the shortage if the pay was reflective of the skills and abilities of these recruits.**

Mental Health of America Augusta Request for funding: 4 position statements

1. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund programs and services to divert and prevent individuals from entering the criminal justice system. We also encourage the funding of mental health services within the jails. Approximately 35% of the population at Middle River Regional Jail report having mental health problems. The Male and Female mental health pods at the Middle River Regional Jail have a capacity to serve a total of 30 inmates. While the daily census changes, there are approximately 700 inmates in the jail. This means that only a small portion of the population who have mental health needs, receive intensive services. MHAA challenges the Legislators to not only fund the clearly needed services within the jail system, but also to fund programs that will prevent those with Substance Abuse and Mental Health Disorders from entering the system. Defunding the Club house program and the substance abuse programs has left the seriously mentally ill and those in need of substance abuse treatment without local services. The societal cost to incarcerate individuals, far exceeds the societal cost of prevention and diversion.**

Mental Health of America Position Statement

The following is justification utilizing MHA adopted position statements.

Position Statement 52: In Support of Maximum Diversion Of Persons With Serious Mental Illness From The Criminal Justice System

CRIMINAL JUSTICE ISSUES

Statement Of Policy

Mental Health America (MHA) supports maximum diversion from the criminal justice system for all persons accused of crimes for whom mental health or substance use treatment is a reasonable alternative to confinement or other criminal sanctions. MHA urges the utilization of outreach programs and other preventative initiatives before interaction with the criminal system occurs. When such interaction does occur, MHA endorses the use of diversion programs at the earliest possible phase of the criminal process, preferably before booking or arraignment. Conversely, MHA supports minimizing the use or threat of use of criminal sanctions to compel mental health treatment. These principles apply with equal force to adults and juveniles.

MHA supports the long-term goal of integrating persons living with mental and substance use conditions into a culturally competent community-based mental health care system focused on consumer empowerment, quality of life, proper treatment and recovery. Over the past two decades, criminal justice diversion programs have emerged as a viable and humane alternative to the criminalization and inappropriate criminal detention of individuals with mental and substance use conditions. Diversion programs benefit the diverted persons, the criminal justice system and the community.

- **Criminal behavior, including violent behavior, is overwhelmingly caused by complex factors other than mental health conditions.**
- **However, many persons with mental health conditions commit crimes because of our failure as a society (due to lack of funding and other resources) to provide them with appropriate and**

timely services. Thus, one of the most effective "diversion" strategies that any jurisdiction can employ is to ensure that persons with mental health conditions receive treatment before they interact with any part of the criminal justice system. To divert people to treatment, we must first fix our broken mental health care system.

- **Additionally, it is crucial that programs designed to divert persons with mental health conditions from the criminal justice system do not divert resources from the already under-funded mental health system. Simply put, no one should have to commit a crime in order to receive mental health services.**
- **Another critical issue for individuals with a mental or substance use condition is that of coercion. MHA is wary of the expanded use of the criminal justice system as a substitute for voluntary community-based treatment.[3]**
- **Avoidance of the coercion inherent in criminal justice surveillance is at the core of the diversion movement, in all its phases.**
- **MHA encourages local and state affiliates, consumers, stakeholders, and other advocates to support the development of diversion strategies that promote police officer training, community engagement, and early intervention in an effort to keep persons with mental and substance use conditions out of the criminal justice system.**

Background

On any given day, over two million people can be found incarcerated in U.S. prisons or jails. [3] Mental illness among today's prisoners is pervasive, with 64% of jail inmates, 54% of state prisoners and 45% of federal prisoners reporting mental health concerns. [4] 37% of state and federal prisoners and 44% of jail inmates have been told by a mental health professional that they had a mental health disorder. [5] Further, more than half of the people in state prisons (53%) and two thirds in local jails (68%) have substance use disorders. These conditions often co-occur; among people with mental health problems in state prisons and local jails, 74% of person in state prisons and 76% or person in local jails also have substance use disorders. [6]

Racial and ethnic minorities have less access to mental health services and are more likely to receive poor quality care when treated. [7] Persons of color are disproportionately represented in both adult and juvenile justice systems. While there are few, if any, differences in the nature and scope of crimes committed by persons of color, their rates of arrest, prosecution, and incarceration, as well as the length of sentences, are substantially higher than the Caucasian population. [8]

Mental health problems among the population of persons in the nation's jails and prisons are serious and growing. The Los Angeles County Jail, Cook County Jail in Chicago and New York City's Riker's Island "each hold more people with mental illness on any given day than any hospital in the United States." [9] In 2015, Cook County Jail in Chicago was described as "America's largest mental hospital" where an estimated one in three inmates has some form of mental illness. [10] In an era of deinstitutionalization, jails and prisons have become de facto mental health treatment facilities.

People with mental and substance use conditions in jails and prisons have complex and challenging needs. Mental health services in prisons and jails are often inadequate. Persons with mental illnesses

are frequently victims of crimes within prisons. The environment in prisons and jails worsens many mental health conditions. Left untreated, persons with serious mental health conditions who are incarcerated for minor crimes may commit additional crimes which may result in extended prison time. These problems can lead to a cycle of suffering, violence and wasted criminal justice resources. [11]

The extraordinary human and financial costs to the criminal justice system argue strongly that effective diversion may produce better results at a lower cost. Community-based programs for people with mental illness and substance use conditions are an effective way to reduce incarceration and resulting costs and harms.

Call To Action

The increasing number of persons with mental health and substance use conditions stuck in the criminal justice system has enormous fiscal, public safety, health and human costs. Diverting individuals with mental and substance use conditions away from jails and prisons and toward more appropriate and culturally competent community-based mental health care has emerged as an important component of national, state and local strategies to provide more effective mental health care. Such diversion also enhances public safety by making jail and prison space available for violent offenders. Diversion programs provide judges and prosecutors with alternatives to incarceration. Diversion programs in communities across the country have been helpful in providing appropriate services to individuals with mental health issues.

Mental Health America recognizes that the development of diversion programs involves negotiation between the mental health system, law enforcement officers, public defenders, prosecutors, court personnel and others in the criminal justice system. Each community must reach consensus on the appropriate type of diversion program to be initiated, since the community is being asked to jeopardize its short-term safety for effective treatment.

Mental Health America supports diversion at the earliest possible point. This includes providing mental health services to at-risk individuals and communities through approachable and convenient avenues. By making these services available before individuals make contact with the criminal justice system, criminalization of individuals with mental health and substance use conditions can be reduced. While there are many terms for and types of this sort of intervention, we will refer to them generally as "Mental Health Programs and Services."

Mental Health Programs and Services

There are a wide variety of outreach programs throughout the nation. These programs aim to identify and treat mental health conditions at the earliest possible point with many of the programs focusing on populations which may otherwise be unlikely to receive any such treatment.

Many mental health programs link mental health services with students attending pre-school through college, these programs focus on identifying children and young adults with mental health needs and providing effective and timely services. [12] Such efforts allow for outreach to individuals who, left untreated, may face serious mental health conditions which may lead to interaction with the criminal justice system.

Other mental health programs aim to create "one-stop shop" care centers which provide comprehensive treatment including but not limited to chemical dependency treatment, primary care screening, and mobile mental-health crisis response. [13] By cutting down on fragmentation of care, such programs provide mental health treatment that is more comprehensive and easier for individuals to navigate. [14] These mental health programs and services strive to both prevent and treat mental health conditions. These goals are in accordance with MHA's support for diversion at the earliest possible opportunity.

Homelessness and housing insecurity, unemployment and under-employment and other aspects of poverty both exacerbate mental health conditions and increase the likelihood of involvement in the criminal justice system. [15] Mental health advocates must work with others to support coordinated efforts to address these risk factors.

Mental Health America recognizes that treatment and prevention are important and necessary but that some individuals will still face the criminal justice system. The Sequential Intercept Model has gained wide acceptance in the criminal justice and behavioral health field as a mechanism for decriminalizing persons with serious mental health conditions. The Sequential Intercept Model envisions a series of points of interception at which intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at subsequent points. [16] Some of these "points" can be identified via two major kinds of jail diversion programs: pre-arrest and post-arrest.

Pre-Arrest ("Pre-Booking") Diversion Strategies

Pre-arrest strategies typically focus on the law enforcement officers who are often the first point of contact with persons in crisis with mental or substance use conditions. Since their initial interactions with persons with mental or substance use conditions are so critical to determining the situation's outcome (i.e., whether or not an individual is to be jailed), pre-arrest jail diversion strategies rely heavily on helping police become knowledgeable about the nature of mental and substance use conditions, including providing officers with tools to de-escalate crisis situations and information regarding options for treatment as an alternative to incarceration that are available in the community.

Examples of pre-arrest strategies include: police training to recognize the signs of mental illness and substance use; deployment of a mobile crisis response team that provides assistance and support to police and the individual; and transportation to treatment rather than jail. One of the nationally-recognized and widely-used models for police training and intervention is called the Memphis Crisis Intervention Team or CIT [17]. Cultural competency training is a critical component; such training seeks to avoid the unequal treatment that comes from stereotyping racial and cultural groups. A comparison of three police-based diversion models found the Memphis CIT program to have high utilization by patrol officers, rapid response time, frequent referrals to treatment, and the lowest arrest rate. [18]

Many persons in crisis have no need of police involvement. Thus, communities should create systems which train "911" operators to identify those persons in crisis whose needs do not require law enforcement intervention. Communities should employ trained mental health professionals and peers to respond to such individuals. This alternative will help reduce the stigma often associated with the presence of the police and with transportation to mental health services by uniformed law enforcement personnel in police vehicles.

Post-Arrest ("Post-Booking") Diversion Strategies

Post-booking diversion programs are the more common type of jail diversion program in the United States. After formal charges have been filed, post-booking programs screen individuals to determine the presence of mental or substance use conditions. These programs involve prosecutors, defense lawyers attorneys, courts and mental health providers in a deliberative process aimed at disposing of the case without additional jail time; and linking the individual with mental health treatment. General jail diversion programs not focused primarily on mental health care and treatment can be helpful guides in developing and implementing mental health-focused strategies. [19] Such services may include transitional housing, court liaisons and prescription medication.

Mental health courts are an example of a post-booking jail diversion program. Mental health courts have been effective at diverting persons charged with non-violent crimes away from jail or prison to community mental health services. [20]

Some jurisdictions have also found it to be effective to divert all persons charged with misdemeanors for whom there is bona fide issue concerning the defendant's fitness to stand trial. Determining whether a defendant is fit to stand trial and restoring her or him to fitness is an expensive process that often results in confinement for longer than the defendant would have been confined if convicted. Moreover, the defendant may not be referred to appropriate services upon release. Thus, referral to community services in lieu of the fitness process may be the more efficient and result in less loss of liberty for the defendant and reduced recidivism. [21]

Diversion Works

Studies show that diversion of persons with mental and substance use conditions accused of misdemeanor crimes into appropriate, community-based mental health treatment programs allows for better long-term results for offenders. [22] Such programs reduce arrests, jail days, hospital stays and total criminal justice expenditures. [23] Beyond the benefits to individuals with mental health conditions, diversion programs also benefit the criminal justice system, allowing it to focus on more serious offenders. Such programs are cost-effective; they save courts time, keep dockets from becoming too large, and reduce prison overcrowding. Additional costs are saved when those with mental illnesses are removed from prisons and provided with appropriate treatment instead. [24]

Dismissal of Charges

Mental Health America believes that successfully completed pre-booking and/or post-booking diversion programs should provide for dismissal of criminal charges. In the case of post-booking diversion, jeopardy of re-involvement in the criminal justice system should be limited in accordance with the criminal justice standards in that jurisdiction. As a guideline, conditions of deferred prosecution, deferred sentence or probation ordinarily should not exceed one year. By avoiding the stigma attached to a criminal sentence, individuals are better able to succeed in society: employment opportunities are more prevalent, completed applications for public benefits are increased in number, and homelessness levels are decreased. [25]

Implementing Effective Diversion Strategies

Timely and accurate mental health screening and evaluation is the single most critical element in a successful diversion program. More treatment resources are desperately needed. Communities must develop services that meet the needs of mental health and substance use consumers. In addition to significant increases in public investment, services must be integrated across public and private agencies. Individual treatment plans should be focused on consumer recovery and choice and should include: mental and physical healthcare, case management, appropriate housing, supportive education, integrated substance abuse treatment, and psychosocial services, in the least restrictive environment possible.

Coalitions

Diversion programs also require the development of community coalitions, including but not limited to partnerships between criminal justice, mental health and substance abuse treatment agencies. Judicial leadership has been particularly instrumental in creating and expanding criminal justice diversion programs across the country, helping to increase public support and funding for alternatives to incarceration. Criminal justice and corrections agencies should be encouraged to develop new sources of funding to expand diversion programs. Coalitions should also be reflective of the diverse make-up of the community. Joint mobile outreach services such as crisis intervention teams are a key element in successful partnering between mental health, substance abuse treatment and law enforcement agencies, with effective diversion to an appropriate treatment plan the critical measure of success. Consumers of mental health and substance abuse services and family members affected by mental illness or substance use need to be included in such coalitions to assure that the real barriers to effective mental health and substance abuse treatment in that community are addressed.

These community coalitions need to reach out to all criminal justice system personnel to ensure that comprehensive culturally competent training is provided at all levels to deal with issues of mental illness and substance use, wherever and whenever they occur. Mental health associations should reach out to or create such coalitions whenever possible. Effective diversion from the earliest point of contact with the criminal justice system of a person with a serious mental illness or serious emotional disorder should be a centerpiece of all mental health planning, with the aim of promoting recovery from mental illness and as an end to all unnecessary use of criminal sanctions.

Effective Period

The Mental Health America (MHA) Board of Directors approved this policy on September 8, 2018. It is reviewed as required by the Mental Health America (MHA) Public Policy Committee.

Expiration: December 31, 2023

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[1] See Mental Health America's Position Statement 72: "Violence: Community Mental Health Response".

[2] See Mental Health America's Position Statements 11-18 on the need to transform our mental health system.

[3] Bureau of Justice Statistics, "Key Statistics, Total Adult Correctional Population: 1980-2015 at www.bjs.gov (2017).

[4] National Research Council, The Growth of Incarceration in the United States: Exploring Causes and Consequences. Washington, DC: The National Academics Press. https://doi.org/10.17226/18613 (2014).

[5] Bureau of Justice Statistics, Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12 at www.bjs.gov (summary published June 2017).

[6] The Center for Health and Justice at TASC, No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives. Chicago: (2013).

[7] U.S. Department of Health and Human Services, Culture, Race, and Ethnicity A Supplement to Mental Health: A Report of the Surgeon General, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health (2001). McGuire, T.G. & Miranda, J., "Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications," Health affairs (Project Hope), 27.2, 393-403, http://doi.org/10.1377/hlthaff.27.2.393 (2008).

[8] Butterfield, F. (1998, March 5). "Prisons Replace Hospitals for the Nation's Mentally ill," New York Times, A1. Testimony of Dr. Arthur Lynch, Director of Mental Health Services for the NYC Health and Hospitals Corporation, before the Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Service, April 22, 1998.

[9] Ford, M., "America's Largest Mental Hospital Is a Jail," The Atlantic. June 8, 2015, https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/ .

[10] See Mental Health America's Position Statement 56: "Mental Health Treatment in Correctional Facilities."

[11] One example of such a program aimed at undergraduate students is Active Minds https://www.activeminds.org/ . For more general information about the importance of providing mental health services to children and adolescents and of the role of prevention, see Mental Health America's Position Statements 41, 42, 46 and 48.

[12] Serre, C.. "Minnesota to pilot innovative 'one-stop shop' model of mental health care," Star Tribune. January 5, 2017.

[13] See Mental Health America's Position Statement 13: "Integration of Mental and General Health Care".

[14] See Mental Health America's Position Statement 38, Housing and Housing First (in process).

[15] Montez, M.R. & Griffin, P.A., "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental illness", Psychiatric Services 57(4):544-9 (2006).

[16] Research and other materials about Crisis Intervention Teams are gathered at www.cit.memphis.edu/publications.html

[17] Steadman, H.J., et al., "Comparing Outcomes of Major Models For Police Response to Mental Health Emergencies", American Journal of Public Health, 51:645-649 (2000).

[18] The Center for Prison Reform, Diversion Programs in America's Criminal Justice System: A Report by the Center for Prison Reform. (Aug. 2015) https://centerforprisonreform.org/wp-content/uploads/2015/09/Jail-Diversion-Programs-in-America.pdf

[19] See Mental Health America's Position Statement 53, Mental Health Courts.

[20] McNeill, D.E. & Binder, R.L., "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence", American Journal of Psychiatry, 164(9):1395-1403 (2007).

[21] See http://www.17th.flcourts.org/11-mental-health-county-court/

[22] See sources on various types of diversion programs and the research demonstrating their effectiveness is available from SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. https://www.samhsa.gov/gains-center/about

[23] Steadman, et al., "Effect of Mental Health Courts on Arrest and Jail Days" Arch. Gen. Psych. 68:167 (2011)

[24] The Center for Prison Reform, Diversion Programs in America's Criminal Justice System: A Report by the Center for Prison Reform. (Aug. 2015). https://centerforprisonreform.org/wp-content/uploads/2015/09/Jail-Diversion-Programs-in-America.pdf .

[25] Zlatan, et. al., "Pretrial Diversion: The Overlooked Pretrial Services Evidence-Based Practice," Federal Probation, v74:1 (June 2010). See also Ty use, S., "The Effectiveness of a Jail Diversion Program in Linking Participants to Federal Entitlements and Stable Housing," Californian Journal of Health Promotion 3: 2, 84-98 (2005). http://www.cjhp.org/Volume3_2005/Issue2/84-98-tyuse.pdf

2. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund Mental Health Specialists at the Virginia community colleges. Through partnerships with the community services boards, Virginia's community college students could obtain needed services. Currently, there is a mental health crisis among the college students. Unfortunately, the community college system is not funded to address this problem.**

Mental Health of America

Position Statement 73: College And University Response To Mental Health Crises

Policy

Colleges and universities ("colleges" refers to any post-secondary education) should be committed to the success and health of every student. Mental Health America ("MHA") envisions healthy college environments in which all students are accorded dignity and fairness, and evidence-based policies are implemented which safeguard students' opportunity to achieve their full potential free from stigma, prejudice, and discrimination. Consistent with this philosophy, MHA supports services and systems that promote the capacity of college students with mental health conditions to live lives that they value and to have the opportunity to attend college in supportive and welcoming environments.

According to the Suicide Prevention Resource Center, one-fifth of college students experience a mental health condition.[a] Students dealing with mental health conditions often feel unable to seek the help they need from their school facilities.[ii] And many colleges and universities are woefully unprepared and under-resourced.[iii] In addition to limited counseling services, comprehensive supports including peer support programs, disability support services, and ongoing outreach and mental health education, are often limited or nonexistent.[iv] For students, this can mean not knowing how to get help, asking for help and getting wait-listed for services, or receiving inadequate supports to navigate their recovery and succeed in school.[v]

For students in crisis, particularly those who manifest self-injurious or suicidal thoughts or behavior, or appear to pose a potential threat to others, the situation is even more dire. College and university administrations, in fear of liability for failure to intervene in time, have taken measures to remove "problematic" students from the school environment by requiring these students to leave school, evicting them from on-campus housing, or charging disciplinary violations.[vi] These policies foster an academic environment where students may live with fear of discussing their mental health concerns or self-injurious or suicidal thoughts with employees of the school and their peers. These responses discourage students from seeking help. Additionally, they isolate students from social and professional supports within the university at a time of crisis, increasing the risk of harm.

Mental health on campus is a complex issue further complicated by triggering life events that may impair mental health or make it more difficult to recognize one's own mental health concerns before a crisis. Colleges and universities have a responsibility to develop policies that will encourage students to seek help without repercussions and to create nondiscriminatory approaches to supporting students in crisis.

This position statement builds on The Bazelon Center for Mental Health Law's Supporting Students: A Model Policy for Colleges and Universities, which led the way in encouraging post-secondary educational

organizations to take more responsibility for safeguarding the mental health of their students.[vii] Bazelon's efforts deserve recognition here.

Background

Age of Onset

Prevalence of mental health issues on college campuses is widespread. An estimated 26% of Americans ages 18 and older live with a diagnosable mental health condition,[a] and half of all serious adult psychiatric illnesses, including major depression, start by age 14, with 75% of all conditions presenting by age 25.[ii] Students have identified depression as one of the top ten impediments to academic performance.[iii] In the 2018 National College Health Assessment, 53.4% of the 104,648 students surveyed reported feelings of hopelessness and 41.9% reported feeling "so depressed that it was difficult to function."[iv] The percentage of students who purposefully injured themselves rose to 27% in the 2016-17 school year.[v] And the same upward trend existed for the percentage of students who seriously considered suicide, which rose to 34.2% over the same period.[vi] While still rare, suicide is still the second leading cause of death among college students.[vii]

College students, many having left home for the first time, face new experiences that put severe stress on their mental health. These concerns include: academic demands, living away from home for the first time, new financial responsibilities, and the need to build new friendships and relationships. As a result of these pressures, depression or other mental health conditions may manifest for the first time during college. Additionally, some students arrive at their new schools with pre-existing mental health needs that have gone undiagnosed or untreated, while others with a history of receiving services may leave for college with no transition plan. Students often do not disclose mental health concerns to an institution because of fear of retaliation. Students and colleges often have incentives to avoid dealing with problems until they surface in disciplinary proceedings or housing decisions.

Lack of Access and Availability

College students can often receive low- or no-cost mental health treatment on campus.[viii] Most four-year residential colleges and universities provide counseling services.[ix] But for students who would like to seek counseling, wait times for an appointment can span weeks.[x] Longer wait times can be dangerous to students who may be at risk of suicide due to their mental health condition, or are experiencing depression. The Center for Collegiate Mental Health reported that by 2015, demand for mental health services had increased by as much as five times the rate of enrollment growth.[xi] However, in the same year, nearly 40% of campus counseling centers reported that their budgets remained unchanged and that they did not gain any professional clinical or psychiatric staff during the past year.[xii] As demand for mental health services continues to outpace supply, students face barriers to receiving the treatments and supports, including disability supports and peer support, they need.

Stigma

While many college campuses have counseling centers for students, the fear of attracting official scrutiny and the stigma attached to mental health often cause students to avoid such resources.[xiii] Only 20-40% of students who experience a mental health disorder seek treatment while in college.[xiv] In one study, while 59% of students reported that they were "aware of free counseling

services on campus" and 49% said that they knew how to access mental health care, only 36% of students who screened positive for major depression received treatment.[xv] Additionally, less than 20% of students who died by suicide had sought on campus counseling.[xvi]

The increasing diversity of college campuses presents additional barriers to accessing mental health services. International students may not engage with campus counseling services because the stigma of mental illness is greater in many countries than in the United States.[xvii] Further, culturally appropriate mental health services may not be available on campus. More than half of campus counseling centers have no staff who identify as Native American, Asian, Black, Latina, Transgender, Gay, Lesbian, or Bisexual.[xviii]

Liability for Colleges and Universities

Colleges and universities historically have not faced liability in cases involving student suicide.[xix] However, in recent years, a few high profile cases have recognized that colleges may have a legal duty to protect students from self-harm and suicide.[xx] In an effort to shield themselves from liability, institutions are enacting policies to enable school officials to suspend a student who exhibits suicidal behaviors.[xxi] These punitive measures conflict with protections under the Americans with Disabilities Act ("ADA") and Fair Housing Act ("FHA").[xxii] If these students are removed due to their mental health conditions, the college or university may face liability under the ADA.[xxiii] Additionally, this practice further stigmatizes mental health conditions and risks a chilling effect on students who need to seek help.

Call To Action

Colleges and universities should provide a variety of mental health resources to proactively reach students where they are.

- **Provide mental health services and no out of pocket cost to students.[a]**
- **Include programs in orientation that discuss the available mental health services, including disability support services, on campus and in the community with students and their families.[ii]**
- **Encourage students with a history of mental health concerns to disclose the concern (with strict confidentiality controls) and to work with the college to create a plan for transitioning to campus.[iii] Advise students on their Family Educational Rights and Privacy Act ("FERPA") rights at orientation and provide the appropriate procedures to be followed by students if they would like to share any of their records with family members.[iv]**
- **Encourage students to create psychiatric advance directives designating their preferences, including who to contact, hospital preferences, and treatment preferences, in the case of crisis.[v]**
- **Create a voluntary program to include the families of students in their counseling services, where family access to treatment is within the sole discretion of the student receiving services. Students should be made aware that they determine the amount of information shared and may revoke this access at any point. This is a controversial idea, but, so long as it is**

a free choice by the student, family support can be very important, and excluding the family invites conflict with the college.

- **Provide education and training so that students, resident advisors, and teaching, administrative, and other staff:**
  - **Are familiar with the signs of mental health conditions, self-harm, and suicide risk;**
  - **Understand and know how to access the range of supports available to students, including peer-run groups, counseling services, and accommodations;**
  - **Know what emergency procedures to follow in a crisis.[vi]**
- **Create student-led steering committees, including representatives from different academic departments, student organizations, staff, and the administration, to identify students' perceptions of barriers and develop solutions on an ongoing basis.**
- **Create student-led peer support programs in partnership with campus counseling centers.[vii]**
- **Offer on-demand teletherapy services[viii], including anonymous mental health screening tools,[ix] with the option to transition to in-person counseling.**
- **Create incentives for student-led initiatives to increase awareness of mental health issues on campus.[x]**
- **Partner with the office of diversity and inclusion, the college administration, and student affinity groups to develop and promote inclusive mental health resources.[xi]**
- **Offer mental health and wellbeing coursework for credit.[xii]**

College and university policies should prevent students with mental health conditions from experiencing stigma and discrimination.

- **Do not include statements in the student conduct code or administer discipline in a way that stigmatizes students with mental health problems and discourages help-seeking.[xiii]**
- **Accommodate students with mental health conditions to enable the student to remain in school, meet academic standards, and maintain social relationships. Accommodations may include:**
  - **Allowing the student to take a reduced course load or complete alternative assignments;**
  - **Allowing the student to postpone assignments and exams;**
  - **Allowing the student to work from home;**
  - **Allowing the student to drop courses;**
  - **Allowing the student to change roommates or rooms;**
  - **Allowing guests to stay in the student's room;**

- Allowing withdrawals from courses if the student experiences academic difficulties due to depression or another mental health condition.[xiv]

- **Create protocols for students to request accommodations.[xv]**
- **Consider absences for treatment to be excused absences.**
- **Provide mental health services on a voluntary basis and allow students to decide whether or not to seek services. But required counseling is often a reasonable alternative to discipline.**

Colleges and universities should develop protocols to respond fairly and effectively to students in crisis.

- **Make emergency psychiatric services, including alternatives to hospitalization, available to students at all times.[xvi] [xvii]**
- **Create protocol to disclose student information to emergency services only when the student will not consent to necessary treatment and interventions.**
- **Train campus police and public safety responders using Crisis Intervention Team ("CIT") programming[xviii].**
- **Establish policies and procedures that hold students with identified mental health conditions responsible for conduct only to the extent that students without a mental health condition would be held responsible.**
- **Permit students to take voluntary leaves of absence for mental health reasons. A student on voluntary leave may maintain contact with, and may visit campus friends and teaching, residence, counseling, and administrative staff and attend campus events.[xix]**
- **Seek involuntary removal of a student only if the student refuses to seek treatment or has displayed behavior that puts the campus at great risk.**
  - **Involuntary removal should have protocols in place to ensure that it is a final step to the college or university's mission to provide a safe and stigma-free environment for students with mental health concerns. Involuntary removal must have due process, in which the student has notice and an ability to appeal the decision. [xx]**
  - **All decisions should be made by objective criteria and input from a counseling professional that has been treating the student.**
  - **Do not hold students who have left school for treatment purposes to a higher standard upon return than other students.**
- **Provide the same arrangements for refunds of tuition or other costs to a student who takes a leave of absence for mental health reasons, whether voluntary or involuntary, as are available for a student who takes a leave of absence for physical health reasons.[xxi]**
- **Allow a student on leave, whether voluntary or involuntary, to request at any time that the college or university evaluate whether the student is ready to return.[xxii]**

- **Colleges and universities should take reasonable steps to insure continuity of care for students whose mental health conditions require that the leave the campus and for students returning from a leave of absence or suspension.**
- **Create re-entry programs for returning students that will help students to build an action plan for academic preparedness, continued wellness, and connection to their community.[xxiii]**

Policies should limit liability for colleges and universities to encourage proper protocols.

- **Mental health services should operate in a way that puts the students' needs first, and not the college's liability concerns. However, significantly, and in distinction from the Bazelon Center's Model Policy,[xxiv] MHA urges a limitation on the liability of colleges that are providing mental health services to their students. It does so based on the belief that such a limitation is necessary in order to encourage these institutions to provide the broadest possible array of mental health services.**
- **State and federal tort laws should not extend liability to residential advisors or other college employees who are unable to successfully address students' mental health needs. Such scrutiny would compromise the advisory function and make identification and remediation of mental health concerns more difficult.**
- **State and federal tort laws should only hold schools liable for student harm caused by mental health conditions when the school is informed of the student's mental health concerns and takes *no* steps to provide, or help provide, the student with mental health services.**

Conclusion

Given the large number of students with mental health conditions attending colleges and universities and the importance of higher education for individuals and society, it is vital that these institutions develop policies which are designed to allow students to participate fully and equitably. We encourage colleges and universities to take advantage of the many innovative programs which are being developed. Many of these are descripted in MHA's "Collegiate Mental Health Innovation Council 2018 Summary Report and Program Highlights"[a] and in the resources referenced in the notes to this report.

Effective Period

The Mental Health America (MHA) Board of Directors approved this policy on March 9, 2019. It is reviewed as required by the Mental Health America (MHA) Public Policy Committee.

Expiration: December 31, 2024

[I] Suicide Prevention Resource Center. Http://Www.Sprc.Org/Settings/Colleges-Universities

[Ii] Public Stigma Of Mental Illness In The United States: A Systematic Literature Review. Https://Www.Ncbi.Nlm.Nih.Gov/Pmc/Articles/PMC3835659/Pdf/Nihms524527.Pdf

[Iii] According To Penn State's Center For Collegiate Mental Health 2017 Annual Report, From 2010-2015 "Counseling Center Utilization Increased By An Average Of 30-40%, While Enrollment Increased By Only 5%." Https://Ccmh.Psu.Edu/Files/2018/02/2017_CCMH_Report-1r4m88x.Pdf

[Iv] Beyond Awareness: Student-Led Innovation In Campus Mental Health. Http://Www.Mentalhealthamerica.Net/Beyond-Awareness-Student-Led-Innovation-Campus-Mental-Health

[V] Center For Collegiate Mental Health 2017 Annual Report. Https://Ccmh.Psu.Edu/Files/2018/02/2017_CCMH_Report-1r4m88x.Pdf

[Vi] Feeling Suicidal, Students Turned To Their College. They Were Told To Go Home. Https://Www.Nytimes.Com/2018/08/28/Us/College-Suicide-Stanford-Leaves.Html

[Vii] Hereafter "Bazelon Center's Model Policy." Http://Www.Bazelon.Org/Wp-Content/Uploads/2017/04/SupportingStudentsCampusMHPolicy.Pdf

[I] Prevalence, Severity, And Comorbidity Of Twelve-Month DSM-IV Disorders In The National Comorbidity Survey Replication (NCS-R). Https://Www.Ncbi.Nlm.Nih.Gov/Pmc/Articles/PMC2847357/Pdf/Nihms176704.Pdf

[Ii] Lifetime Prevalence And Age-Of-Onset Distributions Of DSM-IV Disorders In The National Comorbidity Survey Replication. Https://Jamanetwork.Com/Journals/Jamapsychiatry/Fullarticle/208678

[Iii] American College Health Association. American College Health Association-National College Health Assessment II: Reference Group Executive Summary Spring 2018. Https://Www.Acha.Org/Documents/Ncha/NCHA-II_Spring_2018_Reference_Group_Executive_Summary.Pdf

[Iv] *Id.*

[V] Center For Collegiate Mental Health 2017 Annual Report. Https://Ccmh.Psu.Edu/Files/2018/02/2017_CCMH_Report-1r4m88x.Pdf

[Vi] *Id*.

[Vii] Causes Of Mortality Among American College Students: A Pilot Study. Https://Www.Ncbi.Nlm.Nih.Gov/Pmc/Articles/PMC4535338/

[Viii] While Free Mental Health Counseling Is The Norm On A Majority Of College Campuses, 15 Percent Of Counseling Services Nationwide Still Charge Students Out Of Pocket, Creating A Financial Barrier To Mental Health Treatment. Https://Www.Aucccd.Org/Assets/Documents/Aucccd%25202016%2520monograph%2520-%2520public.Pdf

[Ix] However, Only 8 Percent Of Two-Year Colleges Offer Psychiatric Services. Https://Www.Theatlantic.Com/Education/Archive/2016/10/The-Most-Popular-Office-On-Campus/504701/

[X] According To The 2017 AUCCCD Director Survey The Average Wait Time At College Counseling For All Clients Was 6.7 Business Days. Https://Www.Aucccd.Org/Assets/Documents/Aucccd%202016%20monograph%20-%20public.Pdf

[Xi] Penn State's Center For Collegiate Mental Health 2017 Annual Report. Https://Ccmh.Psu.Edu/Files/2018/02/2017_CCMH_Report-1r4m88x.Pdf

[Xii] The Association For University And College Counseling Center Directors Annual Survey 2015. Https://Www.Aucccd.Org/Assets/Documents/Aucccd%25202015%2520monograph%2520-%2520public%2520version.Pdf

[Xiii] Public Stigma Of Mental Illness In The United States: A Systematic Literature Review. Https://Www.Ncbi.Nlm.Nih.Gov/Pmc/Articles/PMC3835659/Pdf/Nihms524527.Pdf

[Xiv] A Meta-Analysis Of Universal Mental Health Prevention Programs For Higher Education Students. Https://Www.Ncbi.Nlm.Nih.Gov/Pubmed/25744536

[Xv] Help-Seeking And Access To Mental Health Care In A University Student Population. Https://Pdfs.Semanticscholar.Org/515b/5cc53ff418e226ccb64ad8d8238508bb5075.Pdf

[Xvi] National Survey Of College Counseling Centers 2014. Http://D-Scholarship.Pitt.Edu/28178/1/Survey_2014.Pdf

[Xvii] Utilization Of Counseling Services By International Students. Https://Web.A.Ebscohost.Com/Abstract?Direct=True&Profile=Ehost&Scope=Site&Authtype=Crawler&Jrnl=00941956&AN=12010682&H=WpNvRhp1GPdenYM1nw5H9JKTrZkYetF2mMds0ym34ti7H9om9XjSvm10VYwq0vTbY6wTNkmw74D7J1oOUwHJ4w%3d%3d&Crl=C&ResultNs=AdminWebAuth&Resul

[Xviii] The Association For University And College Counseling Center Directors Annual Survey 2017. Https://Www.Aucccd.Org/Assets/2017%2520aucccd%2520survey-Public-Apr17.Pdf

[Xix] The Emerging Crisis Of College Student Suicide: Law And Policy Responses To Serious Forms Of Self-Inflicted Injury. Https://Www.Stetson.Edu/Law/Lawreview/Media/The-Emerging-Crisis-Of-College-Student-Suicide-Law-And-Policy-Responses-To-Serious-Forms-Of-Self-Inflicted-Injury.Pdf

[XXY] See *Schieszler V. Forum College*, 236 F. Supp. 2d 602, 609 (W.D. Va. 2002) (Court Determined College Had An Affirmative Duty To Protect Suicidal Student From Foreseeable Harm); *Shin V. MIT*, No. 020403, 2005 WL 1869101 (Mass. Super. June 27, 2005) (Following A Student Suicide, Parents Were Allowed To Advance Claim Against University Administrators).

[Xxi] Giving Them The Help They Need. Https://Www.Chronicle.Com/Article/Giving-Them-The-Help-They/25347

[XXY] Americans With Disabilities Act Of 1990 (ADA), 42 U.S.C. §§ 12101-12213 & 47 U.S.C. § 225 (2006). The ADA Prohibits Discrimination Against Students Whose Mental Health Problems "Substantially Limit A Major Life Activity," Including Learning. Under The ADA, Colleges And Universities Must Provide Protected Students With "Reasonable Accommodations", Reasonable Modifications To Normal Rules And Procedures To Allow Those Students To Continue And Succeed In Higher Education.

[Xia] *Id*.

[I] If Students Are Referred To Off-Campus Services Requiring Out Of Pocket Expenses, Colleges And Universities Should Implement Programs To Subsidize These Costs, Such As Georgetown's Off-Campus Therapy Stipend Program. Http://Www.Saxafund.Org/Off-Campus-Therapy-Stipend/

[Ii] Currently Three States, Ohio (Http://Codes.Ohio.Gov/Orc/3345.37), Texas (Https://Statutes.Capitol.Texas.Gov/Docs/ED/Htm/ED.51.Htm%2351.9194), And West Virginia (Http://Www.Wvlegislature.Gov/Bill_Text_HTML/2015_SESSIONS/RS/Pdf_bills/HB2535%2520ENR%2520PRINTED.Pdf) Require Their Institutions Of Higher Learning To Provide Students With Information Regarding Available Mental Health And Suicide Prevention Services With Various Requirements Including Dissemination To Staff And Graduate Students And The Posting Of All Materials Online.

[Iii] See Jed Foundation's Transition Of Care Guide. Https://Www.Settogo.Org/Wp-Content/Uploads/2017/03/Transition-Of-Care-Guide.Pdf

[Iv] Such Procedures Can Be Modeled After Illinois' Student Optional Disclosure Of Private Mental Health Act. Http://Www.Ilga.Gov/Legislation/Ilcs/Ilcs3.Asp?ActID=3654&ChapterID=18

[V] See MHA's Guide To Psychiatric Advance Directives. Http://Www.Mentalhealthamerica.Net/Psychiatric-Advance-Directives-Taking-Charge-Your-Care

[Vi] See The Bazelon Center's Model Policy. Http://Www.Bazelon.Org/Wp-Content/Uploads/2017/04/SupportingStudentsCampusMHPolicy.Pdf

For Example, The University Of North Carolina's Mental Health Ambassadors Program Trains Its Ambassadors In Mental Health First Aid, As Well As Campus-Specific Policies And Procedures So That These Ambassadors Know How To Address Mental Health Crises And Can Disseminate Preventive Resources. Https://Uncstudentorgs.Campuslabs.Com/Engage/Organization/Mha

[Vii] The Wolverine Support Network (Https://Www.Umichwsn.Org/) Is An Example Of A Cost-Free Peer-Led Resource That Reflects The Needs Of The University Of Michigan's Student Body. Peer Support Programs Can Extend To Virtual Communities Like The Buddy Project, Which Pairs Students And Young Adults Interested In Raising Awareness For Mental Health. Http://Www.Buddy-Project.Org/ It Is Vital That Peer Service Be Provided By Persons Who Are Trained To Do So. See MHA Position Statement 37 For A Detailed Discussion Concerning Peer Support Services.

[Viii] An Example Of A Teletherapy Service Is Better Mind, An Online Therapy Platform That Allows College Students To Have Live Video-Therapy Sessions With Licensed Mental Health Counselors. Better Mind Is The Only Teletherapy Platform That Focuses Exclusively On College Students. Https://Www.Bettermynd.Com/

[Ix] Mental Health America Offers Free Evidence-Based Screening Tools For Depression, Anxiety, Bipolar, Psychosis, Eating Disorders, PTSD, Work Health, And Addiction. Https://Screening.Mentalhealthamerica.Net/Screening-Tools

[X] Harvard's University Student Health Coordinating Board Created The Vincent Prize To Award $1,500 To Students Who Came Up With The Most Innovated And Practical Ideas About Promoting Mental Health Awareness. Https://News.Harvard.Edu/Gazette/Story/2001/03/Prize-To-Reward-Innovative-Ideas-On-Mental-Health/

[Xi] For An Example Of An Effective Partnership, See Emory University's Black Mental Health Ambassadors, Which Advocates For Black Undergraduate And Graduate Students And Held The University's First Ever Black Mental Health Week. Http://Studenthealth.Emory.Edu/Cs/Outreach_services/Volunteer_opps/Bmha.Html

[Xii] The University Of Illinois At Chicago Successfully Piloted A 2-Credit Mental Health Course And Will Continue To Offer The Course In Subsequent Semesters. Http://Studenthealth.Emory.Edu/Cs/Outreach_services/Volunteer_opps/Bmha.Html

Yale's Most Popular Course, "The Science Of Well-Being," Is Now Available On-Line. Https://News.Yale.Edu/2018/02/20/Yales-Most-Popular-Class-Ever-Be-Available-Coursera

[Xiii] The Jed Foundation Recommends That Colleges And Universities Do Not Include Statements In Their Student Conduct Code That "Prohibit Suicidality Or Self Injurious Behavior" Because Those Statements May Stigmatize Students With Mental Health Problems And Discourage Help-Seeking. Http://Www.Jedfoundation.Org/Wp-Content/Uploads/2016/07/Student-Mental-Health-And-The-Law-Jed-NEW.Pdf

[Xiv] See The Bazelon Center's Model Policy. Http://Www.Jedfoundation.Org/Wp-Content/Uploads/2016/07/Student-Mental-Health-And-The-Law-Jed-NEW.Pdf

[Xv] The Bazelon Center's Model Policy Suggests That Colleges And Universities Should Not Require Students To Disclose Their Mental Health Conditions In Order To Receive Accommodations. Http://Www.Bazelon.Org/Wp-Content/Uploads/2017/04/SupportingStudentsCampusMHPolicy.Pdf

[Xvi] See Mental Health America's Position Statement On Responding To Behavioral Health Crises. Http://Www.Mentalhealthamerica.Net/Issues/Position-Statement-59-Responding-Behavioral-Health-Crises

[Xvii] New Jersey Law Now Requires Colleges And Universities To Have Mental Health Counselors Available To Students 24 Hours A Day, Seven Days A Week Either On Campus Or By Phone. Https://Www.Njleg.State.Nj.Us/2016/Bills/S1000/557_T1.HTM

[Xviii] Crisis Intervention Training Is The Most Comprehensive Police Officer Mental Health Training Program In The Country And CIT Training Programs Are Offered In 45 States As Well As The District Of Columbia. Https://Www.Theatlantic.Com/Health/Archive/2013/10/How-Police-Officers-Are-Or-Aren-T-Trained-In-Mental-Health/280485/

[Xix] See The Bazelon Center's Model Policy. Http://Www.Bazelon.Org/Wp-Content/Uploads/2017/04/SupportingStudentsCampusMHPolicy.Pdf

[XXY] Decisions To Impose Involuntary Leave Or Otherwise Respond To A Student With Depression Or Another Mental Health Condition Should Be Informed By The Guidance Issued By The U.S. Department Of Education, Office For Civil Rights, In Three Decisions, OCR # 03-04-2041 (DeSaille Univ. 2/17/05), OCR # 15-04-2042 (Bluffton Univ. 12/2/04), And OCR # 09-00-2079 (Woodbury Univ. 6/29/01). The Letters Discuss The Application Of The ADA's "Direct Threat" Provisions, Procedural Requirements, Probative Evidence And Other Matters. They Counsel That, Among Other Things:

- **“In A Direct Threat Situation, A College Needs To Make An Individualized Determination Of The Student’s Ability To Safely Participate In The College’s Program, Based On Reasonable Medical Judgment Relying On The Most Current Medical Knowledge Or The Best Available Objective Evidence.”**
- **“In Exceptional Circumstances, Such As Situations Where Safety Is Of Immediate Concern, A College May Take Interim Steps Pending A Final Decision Regarding Adverse Action Against A Student As Long As Minimal Due Process (Such As Notice And An Initial Opportunity To Address The Evidence) Is Provided In The Interim And Full Due Process (Including A Hearing And The Right To Appeal) Is Offered Later.”**

[Xxi] **See The Bazelon Center’s Model Policy.** Http://Www.Bazelon.Org/Wp-Content/Uploads/2017/04/SupportingStudentsCampusMHPolicy.Pdf

[XXY] ***Id*.**

[Xxiii] **Programs Such As Fountain House College Re-Entry Help Students Who Take Leave Due To Mental Health Concerns To Improve Academic Performance, Learn Wellness Tools, And Build A Supportive Network For A Successful Return To College.** Https://Collegereentry.Org/

[XXY] **See Endnote No. 7 Above**

[I] **Http://Www.Mentalhealthamerica.Net/Beyond-Awareness-Student-Led-Innovation-Campus-Mental-Health**

LINKAGE TO BROADER ISSUES

- View All Linkage to Broader Issues
- College and University Response to Mental Health Crises
- Health Care Reform
- Violence: Community Mental Health Response

Sign up to stay connected

3. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund services directed towards the mental health needs of young people. There is a critical shortage of professionals who are qualified to provide psychiatric services, individual and family therapy and school-based interventions to children and youth. It is vital that funding marked to alleviate the shortage and address the needs be provided.**

Mental Health of America Position Statement

The following is justification utilizing MHA adopted position statements.

Position Statement 41: Early Identification Of Mental Health Issues In Young People

CHILDREN'S ISSUES

Policy

Early identification, accurate diagnosis and effective treatment of mental health and substance use conditions[1] can alleviate enormous suffering for young people and their families dealing with behavioral health challenges. Providing early care can help young people to more quickly recover and benefit from their education, to develop positive relationships, to gain access to employment, and ultimately to lead more meaningful and productive lives.

Thus, Mental Health America (MHA) supports universal screening for potential mental health problems for the same reasons and in the same settings that screening has long been mandated for potential physical health problems, like vision and hearing. MHA believes that early identification of mental health and substance use issues should occur where and when young people are mostly likely to present concerns, such as in school. In addition to schools, primary health care providers and other community leaders should be given the tools and supports necessary to identify signs of mental health or substance use issues at the earliest possible time. This position is endorsed by the American Academy of Pediatrics[2] and (for depression in youth over age 11) the United States Preventive Services Task Force.[3] Doing so will reduce the likelihood and consequences of delaying care.

Community outreach and education are necessary to identify problems in order to refer youth to additional comprehensive assessment and to the care they need to cope with mental health and substance use challenges. Funding and promotion of community outreach and education to identify early signs of mental health and substance use conditions can arm parents, teachers, friends, spiritual leaders, mentors, and community leaders with knowledge, skills, and resources for identifying and referring youth into necessary care. Additional research is needed to identify the best curricula for community-wide education that will most likely lead to proper referral and reduce the severity and duration of mental illness and addiction.

Whenever warning signs are observed, resources should be available to parents or guardians to access comprehensive mental health and substance use evaluations and services needed to promote recovery.[4] Access to adequate care can reduce barriers to learning and improve educational, behavioral and health outcomes for our youth. The best services promote collaboration among all of the people available to help, including families, educators, child welfare case workers, health insurers, and

community mental health and substance use treatment providers. Barriers should be reduced, and incentives created to ensure increase collaboration across systems and funding sources.

Background

Mental health problems affect one in five young people at any given time, and about two-thirds of all young people with mental health problems are not getting the help they need. [5] [6] Research shows that early intervention can prevent significant mental health problems from developing.[7] Epidemiological research confirms the relationship between mental health issues and suicide or self-mutilation, substance abuse, suspension, dropping out, expulsion and involvement with the juvenile justice system.[8] The research also shows that effective treatment can reduce the risk of such consequences.[9] [10]

The 2002 New Freedom Commission on Mental Health proposed as a goal that: "In a transformed mental health system, the early detection of mental health problems in children and adults - - through routine and comprehensive testing and screening - - will be an expected and typical occurrence."

The U.S. Centers for Disease Control and Prevention[11] and the Substance Abuse and Mental Health Services Administration[12] conduct comprehensive research on the prevalence rates of mental health and substance use issues as well as the barriers to accessing care. Key recent findings include:

- **Millions of American young people live with depression, anxiety, psychosis, attention problems, autism spectrum disorders, and a host of other mental and behavioral health issues. Attention Deficit and Hyperactivity Disorder (ADHD) was the most prevalent current diagnosis among children and youth aged 3–17 years.[13]**
- **The number of young people with a mental disorder increased with age, with the exception of autism spectrum disorders, which was highest among 6- to 11-year-old children.**
- **Boys were more likely than girls to have attention, behavioral or conduct problems, autism spectrum disorders, anxiety, and cigarette dependence.**
- **Adolescent boys aged 12–17 years were more likely than girls to die by suicide.**
- **Adolescent girls were more likely than boys to have depression or an alcohol use disorder.**

Young people aged 3-17 years had:

- **Attention problems (6.8%)**
- **Behavioral or conduct problems (3.5%)**
- **Anxiety (3.0%)**
- **Depression (2.1%)**
- **Autism spectrum disorders (1.1%)**

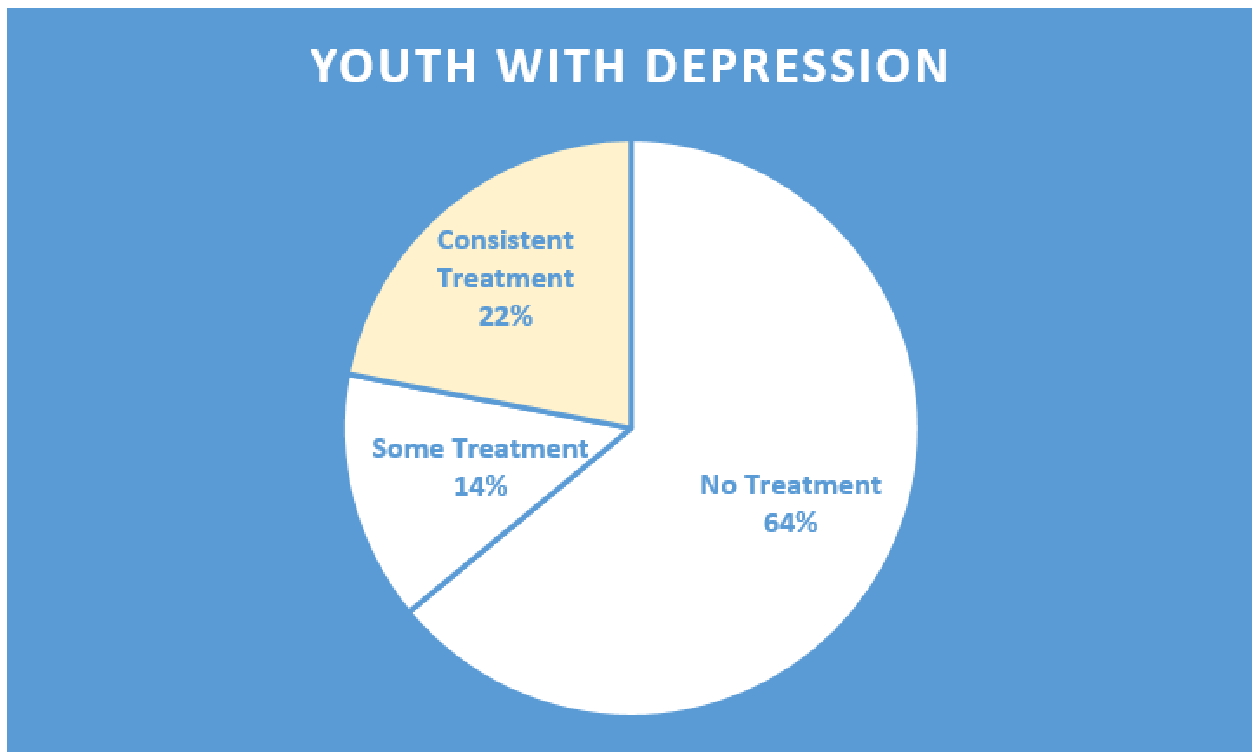
Adolescents aged 12–17 years had:

- **Illicit drug or alcohol dependence or abuse in the past year (5.5%)**

- **Major depression (11%);**
- **Severe depression[14] (7%)**
- **Cigarette dependence in the past month (2.8%)**
- **Bipolar disorder (3%)[15]**
- **Eating disorder (2.7%)[16]**

Recent research on early signs of psychotic illnesses like schizophrenia identified that 100,000 adolescents and young adults experience first episode psychosis each year.[17]

And suicide, which can result from the interaction of mental disorders and other factors, was the second leading cause of death among adolescents aged 12–17 years in 2013.[18]



Evaluating access to care, 64% of youth with major depression did not receive any mental health treatment, while only 22% receive any consistent treatment (7+ visits annually).[19] Despite passage of the Affordable Care Act and mental health parity, 8% of youth do not have any mental health insurance coverage.[20]

Research provides us with an understanding of the prevalence of mental health and substance use problems among youth. The importance of identifying and targeting problems in young people both before and after adolescence is strengthened by the fact that 50 % of mental health problems present themselves before the age of 14 – more often than not tied to brain changes that occur during puberty. [21] [22]

Screening

Universal screening for mental health problems is necessary to reach youth who otherwise would fall through cracks. Pediatricians, primary care physicians and other health care providers are indispensable adjuncts to school-based assessment in identifying signs of mental health problems because they routinely see young people and their families and because confidentiality is assured. Even if specialized mental health treatment is not readily available, the support of a primary care physician and staff can go a long way in providing support and getting people on a path towards recovery. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions are among the most specific in the Social Security Act,[23] but they cover only Medicaid recipients and have not always been fully implemented. Research has provided reliable, culturally and linguistically competent early identification and diagnostic tools.[24] [25] Increasingly, models of collaborative care provide primary care providers with the additional support necessary to provide comprehensive treatment in primary care that meet the individualized needs of the child and family, available on a nondiscriminatory basis.[26] [27] [28]

Although schools are required to identify all mental and other health impediments to learning under the federal Rehabilitation Act and Individuals with Disabilities Education Improvement Act, including mental health issues, screening for emotional or behavioral difficulties in schools has sometimes been controversial and politicized. The concerns regarding school-based screening include the potential conflict between the Family Educational Rights and Privacy Act,[29] which governs most school records, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA),[30] which governs all medical and mental health records. There are concerns about how to protect confidentiality of mental health and substance use evaluations in an educational setting, and there are concerns about how best to follow up with parents or guardians by school personnel to ensure linkage to follow up care. In addition, issues of possible cultural and racial bias are a significant concern among people of color. The development of reliable and culturally and linguistically appropriate screening tools remains an urgent priority.[31]

MHA acknowledges these challenges of school-based mental health screening. However, with appropriate safeguards, MHA supports well-designed pre-school-based and school-based screening programs. Because teachers, school psychologists, social workers and other counselors have extended contact with children on a daily basis, they are often in the best position to recognize early patterns of behavior that pose a risk for a child’s academic, social, emotional or behavioral functioning. While teachers and other school administrators are not and should not become diagnosticians, their candid communication with the family is vital in promoting students' well-being, including their mental health. Where any health problems are noted, their concerns should be shared with the parents or guardian in a timely manner, and parents and guardians should be counseled to see their primary care physician or a mental health professional concerning their child's need for mental or other health care.

Mental health and substance use problems should be treated no differently than other health-related concerns. School personnel should be trained to recognize the early warning signs of mental health and substance use conditions and to know the appropriate actions to take in notifying parents or guardians and in protecting the rights and privacy of young people.
In so doing, it is important to maintain strict confidentiality in accordance with HIPAA, communicating in a clear and culturally competent manner, and involving the parents or guardians in respectful shared decision-making.

Several states have sought to ban mental health screening in schools. MHA opposes such legislation because it compromises the responsibilities of the schools under federal law to provide an education to all young people, regardless of disability, compromises the schools' obligation to identify and address significant impediments to learning of all kinds, discriminates against young people with emotional or behavioral difficulties, and risks constraining free communication by teachers and counselors to parents and guardians, which is essential to early identification and effective treatment of mental health and substance use conditions.

Outreach and education

Promoting community education has been identified as a goal in the U.S. Department of Health and Human Services' Healthy People 2020 initiative. The initiative is significant in recognizing that education programs play a key role in preventing disease, improving health, and enhancing quality of life and includes educating communities on mental illness, behavioral health, substance use, tobacco use, and injury prevention.[32] Public education is needed to assure that parents, friends, teachers, school officials, primary care physicians and other health care providers can identify the early signs of mental health and substance use problems so that young people can receive the help that they need in a timely manner. With long-term investment among stakeholders at various levels in communities, programs related to mental health education have been shown to reduce rates of suicide[33], increase student knowledge of depression[34], and increase in help seeking behaviors.[35] Research testing new models for community health education has demonstrated the effectiveness of increased proactive engagement among key stakeholders to improve youth mental health.[36] Specifically, providing effective community-based outreach and education increases the likelihood of effective referral from a community member (like a teacher or spiritual leader) to supportive services that provide additional comprehensive assessment and therapeutic services. Teachers/educators need to learn de-escalation techniques and skills to decrease crisis situations leading to suspensions of young people with mental health conditions.

In order to prioritize community education, additional funding is needed. Despite the research on the benefits of community education for early identification of mental health problems, no current funding is available for comprehensive community-based education on the early warning signs of mental illness, early brief intervention, and linkage and referrals to treatment. New research has provided a starting point for promising programs in community-based education in mental health, and more research and research funding are needed to identify specific curricula and outreach activities that can promote early identification and effective linkage to appropriate treatment and supports.

Linkage

For early identification to have any value, public and private resources must be available to assure effective treatment. Reliable early identification of health problems in schools and primary care settings and effective, nondiscriminatory treatment can help to address a young person's needs before they lead to greater academic or social problems, including suicide or self-injury, substance use, school failure, suspension, dropping out, or expulsion, or involvement with the juvenile justice system.

In January, 2016, the U.S. Department of Education with and the U.S. Department of Health and Human Services called *Healthy Students, Promising Futures*.[37] The toolkit provided five high impact opportunities for collaboration between health care and schools: 1) help eligible students and family

members enroll in health insurance, 2) provide and expand reimbursable health services in schools, 3) provide or expand services that support at-risk students including through Medicaid-funded case management, 4) promote health school practices through nutrition, physical activity, and health education, and 5) build local partnerships and participate in community needs assessments. Implementing the five opportunities would make significant change towards reducing the burden for teachers and parents to coordinate services, improve children's outcomes, and reduce the need for additional special education services.

Call To Action

- **As part of parity, private and public health insurers should sufficiently reimburse for psychoeducation, screening, brief intervention, referral, and follow-up in the same way that primary health care prevention is reimbursed.**
- **EPSDT compliance, i.e., rates of screening, brief intervention, referral, and follow-up, should be publicly reported and failures to comply should be routinely investigated. Consent decrees have been entered against several states that were not meeting their EPSDT obligations.[38]**
- **States should prohibit the grade retention, suspension or expulsion of a child unless the child has received appropriate mental health screening.**
- **As part of the Every Student Succeeds Act implementation, school districts should identify current programming that supports identification and treatment for mental health and coordinate and augment these efforts to ensure that they fully meet the social and emotional needs of the students, as revealed by the district's needs assessment. Getting and protecting required funding for screening and treatment is essential as schools face cutbacks.[39] States should facilitate the process of health clinics opening branch sites inside of schools to supplement the school-based health center movement.**
- **The Medicare coverage determination and evaluation by CMS should be revised in light of the U.S. Preventive Services Task Force update on depression screening, so that it covers screening, brief intervention, referral, and follow-up, not only screening when supports are in place;**
- **The Department of Education and the Department of Health and Human Services should provide additional technical assistance for its toolkit, *Healthy Students, Promising Futures* (cited above), and states should provide guidance on how to implement the recommendations;**
- **The Office of Civil Rights of the Department of Education should audit states for compliance with the child finding provision of the Individuals with Disabilities Education Act, which requires states to identify children with disabilities.**
- **Additional federal and state funding can support research and implementation of community-based education on early warning signs and early brief strategies for prevention and early intervention.**
- **Affiliates can offer information and training to pediatricians and other primary care providers about early identification and screening.**

- **Affiliates can offer training sessions to parents and school personnel on appropriate early identification of children at risk, alternatives for getting help, and effective communication by school personnel.**
- **Affiliates can support federal efforts in promoting state and local entities in adopting the recommendations from *Healthy Students, Promising Futures.***
- **Affiliates and advocates should encourage early identification and early intervention and should work to defeat any legislation that gets in the way of candid discussion of mental health and substance use issues.**

Effective Period

Mental Health America Board of Directors adopted this policy on September 18, 2016. It will remain in effect for a period of five (5) years and is reviewed as required by the Mental Health America Public Policy Committee

Expiration Date: December 31, 2021

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[1] The term "mental health or substance use conditions" as used in this policy statement is intended to include the federal term "emotional or behavioral disturbance."

[2] AAP *Schedule of Screenings and Assessments for Well-Child Assessments* (February 24, 2014), https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Updates-Schedule-of-Screening-and-Assessments-for-Well-Child-Visits.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR:+No+local+token

[3] PSPSTF *Depression in Children and Adolescents*: *Screening* (February 2016), http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1

[4] Early intervention in response to identified mental health or substance use conditions is distinguished from mental health and sobriety promotion and prevention of mental health and substance use disorders, which are addressed separately in MHA Position Statement 48. http://www.nmha.org/go/about-us/what-we-believe/position-statements/p-48-prevention-in-young-people/position-statement-48-prevention-of-mental-health-and-substance-use-disorders-in-young-people

[5] Centers for Disease Control and Prevention, *Mental Health Surveillance among Children – United States, 2005—2011*, *Morbidity and Mortality Weekly Report* 62:1-35 (2013), http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm.

[6] Merikangas, K.R., He, J. P., Burstein, M.E., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S. & Olfson, M. "Service Utilization for Lifetime Mental Disorders in U.S.

Adolescents: Results from the National Comorbidity Survey Adolescent Supplement (NCS-A)," *Journal of the American Academy of Child and Adolescent Psychiatry* 50(1):32-45 (2011).

[7] O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.), *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities,* National Academies Press (2009).

[8] Centers for Disease Control and Prevention. Suicide: *Facts at a Glance*. (2015), http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf.

[9] U.S. Interagency Working Group of Youth Programs (IWGYP). *How Mental Health Disorders Affect Youth,* http://youth.gov/youth-topics/youth-mental-health/how-mental-health-disorders-affect-youth.

[10] O'Connell, M.E., Boat, T. and Warner, K.E., eds. *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities,* op. cit.

[11] Centers for Disease Control and Prevention, *Mental Health Surveillance among Children – United States, 2005—2011, Morbidity and Mortality Weekly Report*, op. cit.

[12] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages,* http://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2014/NSDUHsaeShortTermCHG2014.pdf)

[13] This may be misleading, since ADHD is often used to diagnose attention problems that are best diagnosed as other mental health conditions. To learn more, visit: http://childmind.org/article/the-most-common-misdiagnoses-in-children/.

[14] i.e., significant depression below the level needed to confirm a major depression diagnosis.

[15] National Institute of Mental Health, *Bipolar Disorder among Children,* http://www.nimh.nih.gov/health/statistics/prevalence/bipolar-disorder-among-children.shtml

[16] National Institute of Mental Health, *Eating Disorders among Children*, http://www.nimh.nih.gov/health/statistics/prevalence/eating-disorders-among-children.shtml

[17]National Institute of Mental Health, *RAISE Questions and Answers,* http://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml

[18] Heron, M., "Deaths:Lleading Causes for 2013." *National Vital Statistics Reports, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System* 65(2):1-96 (2016), http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_02.pdf

[19] Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health* 2013, http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

[20] Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health* 2013, op. cit.

[21] Kessler, R.C., Chiu, W.T., Demler, O., Merikangas, K.R. & Walters, E.E., "Prevalence, Severity, and Comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication," *Arch Gen Psychiatry*. 62(6):617-27 (2005).

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[23] See 42 U.S.C.§§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

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[26] Connor, D.F., McLaughlin, T.J., Jeffers-Terry, M., O'Brien, W.H., Stille, C.J., Young, L.M. & Antonelli, R.C., "Targeted Child Psychiatric Services: a New Model of Pediatric Primary Clinician—Child Psychiatry Collaborative Care," *Clinical Pediatrics* 45(5):423-434 (2006).

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[29] 20 U.S.C. § 1232g; 34 CFR Part 99

[30] P.L. 104-191, 110 Stat.1936 (1996), 29 U.S.C. §1181, 42 U.S.C. §1320, 1395, and associated rulemaking by the Department of Health and Human Services, 45 C.F.R. §§160-164. HIPAA enforcement was substantially strengthened by the passage of the HITECH Act, Public Law 111–5, 123 Stat. 115 (2009), and sections within 45 CFR part 160 finalized in 2013 that relate to the authority of the Secretary of the HHS to impose civil penalties under Section 1176 of the Social Security Act, 42 U.S.C. 1320d–5.

[31] Feeney-Kettler, K.A., Kratochwill, T.R., Kaiser, A.P., Hemmeter, M.L. & Kettler, R. J., "Screening Young Children's Risk for Mental Health Problems: A Review of Four Measures," *Assessment for Effective Intervention* 35(4):218-230 (2010).

[32] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2020*, Education and Community-Based Programs. https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs

[33] Fountoulakis, K.N., Gonda, X., & Rihmer, Z., "Suicide Prevention Programs Through Community Intervention." *Journal of Affective Disorders* 130(1):10-16 (2011).

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[37] *Healthy Students, Promising Futures, State and Local Action Steps and Practices to Improve School Based Health,* Department of Health and Human Services and Department of Education (Jan 2016), http://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf

[38] Over the years, states have not adhered to the ESPTD mandate, and litigation has resulted. EPSDT establishes a broad scope of benefits—all the services listed within the Social Security Act at 42 U.S.C. § 1396d(a)—and a uniform medical necessity definition—services needed to “correct or ameliorate” the child’s physical or mental conditions. 42 U.S.C. §1396d(r)(5). Advocates are citing these broad treatment requirements to obtain coverage for a range of services that children need to live at home and in the community, including screening, rehabilitative services, case management, home health care, and personal care services. See, generally, National Health Law Program, *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)* (October 15, 2013), http://www.healthlaw.org/issues/child-and-adolescent-health/epsdt/health-advocate-epsdt#.V6JEVjUe48I

[39] The Minnesota Association for Children’s Mental Health has prepared two exemplary toolkits for teachers: *Unlocking the Mysteries of Children’s Mental Health: An Introduction for Future Teachers,* Minnesota Association for Children’s Mental Health, St. Paul, MN (Rev. Ed. 2004.) and *A Teacher’s Guide to Children’s Mental Health*, Minnesota Association for Children’s Mental Health, St. Paul, MN (2002). See http://www.macmh.org/macmh-publications/

4. **Mental Health of America Augusta (MHAA) urges the Virginia Legislature to fund increased salaries for the State Hospitals and Commonwealth Center for Children and Adolescents direct care staff. There is a critical shortage of direct care workers at the state hospitals. These shortages are due to low pay and harsh working conditions. Direct care staff salaries are lower than McDonalds. Direct care staff need training to work effectively in these intense environments. Hiring low skill workers does not encourage retention. Locally, the Mental Health two-year degree program at BRCC could impact the shortage if the pay was reflective of the skills and abilities of these recruits. Other qualified workers could be recruited if the pay were increased, and enough workers could be hired to eliminate the frequent mandating of additional work hours due to staff shortages.**

The National MHA does not currently have a position statement on pay levels for direct care staff. MHA does however recognize the shortage of employees to serve the needs of those with mental illness. It is the position of MHAA that low pay and working conditions have served to exacerbate this shortage. Increasing pay and reducing mandating requirements will assist in alleviating this crisis.