Community Conversations About Mental Health

Information Brief

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

On January 16, 2013, President Barack Obama directed Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services and Secretary Arne Duncan of the U.S. Department of Education to launch a national conversation on mental health to reduce the shame and secrecy associated with mental illness, encourage people to seek help if they are struggling with mental health problems, and encourage individuals whose friends or family are struggling to connect them to help.

Mental health problems affect nearly every family. Yet as a nation, we have too often struggled to have an open and honest conversation about these issues. Misperceptions, fears of social consequences, discomfort associated with talking about these issues with others, and discrimination all tend to keep people silent. Meanwhile, if they get help, most people with mental illnesses can and do recover and lead happy, productive, and full lives.

This national conversation will give Americans a chance to learn more about mental health issues. People across the nation are planning community conversations to assess how mental health problems affect their communities and to discuss topics related to the mental health of young people. In so doing, they may also decide how they might take steps to improve mental health in their families, schools, and communities. This could include a range of possible steps to establish or improve prevention of mental illnesses, promotion of mental health, public education and awareness, early identification, treatment, crisis response, and recovery supports available in their communities.

Pamela S. Hyde, J.D.
Administrator
SAMHSA

Paolo del Vecchio, MSW
Director
Center for Mental Health Services
SAMHSA

Goals and Objectives of the Toolkit for Community Conversations About Mental Health

The Toolkit for Community Conversations About Mental Health is designed to help individuals and organizations who want to organize community conversations achieve three potential objectives:

- Get others talking about mental health to break down misperceptions and promote recovery and healthy communities;
- Find innovative community-based solutions to mental health needs, with a focus on helping young people; and
- Develop clear steps for communities to address their mental health needs in a way that complements existing local activities.

The Toolkit includes:

1. An *Information Brief* section that provides data and other facts regarding mental health and mental illness and how communities can improve prevention of mental illnesses, promotion of mental health, public education and awareness, early identification, treatment, crisis response, and recovery supports available in their communities.
2. A *Discussion Guide* section that is intended for use in holding community conversation meetings of 8-12 people each. (In a community forum with more participants, the audience would divide into groups of this size for much of their time together.) It provides discussion questions, sample views, ideas, and an overall structure for dialogue and engagement on mental health issues.
3. A *Planning Guide* section that describes a variety of ways in which people can facilitate their community conversations and take next steps at the local level to raise awareness about mental health and promote access to mental health services.

Mental health issues in our communities—particularly for our youth—are complex and challenging; but, by coming together and increasing our understanding and raising awareness, we can make a difference.

The Information Brief for Community Conversations About Mental Health

The Information Brief is designed to be used alongside the other elements of the Toolkit for Community Conversations About Mental Health and provides data and information to help community conversations participants consider key issues of importance to their communities. The Information Brief follows the format of the Discussion Guide section of the Toolkit for Community Conversations About Mental Health and has the following sections:

- Session 1: Sharing Personal Experiences
  Opening Question: What does mental health mean to me? To us as a community?
- Session 2: Discussion of Challenges
  Opening Question: What are the challenges and factors we should consider?
- Session 3: Exploration of How to Respond
  Opening Question: What can we do to support young people?
- Session 4: Community Solutions
  Opening Question: What steps do we want to take as a community?

Community Conversations About Mental Health

Information Brief

Table of Contents

Acknowledgments

This guide was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates and its subcontractors the Deliberative Democracy Consortium, and Everyday Democracy under contract number [HHSS283200700008I/HHSS28342002T] with SAMHSA, U.S. Department of Health and Human Services (HHS). L. Wendie Veloz and Chris Marshall served as the Government Project Officers.

Disclaimer

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. The listing of any non-Federal resources is not all-inclusive and inclusion in this publication does not constitute endorsement by SAMHSA or HHS.

Electronic Access and Printed Copies

This publication may be downloaded or ordered at **http://store.samhsa.gov**. Or call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration, Community Conversations About Mental Health: Information Brief. HHS Publication No. SMA-13-4763. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

Originating Office

Office of Communications, Substance Abuse and Mental health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857. HHS Publication No. SMA-13-4763. Published July 2013.

SAMHSA Descriptor

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Terms and Definitions

Before we start looking at these central questions, let's define some terms that will be used heavily throughout this informational brief:

Mental Health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.[1]

Mental Illness is defined as "collectively all diagnosable mental disorders" or "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." Under these definitions, substance use might be classified as either a mental health problem or a mental illness, depending on its intensity, duration, and effects.[2]

Mental Health Promotion consists of interventions to enhance the ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen the ability to cope with adversity.[3] This ability to cope is referred to as resilience.

Mental Health Treatment is the provision of specific intervention techniques by a professional for conditions identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). These interventions should have proven effectiveness, the ability to produce measurable changes in behaviors and symptoms, and should be person- and family-centered and culturally and linguistically appropriate.[4]

Prevention is a step or set of steps along a continuum to promote individual, family, and community health; prevent mental and substance use disorders; support resilience and recovery; and prevent relapse.[5]

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. People with mental illnesses can and do recover from these conditions, and hope plays an essential part in overcoming the internal and external challenges, barriers, and obstacles. Controlling or managing symptoms is part of this process. Reducing or eliminating substance use is critical for recovery from addiction.[6]

Recovery Support Services include a focus on providing for the health, housing, vocational, and social support needs of people with mental health problems. These include peer- and family-operated services.[7]

Substance Abuse is defined as the use of alcohol or drugs despite negative consequences.[8]

Substance Use is defined as the consumption of low or infrequent doses of alcohol and other drugs, sometimes called experimental, casual, or social use.[9]

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[10]

Young People/Youth are defined here as persons up to age 25.

Session 1: Sharing Personal Experiences

What Does Mental Health Mean to Me? To Us as a Community?

There are many views and opinions about mental illnesses, their causes, and how we can best treat and respond to these conditions. The following information provides some basic facts about mental health and mental illness to help participants begin the conversation.

Understanding the Basics

Mental health plays an important role in your overall well-being. An estimated 19.6 percent of Americans ages 18 and older—about one in five adults—will experience a mental health problem this year.[11] But studies show that most people with mental problems get better, and many recover completely.

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Over the course of your life, you may experience mental health problems. Your thinking, mood, and behavior could be affected.[12]

Many factors contribute to mental health problems, including:

- Life experiences, such as trauma or a history of abuse
- Biological factors, such as genes or chemical imbalances in your brain
- Family history of mental health problems

Taking care of one's mental health is just as important as taking care of one's physical health. Overall health includes a well-balanced and nutritious diet, regular exercise, stress management, early and ongoing mental health services when needed, and taking time to relax and enjoy family and friends. Finding a good balance between work and home is important to mental and physical health.

Types of Mental Health Problems

People can experience different types of mental health problems. Some can occur for a short time, and some occur over an on-going time period. Just as other health conditions, these are real and diagnosable health conditions that affect and are affected by functioning of the brain, an organ of the body just like the kidney, liver, or heart. Mental health problems can affect your thinking, mood, and behavior. Common types can include:[13]

Anxiety Disorders
People with anxiety disorders respond to certain objects or situations with fear and dread. Anxiety disorders can include obsessive-compulsive disorder, panic disorders, phobias, and Post-Traumatic Stress Disorder (PTSD).

Attention Deficit Hyperactivity Disorder
Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).

Eating Disorders
Eating disorders involve extreme emotions, attitudes, and behaviors involving weight and food. Eating disorders can include anorexia, bulimia, and binge eating.

Co-Occurring Mental and Substance Use Disorders
Mental illnesses and substance use disorders often occur together. Sometimes one disorder can be a contributing factor to or can exacerbate the other. Sometimes they simply occur at the same time.

Mood Disorders
These disorders involve persistent feelings of sadness or periods of feeling overly happy, or fluctuating between extreme happiness and extreme sadness. Mood disorders can include depression, bipolar disorder, Seasonal Affective Disorder (SAD), and compulsion to self-harm.

Personality Disorders
People with personality disorders have extreme and inflexible personality traits that are distressing to the person and/or cause problems in work, school, or social relationships. Personality disorders can include antisocial personality disorder and borderline personality disorder.

Psychotic Disorders
People with psychotic disorders hear, see, and believe things that aren't real or true. An example of a psychotic disorder is schizophrenia.

Substance Use Disorders
Substance use disorders involve the dependence on or abuse of alcohol and/or drugs, including the nonmedical use of prescription drugs.[14]

Suicidal Behavior
Suicide is a serious problem that causes immeasurable pain, suffering, and loss to individuals, families and communities nationwide. Millions of people consider, plan, or attempt suicide each year; many die as a result.

Promotion of Mental Health and Prevention of Mental Illnesses

When we promote mental health, we help people improve their health and well-being, have positive self-esteem, and to be valued and contributing members of their communities. Mental health promotion also helps build resiliency in people, helping them cope better during life's challenges.

Prevention interventions help to reduce the likelihood of developing a mental illness or a substance use disorder and can help delay the onset or reduce the severity of a mental illness. Prevention addresses problems before they happen by addressing those things – risk factors – that can make it more likely for a person to develop problems. These can include working to create healthy environments that reduce the effects of poverty and the risk of violence, child maltreatment, drug/alcohol misuse, and bullying and ensure that people have access to the care that they need when symptoms just begin to appear. Prevention efforts focus on communities or large populations through universal strategies or interventions targeted at high-risk individuals and those who may be showing some minimal signs and symptoms of developing a mental illness or a substance use disorder.

Some important ways that we can promote mental health and prevent mental illness and substance use disorders is to increase protective factors and use promising strategies that address the needs of children, adults, and families in the community. Protective factors include good communication skills, reliable support and discipline from parents and caregivers, support for early learning, quality health care, healthy peer groups, social connectedness, and succeeding schools. Promising strategies emphasize public education and awareness about issues related to mental health and substance use- and include early identification of mental health problems and access to appropriate interventions.

Treatment for Mental Health Problems

Most people who experience mental illnesses will improve if they receive appropriate supports, services, and treatment. The first step to getting the right treatment is to see a health care professional and review your symptoms and life circumstances. Treatment options are tailored to each specific person and condition; however, the most common forms of treatment include:

- ***Psychotherapy, or "talk therapy" (sometimes called counseling)***—teaches people strategies and gives them tools to deal with stress and uncomfortable thoughts and behaviors. Psychotherapy helps people manage their symptoms better and function at their best in everyday life.[15]
- ***Cognitive behavioral therapy (CBT)***—helps people learn how to identify unhelpful thinking patterns, recognize and change inaccurate beliefs, relate to others in more positive ways, and change behaviors accordingly. CBT can be applied and adapted to treat many specific mental disorders.[16]

- ***Medications***—used to treat the symptoms of many mental disorders such as schizophrenia, depression, bipolar disorder (sometimes called manic-depressive illness), anxiety disorders, and attention deficit-hyperactivity disorder (ADHD). Medications can also be used to manage the cravings and relapse associated with certain kinds of addictions. Sometimes medications are used with other treatments such as psychotherapy or counseling.[17]
- ***Rehabilitative services***—include recovery-focused activities or treatment/therapeutic interventions such as assistance in improving or restoring daily living skills, social and leisure skills, grooming and personal hygiene skills, and meal preparation skills; other support resources; and/or medication education.

Recovery from Mental Health Problems

Studies show that most people with mental health problems get better, and many recover completely. Recovery is defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery is supported by mental health treatment and support services in the community.[18]

Recovery is built on:

- ***Health***—overcoming or managing one's disease(s) or symptoms – including abstinence if one has an addiction – and making informed, healthy choices that support physical and emotional wellbeing.
- ***Home***—a stable and safe place to live.
- ***Purpose***—meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society.
- ***Community***—relationships and social networks that provide support, friendship, love, and hope.

Attitudes and Beliefs About Mental Health

We know a lot about what Americans believe about mental health and mental illness from national surveys. These surveys reveal that while Americans have learned a great deal about characteristics and causes of mental illnesses over the last several decades, negative beliefs about people with mental illnesses continue to grow.[19]

These negative attitudes about people with mental illnesses are mostly influenced by the misconception that people with mental illnesses are more violent than the general population.[20] People with mental illnesses are no more violent than the general population unless certain other risk factors are involved, including alcohol abuse or untreated, active psychosis

associated with paranoia and including specific types of command hallucinations.[21] In fact, people with mental illnesses only commit three to five percent of violent acts every year.[22] People with mental illnesses are much more likely to be victims of crime than perpetrators.[23]

Impact of Attitudes and Beliefs

People's attitudes and beliefs about mental illness set the stage for how they interact with and support a person with mental illness.

- When people have positive attitudes about mental health, they may engage in supportive and inclusive behaviors (e.g., willingness to date a person with mental illness or to hire a person with mental illness).[24]
- When attitudes and beliefs are expressed negatively, they may result in avoidance, exclusion from daily activities, and, in the worst case, exploitation and discrimination.[25]

Attitudes and beliefs about mental illness are shaped by personal knowledge about mental illness and knowing and interacting with someone living with a mental illness. Attitudes and beliefs can be influenced by cultural stereotypes, media stories, and institutional practices.

Mental Health in the Community

There are many intertwined factors that influence the mental health of an individual and the resources available in a community to meet the needs of people with mental health problems.

Spirituality and Mental Health

Many turn to faith communities for support in dealing with mental health problems. Faith can provide important elements of solace and support for such individuals. Faith communities can also play a key role in educating their members about mental health problems.[26] Supportive relationships, such as family, long-term friendships, and meaningful onnections through faith can be important to building resilience and well-being.

Culture and Mental Health

Culture can provide a lens for how people think about mental health, whether they seek help for mental health problems, and how people and mental health professionals interact with one another.[27] People typically think of culture in terms of race or ethnicity, but culture also refers to other social groups defined by characteristics such as age, gender, religion, income level, education, geographical location, sexual orientation, disability, or profession.[28] Rates and types of mental health problems and seeking treatment can vary according to the population.[29] Racial and ethnic minorities bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity.[30]

Mental Health is a Public Health Issue

Providing for and supporting good mental health is a public health issue just like assuring the quality of drinking water or preventing and managing infectious diseases. Communities prosper when the mental health needs of community members are met. Unaddressed mental health issues can have a negative influence on homelessness, poverty, employment, safety, and the local economy. For young people, mental health is influenced by a web of interactions among the young person, the family, child service systems (school, health, foster care), and the neighborhoods and communities in which they live.

- Approximately one in five Americans will have a mental health problem in any given year, yet only a little over one in three people with a mental health problem will receive mental health services.[31]
- Over 38,000 Americans died by suicide in 2010, making the number of Americans who die by suicide more than double the number who died by homicide.[32]
- One-third of individuals with severe mental illnesses who receive community mental health services after lengthy stays in a state hospital achieve full recovery in psychiatric status and social function, and another third improve significantly in both areas.[33]
- Of the more than six million people served by state mental health authorities across the nation, only 21 percent are employed.[34]
- Supported employment programs that help people with the most serious mental illnesses place more than 50 percent of their clients into paid employment.[35]
- Between 2007-2009, the average expenditure per adult ages 18-26 for the treatment of mental health disorders was about $2,000. Of this population, average expenditure for treatment of mental health problems was higher for young adults ages 18-21 estimated at $2,300 per year than for those ages 22–26 estimated at $1,800.[36]
- In 2006, 186,000 young adults received social security disability benefits because their mental illness was so severe that they were found to be unable to engage in substantial gainful activity.[37]
- Serious mental illnesses cost the U.S. an estimated $193.2 billion in lost earnings per year.[38] Effective nationwide school-based substance abuse prevention programming can offer states savings within 2 years ranging from:[39]
    - $36 million to $199 million in juvenile justice[40]
    - $383 million to $2.1 billion in education[41]
    - $68 million to $360 million in health services[42]

Did You Know?

Homelessness, Mental Health, and the Community

From the January 2010 HUD Point-in-Time (PIT) counts, Continuums of Care reported that:

- 26.2 percent of sheltered adults who were homeless had a severe mental illness, and
- 46 percent of sheltered adults on the night of the PIT count had a chronic substance abuse problem and/or a severe mental illness.

Prejudice and discrimination associated with mental and substance use disorders create enormous housing challenges for these individuals.[43]

Substance Abuse and Communities

Substance abuse takes a tremendous toll on America's communities. Mental and substance use conditions often co-occur. In other words, individuals with substance use conditions often have a mental health condition at the same time, and persons with mental health problems often abuse substances or experience addiction at the same time. The following includes statistics on substance abuse and co-occurring mental and substance use disorders:

- In 2011, an estimated 20.6 million persons (8.0 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year.[44]
- 19.3 million persons (7.5 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment.[45]
- Approximately eight million adults have co-occurring disorders.[46]
- Only 6.9 percent of individuals receive treatment for both conditions while 56.6 percent receive no treatment at all.[47]
- Co-occurring mental and substance use disorder rates are high among people who experience homelessness.[48]
- One study reported a 23 percent lifetime prevalence rate of co-occurring disorders for individuals who experience homelessness, and these people may face complex physical, social, and psychological challenges to recovery.[49]
- With treatment, emergency room visits, hospital stays, and periods of incarceration are significantly reduced.[50] Likewise, high-risk and harmful substance use is decreased. Stable housing along with supportive services provides a higher quality, self-directed, and satisfying life in the community.[51]

Did You Know?

The Treatment Gap in America

Almost two-thirds of the over 45 million adults with any mental illness and almost 90 percent of the over 21 million adults with substance use disorders go without treatment in our country every year.[52]

Research About the Mental Health of Young People

The research supports the need for prevention and early intervention strategies to address the mental, emotional and behavioral problems that can occur throughout a young person's life.

- More than half of adolescents in the United States who fail to complete high school have a diagnosable psychiatric disorder.[53]
- Individuals with mental illnesses die on average 8.5 years earlier than the general population, due mostly to preventable health conditions like heart disease, diabetes, hypertension, and tobacco use.[54]
- Bullying can have significant mental health consequences for both victims and bullies.[55]
    - Compared to individuals who were not bullied, victims of bullying were nearly three times as likely to have issues with generalized anxiety as those who were not bullied and 4.6 times as likely to suffer from panic attacks or agoraphobia.
    - Children who reported being both bullies and victims showed a nearly five times greater risk of depression as young adults compared to those who had only experienced being a bully or only experienced being a victim.
- Research has demonstrated that prevention efforts can delay the first use of tobacco and alcohol.[56]
- Binge drinking and heavy alcohol use peaks between those aged 18-25, with nearly 40 percent of people in that age group reporting binge drinking and 12 percent reporting heavy alcohol use.[57]
- Abuse of prescription drugs is highest among young adults aged 18 to 25, with 5 percent reporting nonmedical use in the past month.[58]
- Data from SAMHSA's Children's Mental Health Initiative indicated that among youth 12 and older who identified substance use problems at intake in Children's Mental Health Initiative-funded systems of care, 36 percent involved with the child welfare system and 32 percent involved with the juvenile justice system reported no substance use problems after 6 months.[59]
- By preventing a child from becoming dependent on alcohol, we can save approximately $700,000 over the course of the child's lifetime.[60]
- By helping a child graduate from high school who would otherwise have dropped out, we can save as much as $388,000 over the course of the child's lifetime.[61]

Session 2: Discussion of Challenges

What Are the Challenges and Factors We Should Consider?

To make progress on mental health issues, we need to think strategically about the challenges we are facing and the factors that have the greatest influence on mental health—particularly those that affect young people. This session will help you consider some of those challenges and factors and begin thinking about how to address them.

Challenges to Promoting Mental Health

In the past, the science did not exist about how to effectively promote mental health and prevent mental illnesses. Now, we have the know-how but still need to educate communities, service providers, and others that prevention is possible. Promotion and prevention will help us to ultimately reduce disability and hardship by reducing the prevalence of mental health disorders.[62]

Promotion and prevention involves a new approach to mental health issues. This approach requires people and communities to think and act differently by addressing mental health issues before they become mental illnesses.

Challenges for Youth Transitioning to Adulthood

As youth become adults, a large number have behavioral health problems, and very few actually receive treatment.

- Youth transitioning to adulthood typically have difficulties accessing health care and the highest uninsured rate in the United States.[64] Additionally, they often have low perceptions of risk[65] although this population has the highest rate of homicide,[66] and high rates of homelessness,[67] arrests,[68] mental health problems,[69] school dropouts,[70] and substance abuse.[71]
- It is estimated that 6-12 percent of transition-age youth and young adults struggle with a serious mental health condition (2.4-5 million individuals).[72]
- According to the Treatment Episode Data Set for 2009, among substance abuse treatment admissions aged 12 to 17, fewer than one in eight (11.9 percent) were referred by schools.[73]
- Treatment admissions aged 15 to 17 most frequently reported marijuana (71.9 percent) or alcohol (17.7 percent) as their primary substance of abuse.[74]

Did You Know?

The Importance of Involving Families

Family-driven care means that families have a decision-making role in the care of their own children as well as the policies and procedures that shape care for children in their community, state, tribe, territory, and nation.[63]

Access to Support, Services, and Treatment

Attitudes and beliefs can prevent a person from seeking treatment, although research tells us that treatment is effective and people do recover.

- Only 38 percent of adults with diagnosable mental health conditions get treatment. Of the 45.9 million people 18 and older who have behavioral health conditions, just 17.9 million received treatment.[75]
- Less than one in five adolescents get treatment for diagnosable mental health conditions.[76]
- As with other chronic illnesses, individuals who seek treatment and recovery support services for mental health problems learn new life skills and go on to live healthy, empowered, and productive lives.[77]
- Stable housing is important to individuals seeking treatment and for delivering services to the person in their living environment and community. Through research we know that treatment is effective and recovery is possible but not when a person's basic need for safety and housing are lacking.[78]

Paying for Mental Health Care

Lack of ability to afford care is among the top reasons that people with unmet need reported for not seeking treatment.[80]

- People with mental health and substance abuse problems have historically had high rates of being uninsured.[81]
- As a consequence, mental health and substance abuse treatment spending has depended more on public payers than all health care, with public payers—such as Medicaid—accounting for approximately 60 percent of mental health spending.[82]

As a result of the Affordable Care Act, many currently uninsured Americans with mental health and substance abuse problems will become eligible for affordable health insurance coverage. Beginning in 2014 under the law, all new small group and individual market plans will be required to cover ten Essential Health Benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits. The Mental Health Parity and Addictions Equity Act (MHPAEA) requires group health plans and insurers that offer mental health and substance use disorder benefits to provide coverage that is comparable to coverage for general medical and surgical care. As a result of these two pieces of legislation, an estimated 62 million Americans will have improved access to services for mental and substance use disorders.[83]

Did You Know?

Economic Costs of Mental Health Problems

The annual cost of mental, emotional, and behavioral disorders among young people is estimated to be $247 billion – including the costs of treatment and lost productivity.[79]

Perceptions of Violence and Mental Illness

Too often, depictions and perceptions of violence and mental illness can perpetuate negative attitudes and myths about individuals living with a mental illness.

- People with mental illnesses only commit three to five percent of violent acts and are much more likely to be victims than perpetrators of violence.[84]
- Research has demonstrated that individuals who received treatment for mental illnesses in the community (outpatient, day, and residential treatment) were 11 times more likely to have been the victims of violent crime than the general population in the past year.[85]

Criminal Justice Involvement

Nevertheless, there are high rates of mental illnesses and substance abuse problems among people in the criminal justice system.

- Approximately 70 percent of jail inmates with mental illnesses are incarcerated for non-violent offenses.[86]
- In 2005, individuals who experienced mental health problems accounted for 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates.[87]
- Sixty-seven to seventy percent of youth in the juvenile justice system have a diagnosable mental disorder.[88]

Sexual Orientation

Social attitudes regarding sexual orientation can also impact how we view people with mental health problems:

- The rejection of lesbian, gay, bisexual, and transgender (LGBT) youth by their families, or by their peers and community, can have profound and long-term impacts, including depression, use of illegal drugs, and suicidal behavior.[89]

Session 3: Exploration of How to Respond

What Can We do to Support Young People?

Young people experience some of the highest prevalence rates of mental illness and yet have some of the lowest help seeking rates of any group. Additionally, childhood emotional and behavioral disorders are the most costly of all illnesses in children and youth.

Did You Know?

Early Childhood Experiences Help Build Success Later in Life

Children begin developing social and emotional skills at a very young age, and these skills form an important foundation for being able to succeed in school, in relationships, and in life.[94]

Early Life Experiences

Early life experiences are important in shaping an individual's life into adulthood and can impact how an individual learns and responds to stressful events.[90]

- When young children are exposed to repeated traumatic experiences (e.g., child abuse, witnessing violence), they are at increased risk of developing mental health problems, substance abuse, and chronic health problems (like heart disease and diabetes).[91]
- The negative impacts of these early experiences (sometimes referred to as "toxic stress") can be prevented or reversed when a child has a relationship with a supportive, responsive, and caring adult at an early age.[92]
- Adverse Childhood Experiences, or ACEs, is a term that describes all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18. These can have a profound impact on that child's future health. In fact, a person who experiences four or more ACEs were 7.4 times more likely to consider themselves alcoholics, 3.9 times more likely to have chronic bronchitis or emphysema, 4.6 times more likely to report being depressed, and 1.9 times more likely to develop cancer.[93]

Schools Play an Important Role

Schools play a critical role in ensuring that behavioral problems are identified early so that young people can grow and thrive in a healthy environment. Schools can lead coordination efforts in bringing youth-serving agencies together to guarantee that children, youth, and families can easily access services that are community based, child centered, family focused, and culturally and linguistically competent.

- Children who have not developed social and emotional skills by the time they enter school are at a disadvantage. For example, children need to be able to

pay attention, respond appropriately to directions, interact positively with peers and adults, and control their emotions and behaviors in school in order to be successful.[95]

- Students with poor social skills are more likely to: experience difficulties in interpersonal relationships with teachers and peers; show signs of depression, aggression, or anxiety; demonstrate poor academic performance; and have a higher incidence of involvement in the criminal justice system as adults.[96]
- Without adequate treatment, young adults in college with a mental illness are more likely to receive lower GPAs, drop out of college, or be unemployed than their peers who do not have a mental health challenge.[97] Thirty-one percent of college students have found it difficult to function due to depression in the past year, while more than 50 percent have felt overwhelming anxiety, making it hard to succeed academically.[98]
- Approximately 50 percent of students age 14 and older with a mental illness drop out of high school. This is the highest dropout rate of any disability group.[99]

Left untreated, childhood mental and emotional disorders can lead to poor outcomes in school, limited employment opportunities, and other negative economic impacts in adulthood.

Early Onset of Mental and Substance Use Disorders

Mental health problems often begin at an early age and become more significant during adolescence and young adulthood.

- Half of adult mental health problems begin before age 14, and three-quarters begin before age 24.[100]
- In 2007, 8.2 percent of adolescents, an estimated 2.0 million youths aged 12 to 17, experienced at least one major depressive episode.[101]
- Among all adolescents with major depressive episodes in the past year, nearly two thirds (62.3 percent) did not receive treatment for their depression. 8.4 percent of full-time college students aged 18 to 22 experienced major depression in the past year.[102]
- Of children and youth in need of mental health services, 75-80 percent of these youth do not receive services.[103]

Did You Know?

The importance of seeking treatment early

Delays in receiving treatment after the first onset of symptoms of schizophrenia or psychosis are found to be related to: poorer response to antipsychotic medications, presence of more severe symptoms, more frequent recurrences and hospitalizations, and higher suicide risk.[104]

Suicide Prevention is Key

Far too many of our nation's youth take their own lives:

- Suicide is the third leading cause of death among youth ages 15-24.[105]
- One survey found that in a 12-month period, almost 13.8 percent of high school students had seriously considered suicide, 10.9 percent of high school students had made a suicide plan, and 6.3 percent of high school students attempted suicide at least once.[106]
- One out of every 53 high school students (1.9 percent) report having made a suicide attempt that was serious enough to be treated by a doctor or a nurse.[107]
- The toll among some groups is even higher. For example, the suicide death rate among 15–19-year-old American Indian/Alaska Native males is two and one-half times higher than the overall rate for males in that age group.[108]
- Suicide touches everyone, but there is help and hope when individuals, communities, and professionals join forces to prevent suicide. See SAMHSA's Preventing Suicide: A Toolkit for High Schools (http://store.samhsa.gov/shin/content/SMA12-4669/SMA12-4669.pdf) and SAMHSA's Suicide Prevention Resource Center's Roles in Preventing Suicide (http://www.sprc.org/basics/roles-suicide-prevention).

If you or someone you care about is feeling alone, hopeless, or is in crisis, call or chat with caring counselors at the **National Suicide Prevention Lifeline** at 1-800-273-TALK (8255) or (http://suicidepreventionlifeline.org/GetHelp/LifelineChat2.aspx).

Session 4: Community Solutions

What Steps Do We Want To Take as a Community?

Whether you are part of a small group of concerned citizens or a community-wide planning process, you can start working on local ideas and can focus on identifying individual and community solutions.

It is important to first identify what mental health resources currently exist in the community and determine what else is needed. Work with community members to map out what prevention strategies, treatment, and recovery support services currently exist and how they are meeting the needs of those served.

A person's mental health can be affected by many elements of our society. The places where individuals and communities choose to focus their efforts can be much broader than many people might think. For communities, it is difficult to know where to start since the topic involves schools, human services, provider networks, families, neighborhoods, faith communities, and many other stakeholders.

The following are a list of community factors that can impact mental health.[109]

- Cultural norms – such as alcohol use, bullying
- Discrimination
- Employment opportunity
- Food insecurity – not knowing where your next meal will come from
- Housing quality
- Income inequality
- Neighborhood conditions
- Physical isolation
- Public services
- Social status
- Access to health services

Getting the Facts About What Works

To assist with community planning and implementation, there are a variety of resources to identify effective approaches to meet the mental health needs of young people. When choosing evidence-based approaches, it is important to identify and prioritize the needs of young people in the community so that you can determine which type of intervention, strategy, or approach will be the most appropriate.[110] It is also important to assess the community's capacity (e.g., financial resources, organizational commitment, community buy-in) to implement an intervention, strategy, or approach while preserving the components that made the original practice effective.[111] Communities can work together to decide what interventions, strategies and approaches match the needs of young people in the community and can be implemented within the community's capacity.

For more information on evidence-based practices, refer to Appendix, "Helpful Resources and Websites."

Additional Suggestions for Community Planning

Tailor your efforts to your community.
Every community is different when it comes to developing the next steps in supporting our children, youth, and families.

Celebrate what has been done in your community to strengthen mental health.
Every community is starting from a unique point with existing assets and resources. It is important to celebrate the things that are already taking place in your community.

Highlight what work still needs to be done.
There will always be more to do to support the healthy development of young people. Take time to recognize how everyone in the community can pitch in and support mental health.

Describe what direction you plan to take as a community.
Create a vision for how your community will address the mental health needs of youth and families.

Keep working together.
Effective efforts to address mental health require the need to form and sustain partnerships from many different parts of the community. Community conversation meetings should be considered just the start of an on-going dialogue to plan, implement, and evaluate efforts.

For more information you could use to host a conversation in your community, please go to **www.CreatingCommunitySolutions.org** and refer to Appendix, "Helpful Resources and Websites."

(These materials and links are offered for informational purposes only and should not be construed as an endorsement of the referenced organization's programs or activities.)

Appendix: Helpful Resources and Websites

(Note: These organizations, materials and links are offered for informational purposes only and should not be construed as an endorsement of the referenced organization's programs or activities.)

Resources	
• Information About Mental Health	• http://www.MentalHealth.gov
• Substance Abuse and Mental Health Services Administration (SAMHSA)	• http://www.SAMHSA.gov
• National Institute of Mental Health (NIMH)	• http://www.nimh.nih.gov
• Additional information you could use to host a conversation in your community	• http://www.CreatingCommunitySolutions.org
Promoting Mental Health and Preventing Mental Illness	
• Suicide Prevention Resource Center	• http://www.sprc.org
• The Institute of Medicine's *Preventing Mental, Emotional and Behavioral Disorders Among Young People*: Progress and Possibilities	• http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx
• Addressing Bullying	• http://www.stopbullying.gov
• National Center for Mental Health Promotion and Youth Violence Prevention	• http://www.promoteprevent.org
• Find Youth Info	• http://www.findyouthinfo.gov
• Million Hearts	• http://millionhearts.hhs.gov/index.html
Addressing Public Attitudes	
• Resource Center to Promote Acceptance, Dignity, and Social Inclusion	• http://promoteacceptance.samhsa.gov
• Voice Awards	• http://www.samhsa.gov/voiceawards
• Children's Mental Health Awareness Day	• http://www.samhsa.gov/children
Evidence-Based Practices for Treatment	
• National Registry for Evidence-Based Programs and Practices	• http://www.nrepp.samhsa.gov
• National Center for Trauma-Informed Care	• http://www.samhsa.gov/nctic
• Children's Mental Health Initiative Technical Assistance Center	• http://www.cmhnetwork.org
Recovery Support Services	
• National Consumer Technical Assistance Centers	• http://ncstac.org/index.php
• Homeless Resource Center	• http://www.homeless.samhsa.gov
• Shared Decision Making in Mental Health Tools	• http://162.99.3.211/shared.asp
• College Drinking: Changing the Culture	• http://www.collegedrinkingprevention.gov

Reference List

1. World Health Organization. (2001). Strengthening Mental Health Promotion (Fact sheet no. 220). Geneva: World Health Organization. Retrieved from https://apps.who.int/inf-fs/en/fact220.html
2. Ibid.
3. Ibid.
4. Substance Abuse and Mental Health Services Administration. (2013). Definitions of Trauma and Resilience. Retrieved from http://www.samhsa.gov/children/trauma-resilience-definitions.asp
5. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). National Prevention Week Participant Toolkit (HHS Publication No. (SMA) 12-4687). Rockville, MD: Substance Abuse and Mental Health Services Administration.
6. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's Working Definition of Recovery (HHS Publication No. PEP12-RECDEF). Rockville, MD. Retrieved from http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF
7. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2009). Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? (HHS Publication No. (SMA) 09-4439). Rockville, MD: Center for Substance Abuse Treatment. Retrieved from http://partnersforrecovery.samhsa.gov/docs/Guiding_Principles_Whitepaper.pdf
8. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). National Prevention Week Participant Toolkit (HHS Publication No. (SMA) 12-4687). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.
9. Ibid.
10. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Trauma definition. Retrieved from http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx
11. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (NSDUH Series, H-45, HHS Publication No. (SMA) 12-4725). Rockville, MD. Retrieved from http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm
12. U.S. Department of Health and Human Services. (2013). What Is Mental Health? Retrieved from http://www.mentalhealth.gov/basics/what-is-mental-health/index.html
13. U.S. Department of Health and Human Services. (2013). What to Look For? Retrieved from http://www.mentalhealth.gov/what-to-look-for/index.html
14. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2008). Results From the 2007 National Survey on Drug Use and Health: National Findings. (DHHS Publication No. (SMA) 08-4343). Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/nsduh/2k7nsduh/2k7results.pdf
15. National Institute of Mental Health. (2013). Psychotherapies. Bethesda, MD. Retrieved from http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml.
16. Ibid.
17. National Institute of Mental Health. (2013). Mental Health Medications. Bethesda, MD. Retrieved from http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml.
18. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's Working Definition of Recovery (HHS Publication No. PEP12-RECDEF). Rockville, MD. Retrieved from http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF

19. Smith, T.W., Marsden, P., Hout, M., & Kim, J. (2011). General Social Survey, 1972-2010 [machine-readable data file and codebook]. Storrs, CT: The Roper Center for Public Opinion Research, University of Connecticut/Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributors]. Retrieved from http://dx.doi.org/10.3886/ICPSR31521.v1.

20. Pescosolido, B., Martin, J., Link, B., Kikuzawa, S., Burgos, G., Swindle, R., et al. (2000). Americans' Views of Mental Health and Illness at Century's End: Continuity and Change. Public report on the MacArthur Mental Health Module, 1996 General Social Survey. Bloomington, Indiana: Indiana Consortium for Mental Health Services Research and Joseph P Mailman School of Public Health, Columbia University.

21. Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., et al. (2001). Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York: Oxford University Press.

22. Appelbaum, P. & Swanson, J. (2010). Law & Psychiatry: Gun Laws and Mental Illness: How Sensible Are the Current Restrictions? Psychiatric Services, 61(7), 652-654.

23. Teplin, L., McClelland, G., Abram, K., & Weiner, D. (2005). Crime victimization in adults with severe mental illness: Comparison with the National Crime Victimization Survey. Archives of General Psychiatry, 62(8), 911-921. doi: 10.1001/archpsyc.62.8.911.

24. Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Association of County Behavioral Health & Developmental Disability Directors, National Institute of Mental Health, & The Carter Center Mental Health Program. (2012). Attitudes Toward Mental Illness: Results from the Behavioral Risk Factor Surveillance System. Atlanta, GA: Centers for Disease Control and Prevention.

25. Ibid.

26. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2004). Building Bridges: Mental Health Consumers and Members of Faith-Based and Community Organizations in Dialogue (DHHS Pub. No. 3868). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

27. U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: Center for Mental Health Services.

28. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2013). Infusing Cultural Competency into the SPF. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. Retrieved from: http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework/cultural-competence/elements-culture

29. U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: Center for Mental Health Services.

30. Ibid.

31. Kessler, R., McGonagle, K., Zhao, S., Nelson, C., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey. Archives of General Psychiatry, 51(1), 8-19.

32. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). Ten Leading Causes of Injury Deaths by Age Group Highlighting Violence-Related Injury Deaths. Atlanta, GA: National Center for Injury Prevention and Control. Retrieved from http://www.cdc.gov/injury/wisqars/pdf/10LCID_Violence_Related_Injury_Deaths_2010-a.pdf

33. Harding, C., Brooks, G., Ashikaga, T., Strauss, J.S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness. American Journal of Psychiatry, 144 (6), 727–735.

34. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2009). 2009 CMHS Uniform Reporting System output tables. Retrieved from http://www.samhsa.gov/dataoutcomes/urs/urs2009.aspx

35. Cook, J., Leff, H., Blyler, C., Gold, P., Goldberg, R., Mueser, K., et al. (2005). Results of a multisite randomized trial of supported employment interventions for individuals with severe mental illness. Archives of General Psychiatry, 62(5), 505–512.

36. Davis, K. (2012). Statistical Brief #358: Expenditures for Treatment of Mental Health Disorders among Young Adults, Ages 18-26, 2007-2009: Estimates for the U.S.Civilian Noninstitutionalized Population. Rockville, MD: Medical Expenditures Panel Survey, Agency for Healthcare Research and Quality.

37. United States Government Accountability Office. (2008). Young Adults with Serious Mental Illness: Some States and Federal Agencies Are Taking Steps to Address Their Transition Challenges (Report to Congressional Requestors, GAO-08-678). Retrieved from http://www.gao.gov/new.items/d08678.pdf

38. Kessler, R., Heeringa, S., Lakoma, M., Petukhova, M., Rupp, A., Schoenbaum, M., et al. (2008). The individual-level and societal-level effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. American Journal of Psychiatry, 165(6), 703-11. doi: 10.1176/appi.ajp.2008.08010126.

39. Miller, T. & Hendrie, D. (2008). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis (DHHS Pub. No. (SMA) 07-4298). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

40. Ibid.

41. Ibid.

42. Ibid.

43. U.S. Department of Housing and Urban Development. (2011). The 2010 Annual Homeless Assessment Report to Congress (HUD No.11-121). Retrieved from https://www.onecpd.info/resources/documents/2010homelessassessmentreport.pdf; Folsom, D., Hawthorne, W., Lindamer, L., et. al. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. American Journal of Psychiatry, 162(2), 370-376.

44. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings (NSDUH Series H-44, HHS Publication No. (SMA) 12-4713). Rockville, MD: Substance Abuse and Mental Health Services Administration

45. Ibid.

46. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings. (NSDUH Series H-45, HHS Publication No. (SMA) 12-4725). Rockville, MD: Substance Abuse and Mental Health Services Administration.

47. Ibid.

48. U.S. Department of Housing and Urban Development. (2011). The 2010 Annual Homeless Assessment Report to Congress (HUD No.11-121). Retrieved from https://www.onecpd.info/resources/documents/2010homelessassessmentreport.pdf

49. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2005). Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP Series 42, DHHS Publication No. (SMA) 12-3992). Rockville, MD. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf; Polcin D. & Henderson, D.M. (2008). A clean and sober place to live: philosophy, structure, and purported therapeutic factors in sober living houses. Journal of Psychoactive Drugs, 40(2), 153-159; Hannigan, T., & Wagner, S. (2003). Developing the "Support" in Supportive Housing: A Guide to Providing Services in Housing. Retrieved from Corporation for Supportive Housing website at http://documents.csh.org/documents/pubs/DevelopingSupport-full.pdf; Larimer, M.E., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. Journal of the American Medical Association, 301(13), 1349–1357.

50. Culhane, P., Metraux, S., & Hadley, T. (2002). Public service reduction associated with placement of homeless persons with severe mental illness in supportive housing. Housing Policy Debate, 13(1), 107-163.

51. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2010). Permanent Supportive Housing: Building Your Program (HHS Pub. No. SMA-10-4509). Rockville, MD: Center for Mental Health Services.

52. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (NSDUH Series, H-45, HHS Publication No. (SMA) 12-4725). Rockville, MD. Retrieved from http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm

53. U.S. Department of Education. (2001). Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act. Washington, D.C.: U.S. Department of Education.

54. Druss, B. (2011). Understanding Excess Mortality in Persons with Mental Illness. Medical Care, 49(6), 599-604.

55. Copeland, W., Wolke, D., Angold, A.,& Costello, E. (2013). Adult Psychiatric Outcomes of Bullying and Being Bullied by Peers in Childhood and Adolescence. JAMA Psychiatry, 70(4), 419-426.

56. Miller, T., & Hendrie, D. (2008). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis (DHHS Pub. No. (SMA) 07-4298). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

57. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings (NSDUH Series H-44, HHS Publication No. (SMA) 12-4713). Rockville, MD: Substance Abuse and Mental Health Services Administration.

58. Ibid.

59. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Promoting Recovery and Resilience for Children and Youth Involved in the Juvenile Justice and Child Welfare Systems. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

60. Ibid.

61. Ibid.

62. Department of Health. (2001). Making it happen: a guide to delivering mental health promotion. London, UK. Retrieved from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007907

63. National Federation of Families for Children's Mental Health. (2013). Definition of Family-Driven Care. Retrieved from http://ffcmh.org/family-driven-definition

64. U.S. Department of Labor, Employee Benefits Security Administration. (2010). Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses. Washington, DC. Retrieved from http://www.dol.gov/ebsa/pdf/fsdependentcoverage.pdf; Lotstein, D., Inkelas, M., Hays, R., Halfon, N., Brook, R. (2008). Access to Care for Youth with Special Health Care Needs in the Transition to Adulthood. Journal of Adolescent Health, 43(1), 23-29.

65. Millstein, S., & Halpern-Felsher, B. (2001). Perceptions of Risk and Vulnerability. In Fischhoff, B., Nightingale, E., & Iannotta, J. (Eds.) Adolescent Risk and Vulnerability: Concepts and Measurement. (pp.15-29). Retrieved from http://www.nap.edu/openbook.php?record_id=10209&page=15

66. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). National Vital Statistics System, National Center for Health Statistics. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. Retrieved from http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf

67. Embry, L., Vander Stoep, A., Evens, C., Ryan, K., Pollack, A. (2000). Risk factors for homelessness in adolescents released from psychiatric residential treatment. Journal of the American Academy of Child & Adolescent Psychiatry, 39(10), 1293-9.

68. Davis, M., Banks, S., Fisher, W., Gershenson, B., Grudinskas, A. (2007). Arrests of adolescent clients of a public mental health system during adolescence and young adulthood. Psychiatric Sercices, 58(11), 1454-60.

69. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2013). Mental Health Surveillance Among Children — United States, 2005–2011. MMWR, 62(02), 1-35. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6201a2_w

70. U.S. Department of Education, National Center for Education Statistics. (2008) The Condition of Education 2008 (NCES Pub. No. 2008-031). Washington, DC. Retrieved from http://www.eric.ed.gov/PDFS/ED501487.pdf

71. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). Overview of Fnidings from the 2002 National Survey on Drug Use and Health (NHSDA Series H-22, DHHS Publication No. (SMA) 03-3836). Retrieved from http://samhsa.gov/data/NHSDA/2k2NSDUH/2k2SoFOverviewW.pdf; Neinstein, L. (2013). The New Adolescents: An analysis of health conditions, behaviors, risks and access to services among emerging young adults. Retrieved from http://www.usc.edu/student-affairs/Health_Center/thenewadolescents/doc/TheNewAdolescents_Final_Locked.pdfaffairs/Health_Center/thenewadolescents/doc/TheNewAdolescents_Final_Locked.pdf

72. Davis, M., & Vander Stoep, A. (1997). The transition to adulthood for youth who have serious emotional disturbance: Developmental Transition and young adult outcomes. Journal of Mental Health Administration, 24(4), 400-426.

73. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Data Spotlight: Fewer than One in Eight Adolescent Substance Abuse Treatment Admissions Are Referred to Treatment by Schools. Rockville, MD: Center for Behavioral Health Quality and Statistics, Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/spotlight/Spot057EduReferrals2012.pdf

74. Ibid.

75. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (NSDUH Series, H-45, HHS Publication No. (SMA) 12-4725). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm

76. Kataoka, S., Zhang, L., & Wells, K. (2002). Unmet Need for Mental Health Care Among U.S. Children: Variation by ethnicity and insurance status. American Journal Psychiatry, 159(9), 1548-55. doi: 10.1176/appi.ajp.159.9.1548.

77. National Alliance on Mental Illness. (2010). Mental Illness and the Workplace. Arlington, VA. Retrieved from http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Workplace.pdf

78. Culhane, P., Metraux, S., & Hadley, T. (2002). Public service reduction associated with placement of homeless persons with severe mental illness in supportive housing. Housing Policy Debate, 13(1); U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2010). Permanent Supportive Housing: Building Your Program (HHS Pub. No. SMA-10-4509). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

79. Eisenberg, D., & Neighbors, K. (2007). Economics of Preventing Mental Disorders and Substance Abuse Among Young People. Paper commissioned by the Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. Washington, DC: Research Advances and Promising Interventions, Board on Children, Youth, and Families, National Research Council and Institute of Medicine.

80. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2011). The NSDUH Report: Sources of Payment for Mental Health Treatment for Adults. Rockville, MD: Substance Abuse and Mental Health Services Administration.

81. Ibid.

82. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2010). National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005 (DHHS Publication No. (SMA) 10-4612). Rockville, MD:Center for Mental Health Services and Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

83. Beronio, K., Po, R., Skopec, L., & Glied, S. (2013). Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans. Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Retrieved from: http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm

84. Appelbaum, P. & Swanson, J. (2010). Law & Psychiatry: Gun Laws and Mental Illness: How Sensible Are the Current Restrictions? Psychiatric Services, 61(7), 652-654.

85. Teplin, L.A., McClelland, G.M., Abram, K.M., & Weiner, D.A. (2005). Crime Victimization in Adults With Severe Mental Illness: Comparison with the national crime victimization survey. Archives of General Psychiatry, 62(8), 911-921.

86. Judge, D.L. (2005). Fact Sheet #3: Individuals with Mental Illnesses in Jail and Prison. Retrieved from http://data.opi.mt.gov/bills/2005/Minutes/House/Exhibits/jhh14a200.pdf

87. U.S. Department of Justice, Office of Justice Programs. (2006). Bureau of Justice Statistics special report: mental health problems and jail inmates (NCJ213600). Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf

88. Skowyra, K., & Cocozza, J. (2006). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. Delmar, NY: The National Center for Mental Health and Juvenile Justice and Policy Research Associates, Inc.

89. Ryan, C., Huebner, D., Diaz, R.M., & Sanchez, J. (2009). Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. Pediatrics, 123(1),346–352.; National Prevention Council. (2011). National Prevention Strategy. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

90. Gebhard, B. (2009). Early Life Experiences Matter: A Guide to Improved Policies for Infants and Toddlers. Washington, D.C.: Zero to Three. Retrieved from http://main.zerotothree.org/site/DocServer/Policy_Guide.pdf?docID=8401

91. Perry, B., Pollard, R., Blakley, T., Baker, W., & Vigilante, D. (1995). Childhood Trauma: The Neurobiology of Adaptation and 'Use-Dependent' Development of the Brain. Infant Mental Health Journal, 16(4), 271–291.

92. Center on the Developing Child, Harvard University. (2008). In Brief: The Science of Early Childhood Development. Boston, MA: NGA Center for Best Practices, National Conference of State Legislatures, and Center on the Developing Child, Harvard University. Retrieved from http://developingchild.harvard.edu/index.php/resources/briefs/inbrief_series/inbrief_the_science_of_ecd/

93. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258.

94. Ladd, G., Birch, S., & Buhs, E. (1999). Children's Social and Scholastic Lives in Kindergarten: Related Spheres of Influence? Child Development, 70(6): 1373–1400.; Raver, C. (2002). Emotions Matter: Making the Case for the Role of Young Children's Emotional Development for Early School Readiness. Social Policy Report of the Society for Research in Child Development, 16(1), 3–23.

95. Raver, C. (2002). Emotions Matter: Making the Case for the Role of Young Children's Emotional Development for Early School Readiness. Social Policy Report of the Society for Research in Child Development, 16(1), 3–23.

96. National Association of School Psychologists. (2002). Social Skills: Promoting Positive Behavior, Academic Success, and School Safety. Bethesda, MD. Retrieved from http://www.nasponline.org/resources/factsheets/socialskills_fs.aspx

97. United States Government Accountability Office. (2008). Young Adults with Serious Mental Illness: Some States and Federal Agencies Are Taking Steps to Address Their Transition Challenges (Report to Congressional Requestors, GAO-08-678). Retrieved from http://www.gao.gov/new.items/d08678.pdf

98. American College Health Association. (2012). American College Health Association-National College Health Assessment II: Reference Group Executive Summary Spring 2012. Hanover, MD: American College Health Association. Retrieved from http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Spring2012.pdf

99. U.S. Department of Education. (2001). Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act. Washington, D.C.: U.S. Department of Education.

100. Kim-Cohen, J., Caspi, A., Moffitt, T., Harrington, H., Milne, B., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. Archives of General Psychiatry, 60(7), 709-717.

101. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (NSDUH Series H-45, HHS Publication No. (SMA) 12-4725). Rockville, MD: Substance Abuse and Mental Health Services Administration.

102. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Data Spotlight: Major Depressive Episode among Adolescents Living in Poverty. Rockville, MD: Center for Behavioral Health Quality and Statistics. Retrieved from http://www.samhsa.gov/data/spotlight/Spotlight_064_Poverty_2012/CBSHQ_Spotlight_064_Poverty_2012.pdf

103. Kataoka, S., Zhang, L., & Wells, K. (2002). Unmet needs for mental health care among U.S. children: Variation by ethnicity and insurance status. American Journal of Psychiatry, 159(9), 1548-1555.

104. Dell'Osso, B., Glick, I., Baldwin, D., & Altamura, A. (2013). Can Long-Term Outcomes Be Improved by Shortening the Duration of Untreated Illness in Psychiatric Disorders? A Conceptual Framework. Psychopathology, 46(1), 14-21.

105. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). National Vital Statistics System, National Center for Health Statistics. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. Retrieved from http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf

106. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). Youth risk behavior surveillance—United States, 2009. Surveillance Summaries. MMWR, 59(SS-5).

107. Ibid.

108. Heron, M. (2007). Deaths: Leading causes for 2004. National Vital Statistics Reports (l56-5). Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_05.pdf

109. Adler School Institute on Social Exclusion & Adler School Institute on Public Safety and Social Justice. (2011). Defining terms: Social determinants of mental health. Intersections: A Transdisciplinary Exploration of Social Issues, 6(4), 9.

110. Ibid.; Administration for Children and Families. (2013). Child Welfare Information Gateway, Fidelity in Evidence-Based Practice. Retrieved from https://www.childwelfare.gov/management/practice_improvement/evidence/fidelity.cfm

111. Substance Abuse and Mental Health Services Administration. (2013). SAMHSA's National Registry of Evidence-based Programs and Practices, Frequently Asked Questions. Retrieved from http://www.nrepp.samhsa.gov/FAQ.aspx

Notes:

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

SMA-13-4763
July 2013

MentalHealth.gov