CARCERAL APPROACHES TO YOUTH MENTAL HEALTH

Mental healthcare in the United States was built on carceral foundations. From its roots in the asylum era, too much of our mental health "care" has been about controlling, containing, surveilling, and brutally punishing those in need of real support. Today's young people have inherited this legacy: whether in schools, prisons, or psychiatric hospitals, they are still controlled, contained, surveilled, and punished for their mental health. This factsheet outlines some of the forms these carceral approaches currently take.

School Police Responses	
What is it?	When a community member is thought to be experiencing a mental health crisis, the police are often dispatched to respond. The same is true in our schools. School police officers are sent to respond when a child is seen as being "in crisis," suicidal, or depressed. They go to students' homes to do "wellness checks." Increasingly, they view and frame themselves as "counselors" who have a role responding to all kinds of student mental health needs.

School Police Responses

Examples of Federal/ State/Local Policy	• The United States Department of Justice's Community Oriented Policing Services (COPS) program provides funding that local law enforcement agencies can use to hire School Resource Officers (SROs)—in 2022, up to $156 million was available.[1] COPS also provides several descriptions of the roles and responsibilities of SROs. These roles include being an "adviser" and "mentor" to students as well as a "counselor."[2] Given this widespread framing of school police officers' role, it is not surprising that they see responding to student mental health as part of their job. • The National Association of School Resource Officers (NASRO)—the lead organization representing and training school police officers—offers an "Adolescent Mental Health Training" for its members. The purpose of this training is to help officers "identify and respond to students who are suspected of having a mental health need" (later described as "mental health problems").[3] One unit focuses on "gaining compliance" from youth in crisis.[4] Another helps participants generate a list of "emergency" mental health care providers, with no guidance to prevent an officer from resorting to an involuntary commitment of the youth.[5] Overall, the training emphasizes the "important role" SROs play in responding to student mental health.[6]
Data & Examples of Usage	• At least 14 million students are in schools with police but no counselor, nurse, psychologist, or social worker.[7] • Although it is common for school police officers to respond to student mental health, this practice is not evidence-based. There has been no rigorous evaluation showing a positive effect of school police responses to mental health.[8] • On the other hand, there is substantial evidence that police contact is harmful to youth mental health, particularly for Black, Latine, and other students of color.[9] One study showed that police presence and contact at school led to heightened emotional distress.[10] • Denver Public Schools' Department of Safety (school police department) has call codes indicating the type of situation the school police officers responded to. Between 2021 and 2022 school police officers responded to suicide threats and attempts (744 times), child in crisis (287 times), depression (43 times), and made home visits/welfare checks (446 times). • Chicago Public Schools' police incident codes between April 2019 and April 2022 include wellness checks (33 times), suicidal behavior (48 times), and social emotional needs (155 times).

[1] "COPS Hiring Program," DOJ COPS, accessed Feb. 10, 2023, https://cops.usdoj.gov/chp.

[2] Fran Sterling, Beyond the Badge: Profile of a School Resource Officer (Washington, DC: Office of Community Oriented Policing Services, 2016), 6, accessed Feb. 10, 2023, https://cops.usdoj.gov/ric/Publications/cops-p357-pub.pdf.

[3] "Adolescent Mental Health Training for School Resource Officers and Educators Course Outline and Objectives," NASRO, 1, accessed Feb. 10, 2023, https://www.nasro.org/clientuploads/Course%20Agendas/AMHT-SRO_Course_Outline_and_Objectives.pdf.

[4] NASRO, 4.

[5] Ibid. Involuntary commitments are discussed in greater detail later in this factsheet.

[6] Ibid, 2.

[7] "Cops and No Counselors," ACLU, accessed Feb. 10, 2023, https://www.aclu.org/issues/juvenile-justice/school-prison-pipeline/cops-and-no-counselors.

[8] Kristen R. Choi *et al.*, "A Scoping Review of Police Involvement in School Crisis Response for Mental Health Emergencies," School Mental Health 14 (2022): 435-36, https://link.springer.com/content/pdf/10.1007/s12310-021-09477-z.pdf.

[9] Choi *et al.*, 432.

[10] Ibid.

School Police Responses	
Why is it harmful?	• ***Policing is traumatizing and harmful to youth mental health.*** Students struggling with their mental health—or acting in accordance with a mental health disability they have—need real support, not policing. Policing makes difficult situations worse by treating students as the problem and subjecting them to cruelty, surveillance, and incarceration. • ***Mental health training won't change the fundamental role of policing.*** As seen in NASRO's own mental health training, the role of an officer is to obtain "compliance," not to provide mental health care. Someone who has the power to put a young person in handcuffs cannot also be authentically entrusted with that person's mental health and wellbeing. School districts' failure to provide mental health support does not mean police officers should take on that role; calling a police officer a counselor does not truly make them one.

Involuntary Commitments	
What is it?	The process of involuntary commitment of a youth or adult typically begins with a brief hold (called an involuntary hold, a 72-hour hold, emergency hold, or psychiatric hold) in a psychiatric hospital or other healthcare facility against the person's will, for the supposed purpose of preventing harm to themself or others and determining whether a longer commitment is needed.[11] Young people experiencing these holds, and further involuntary commitment, may experience: an arrest-like experience with handcuffs and transport in a police car; strip-searching; constant surveillance; restraint with physical restraints; restraint with chemical restraints (forced medication); sleep disruptions for vitals checks; limited meal options with restrictions on outside food brought in; rules forbidding them to step foot outside; extremely limited contact with the outside world; having to ask permission for everything from receiving menstrual products to being allowed to use the bathroom; among many other possible restrictions on liberty.
Examples of Federal/ State/Local Policy	***Every state and D.C. have involuntary commitment laws, though the laws vary on how long the initial hold is, who can initiate it, and the patient's rights.***[12] • Usually, involuntary commitments apply to those with "mental illness" who "present a danger to themselves or others," though states may have additional criteria for holds. • In all states, police officers are authorized to detain a person seen to pose an "imminent danger," and 38 states explicitly authorize police officers to initiate involuntary commitments. In two states—Wisconsin and Kansas—only police officers may initiate an involuntary commitment.[13] • 22 states require some form of judicial review of the hold process. 9 require a judge's approval prior to hospitalization. 5 do not require assessment by a mental health professional during the hold.

[11] Leslie C. Hedman *et al.*, "State Laws on Emergency Holds for Mental Health Stabilization," Psychiatric Services, Feb. 29, 2016, https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201500205.

[12] Hedman *et al.*, ibid.

[13] Ibid.

Involuntary Commitments	
Examples of Federal/ State/Local Policy	***Every state and D.C. have involuntary commitment laws, though the laws vary on how long the initial hold is, who can initiate it, and the patient's rights.***[14] • 21 states protect the right for a patient to make phone calls from the hospital. • 26 states allow the patient to see an attorney. • 12 states must allow the patient to refuse treatment. • 8 states have a right to appeal the hold. • 29 states require written notification of the reason for the hold. • 10 states require transportation for the patient after the hold. Of the 25 states that provide data on involuntary commitments, five states, representing 59.2% of the states' populations, accounted for 79.8% of the involuntary commitments. These states are Florida, California, Massachusetts, Texas, and Colorado.[15] Florida, under its Baker Act, uses involuntary commitments at a greater rate than any other state, committing more than 37,000 children a year, often for experiencing any sort of distress at school. 25% of children committed are Black, though Black children are only 15% of the youth population.[16]
Data & Examples of Usage	From 2010 to 2020, the rate of involuntary commitments for youth and adults rose sharply.[17] Though youth-specific data is limited, commitment of youth and adults follow the same general trends.[18] ***Young people are generally more likely to experience involuntary commitment if they:***[19] • Are deemed at risk of harming themselves or others • Experience psychosis • Have an intellectual disability • Are suspected of substance misuse • Are older than 12 years old • Are Black ***Children under 10 are more likely to experience involuntary commitment if they:***[20] • Are male • Are Latino • Have some history of CPS family involvement • Have experienced a prior psychiatric hospitalization

[14] Ibid.

[15] Gi Lee and David Cohen, "Incidences of Involuntary Psychiatric Detentions in 25 U.S. States," Psychiatric Services, Nov. 3, 2020, https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900477.

[16] *Costly and Cruel: How Misuse of the Baker Act Harms* 37,000 Florida Children Each Year, SPLC (2021), 14, https://www.splcenter.org/sites/default/files/com_special_report_baker_act_costly_and_cruel.pdf.

[17] Les Dunseith, "Study finds involuntary psychiatric detentions on the rise," UCLA, Nov. 3, 2020, https://newsroom.ucla.edu/releases/involuntary-psychiatric-detentions-on-the-rise.

[18] Lee and Cohen, ibid.

[19] Kara Grant, "Involuntary Psychiatric Holds in Kids: The Known Unknowns," MedPage Today, April 30, 2021, https://www.medpagetoday.com/psychiatry/generalpsychiatry/92351.

[20] Genevieve Santillanes *et al*., "Involuntary Psychiatric Holds in Preadolescent Children," West J. Emerg. Med 18(6) (2017), 1159–1165, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5654888/.

Involuntary Commitments	
Data & Examples of Usage	Most holds for children under 10 are for "danger to self or others." Young children have been hospitalized for behaviors like play-fighting. Researchers question the necessity or therapeutic value of the holds. Involuntary commitments can be traumatic and increase the risk of exposure to further coercive tools like seclusion and restraints. Youth experiencing involuntary commitments may be more likely to experience further coercive care in adulthood.[21] One study found that 3/4 of youth reported negative impacts of involuntary commitment on trust in the mental healthcare system, leading to unwillingness to disclose suicidal thoughts and feelings to mental healthcare providers. Youth reported that the involuntary commitment was punitive, the staff were judgmental, and the hospitalization did not help them feel better.[22]
Why is it harmful?	***Involuntary commitments are punitive and carceral.*** Often, involuntary commitment is used not when a young person is in crisis but is experiencing a manifestation of a disability or simply a human experience of distress. Locking them up somewhere they may be strip-searched, restrained, surveilled, and allowed limited contact with the outside world is not therapeutic but punitive and traumatic, not to mention a steep medical expense for their families. Even when a young person is at risk of harming themself or others, they deserve crisis response that is non-carceral and provides them with the support they need. ***Involuntary commitments take youth even further from support.*** The traumatizing experience of involuntary commitment makes young people less likely to seek out any form of mental health care, for fear they will be committed against their will. Unfortunately, a prior hospitalization makes a subsequent one more likely, so this fear is a reasonable one.

Criminalizing of Mental Health Disabilities	
What is it?	Children and youth with disabilities are more likely to be pushed out of school and into the juvenile justice system. This is especially true for those with mental health disabilities, specifically those categorized as emotional disabilities. Emotional disabilities can encompass anything from conditions diagnosed as anxiety disorders, depression, bipolar disorder and psychotic disorders to eating disorders and so-called "conduct disorders."
Examples of Federal/ State/Local Policy	The school to prison pipeline is driven by state and local laws as well as individual school policies. Over ten thousand children a year are arrested for some form of "disturbing school," whether through specific state school disturbance laws or disorderly conduct or disturbing the peace statutes.[23] Because these laws can encompass a broad range of conduct—anything that can be seen to "disturb" a school—students with mental health disabilities

[21] Susan Walker *et al.*, "Clinical and social factors associated with involuntary psychiatric hospitalisation in children and adolescents: a systematic review, meta-analysis, and narrative synthesis," Lancet Child Adolesc. Health 5(7) (2021), 501–512, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8205858/.

[22] Nev Jones *et al.*, "Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care," Soc Psychiatry Epidemiol 56(11) (2021), 2017-2027, https://pubmed.ncbi.nlm.nih.gov/33751175/.

[23] Noelia Rivera-Calderón, "Arrested at the Schoolhouse Gate," National Lawyers Guild Review 76, no. 1 (Spring 2019): 1.

Criminalizing of Mental Health Disabilities	
Examples of Federal/ State/Local Policy	are frequently arrested under these laws. In general, students with disabilities represent a quarter of all students arrested for school-based conduct, though they represent only 12% of the student population.[24] A full 20% of students with emotional disabilities have been arrested under these laws.[2] Both the federal Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act require schools to determine if a student's misconduct occurred as a result of their disability within 10 days of subjecting them to a "change in placement" (such as a suspension for longer than 10 days or an expulsion, but not limited to those situations). This is called a manifestation determination meeting. However, this protection is only useful so long as it is enforced, and practices like unofficial, informal, or off-the-record suspensions make enforcement even harder. Additionally, the IDEA was amended by Congress specifically to say that it does not prevent law enforcement from applying laws equally to students with disabilities.[26]
Data & Examples of Usage	***Disabilities, and especially mental health disabilities, are punished and criminalized:*** • More than one in four Black boys and one in five Black girls with disabilities will be suspended in a given school year.[27] • Upwards of 70% of legal system-involved youth have a diagnosable mental health condition, and at least 75% have experienced trauma.[28] • Youth in juvenile detention are 10 times more likely to experience psychosis than youth not in detention.[29] ***Emotional disabilities are particular targets of the school-to-prison pipeline:*** • Children with emotional disabilities (which may be classified as an "Emotional Disturbance" under the IDEA) are three times as likely to be arrested before leaving school compared to all students.[30] • For example, one Mississippi student was sent to a mental health treatment facility and criminally charged for a manifestation of his bipolar disorder.[31] • One third of all K-12 students with emotional disabilities have been suspended at least once.[32] • At least 73% of youth with emotional disabilities who drop out of school are arrested within five years.[33]

[24] Rivera-Calderón, 15.

[25] Ibid.

[26] Ibid.

[27] Katherine Reynolds Lewis, "Why Schools Over-Discipline Children With Disabilities," The Atlantic, July 24, 2015, https://www.theatlantic.com/education/archive/2015/07/school-discipline-children-disabilities/399563/.

[28] Aly Feye *et al.*, "Caring for Youth with Behavioral Health Needs in the Juvenile Justice System: Improving Knowledge and Skills of the Professionals Who Supervise Them," National Center for Youth Opportunity and Justice, (2020), 2, https://ncyoj.policyresearchinc.org/img/resources/CaringforYouthwithBehavioralHealthNeedsinJJ-946799.pdf.

[29] "Intersection between Mental Health and the Juvenile Justice System," Office of Juvenile Justice and Delinquency Prevention, (July 2017), 3, https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/intsection_between_mental_health_and_the_juvenile_justice_system.pdf.

[30] Jim Comstock-Galagan and Rhonda Brownstein, "Stopping the Schoolhouse to Jailhouse Pipeline by Enforcing Federal Special Education Law," Southern Disability Law Center & Southern Poverty Law Center, https://www.njjn.org/uploads/digital-library/resource_422.pdf.

[31] Jackie Mader and Sarah Butrymowicz, "Pipeline to Prison: Special education too often leads to jail for thousands of American children," Hechinger Report, Oct. 26, 2014, https://hechingerreport.org/pipeline-prison-special-education-often-leads-jail-thousands-american-children/.

[32] Reynolds Lewis, ibid.

[33] "Beyond Suspensions: Examining School Discipline Policies and Connections to the School-to-Prison Pipeline for Students of Color with Disabilities," United States Commission on Civil Rights (July 2019), 37, https://www.usccr.gov/files/pubs/2019/07-23-Beyond-Suspensions.pdf.

Criminalizing of Mental Health Disabilities

Data & Examples of Usage

One particular type of emotional disability—a "conduct" or "behavior" disorder—is diagnosed and then criminalized along racial lines.

- One study of youth in residential treatment facilities found that less than one-quarter of non-Latine white youth were diagnosed with a conduct disorder (24.4%), compared to 43.3% of Latine youth and 34.4% of Black youth.[34]
- Black and Latine youth are far more likely to be diagnosed with a conduct disorder than with ADHD—even though the diagnostic criteria are very similar. Black children were 69% less likely, and Latine children 50% less likely, than white non-Latine children to receive an ADHD diagnosis.[35]

Why is it harmful?

Our schools and juvenile legal institutions are designed to punish young people for their mental health disabilities. The prevalence of punishment, school pushout, and juvenile or adult legal system involvement and confinement for young people with mental health disabilities indicates that they are being punished specifically for their disabilities. Those with emotional disabilities are particularly impacted by systems that are not interested in supporting them, only in containing them.

Being criminalized causes further harm to mental health, leading to a vicious cycle of harm, punishment, further harm, and further punishment. Systems of punishment and criminalization not only target those with mental health disabilities, they cause further trauma and mental health harm to those young people. Early childhood incarceration is linked to severe mental health struggles in adulthood.[36] This brings young people even further from support and makes them more likely to be criminalized again and again throughout their lives in a vicious cycle.[37]

Mandatory Reporting

What is it?

Mandatory reporting laws require those in certain "helping professions"—such as social workers, counselors, teachers, and medical professionals—to report suspected child abuse or neglect to the state for investigation. Mandatory reporting officially started with the Child Abuse Prevention and Treatment Act of 1974, which provided funding for states to develop their own Child Protective Services agencies and staff reporting hotlines. However, the practice built on a century of removing poor children of color from their homes to place them with wealthier, white parents. 1960s and 70s narratives about "battered child syndrome" and "crack babies" contributed to the expansion of the child welfare system.[38] Against this backdrop, mandatory reporting laws were premised on the idea that child abuse was far more prevalent than it actually was.[39]

[34] Cameron M *et al.*, "Diagnosing conduct problems of children and adolescents in residential treatment," Child Youth Care Forum 2007; 36(1):1–10.

[35] Morgan PL *et al.*, "Racial and ethnic disparities in ADHD diagnosis from kindergarten to eighth grade," Pediatrics, 2013; 132(1):85–93.

[36] Ryan Hatoum, "Early childhood incarceration is linked to high rates of severe physical and mental health issues in adulthood," UCLA, March 29, 2018, https://newsroom.ucla.edu/releases/early-childhood-incarceration-is-linked-to-high-rates-of-severe-physical-and-mental-health-issues-in-adulthood.

[37] See "Intersection between Mental Health and the Juvenile Justice System" at 4-5.

[38] G Inguanta & Catherine Sciolla, "Time Doesn't Heal All Wounds: A Call to End Mandated Reporting Laws," Columbia Social Work Review, Vol. XIX (2021): 119-120, https://journals.library.columbia.edu/index.php/cswr/article/view/7403/4230.

[39] For more on ending the harms of the punitive child welfare system and mandatory reporting, look to the work of organizations like JMACforFamilies, https://jmacforfamilies.org/, and the Movement for Family Power, https://www.movementforfamilypower.org/.

Mandatory Reporting	
What is it?	As a companion to mandatory reporting laws, 1976 case Tarasoff v. Regents of Univ. of Cal. inspired a wave of "duty to warn" or "duty to protect" laws.[40] The case involved a psychologist's patient killing a third party who was not warned by the psychologist. In the two decades following the case, nearly every state passed a law providing that a mental health professional either must or may warn law enforcement and the intended victim of a crime (if any) of a patient's suspected intent to harm themself or others. These laws can also apply to threats of suicide, and some provide that the parents of a minor must or may be warned if the young person indicates intent to end their life.
Examples of Federal/ State/Local Policy	***48 states, D.C., and Puerto Rico designate professions who are required by law to report suspected abuse and neglect.[41]*** • Nearly always, this includes school counselors. 6 states specify school counselors explicitly, nearly all reference counselors in general, and all include those who work directly with children—which includes school counselors.[42] • Teachers are also explicitly included in nearly all state laws and implicitly included in the rest.[43] ***Other professions covered by state mandatory reporting laws include:[44]*** • Social workers • Physicians and other health-care workers • Mental health professionals • Childcare providers • Medical examiners or coroners • Law enforcement officers • Domestic violence workers (in 6 states) • Clergy (in 26 states) In 18 states and Puerto Rico, any person who suspects abuse or neglect is required to report.[45] In all other states, reporting by any person is permissive. Most (32) state duty to warn laws are mandatory. 11 are permissive. The remaining states have no duty to warn law.[46] 3 states have a specific duty to warn law for suicide,[47] but even in other states, mental health professionals often interpret their duties under existing law to include suicidal indications.

[40] Griffin Edwards, "Tarasoff, Duty to warn laws, and suicide," International Review of Law and Economics 34 (2013): 2, https://www.sciencedirect.com/science/article/pii/S0144818812000634.

[41] "Mandatory Reporters of Child Abuse and Neglect: Summary of State Laws," Child Welfare Information Gateway, 1, accessed Feb. 10, 2023, https://www.childwelfare.gov/pubPDFs/mandaall.pdf.

[42] "Mandatory Reporters of Child Abuse and Neglect," Child Welfare Information Gateway, accessed Feb. 10, 2023, https://www.childwelfare.gov/pubpdfs/manda.pdf.

[43] Ibid.

[44] Summary of State Laws, 2.

[45] Ibid., 3.

[46] Griffin Edwards, 2.1.

[47] Ibid.

Mandatory Reporting	
Data & Examples of Usage	A report by Hilltop News, the student newspaper of Atascadero High School in Atascadero, CA, revealed that mandatory reporting causes some students to avoid seeking help with their mental health.[48] Noting that the school's wellness center is "not completely confidential," the report shares concerns from students who hesitate to bring up that they are being abused for fear of a law enforcement investigation making it worse or hesitate to bring up suicidal thoughts for fear they will be shared with their parents or with law enforcement.[49] This undermines the therapeutic relationship and leads to students saying nothing at all or not trusting the wellness center, even if they're struggling and could use support. One study found that states with mandatory duty to warn laws around suicide have a teen suicide rate 9% higher than states with permissive duty to warn laws.[50] The study concludes that, due to mandatory duty to warn laws, teens with suicidal feelings are less likely to report them to a mental health professional, leading to them not getting the support they need.[51] Black families are far more likely to be reported under mandatory reporting laws than white families.[5] One study of domestic violence survivors showed that 62% felt that mandatory reporting made the situation much worse or a little worse, and an additional 20% felt it made no difference at all.[53] Though there is little data on the overall effects of mandatory reporting on youth mental health, one study found that family separation as a result of mandatory reporting leads to trauma and depression in children.[54]
Why is it harmful?	***Reports aren't supports.*** When children seek help from a teacher, a mental health professional, or a school counselor, they are doing so because they need support. They may be struggling with their mental health, with trauma, with a family situation, or with other difficulties in their lives. With mandatory reporting laws, they don't get the support they need. Instead, they and their families are policed and surveilled. This only makes the struggles they are experiencing worse. ***Reporting undermines the therapeutic relationship.*** When a child speaks to a counselor, they are doing so under the expectation of confidentiality. The expectation is that the counselor is there to help them and will not repeat what they say to anyone. Under both mandatory reporting and duty to warn laws, this confidentiality becomes limited. If a young person cannot trust that what they say will remain confidential, they will be less forthcoming and be too afraid to ask for the support they really need. This can increase the risk the young person will become suicidal, engage in behavior harmful to themself or others, or endure an abusive situation without support. Without true confidentiality, the entire therapeutic relationship is undermined.

[48] "Mandatory Reporting can cause some students to avoid seeking help with mental health issues," Hilltop News, Oct. 4, 2019, https://www.ahshilltopnews.com/single-post/2019/10/04/mandatory-reporting-can-cause-some-students-to-avoid-seeking-help-with-mental-health-issu.

[49] Ibid.

[50] Griffin Edwards, 4.

[51] Ibid.

[52] Inguanta & Sciolla, 127.

[53] Carrie Lippy, Connie Burk and Margaret Hobart, "There's no one I can trust," National LGBTQ DV Capacity Building Learning Center (2016), 4, http://www.ncdsv.org/Natl-LGBTQ-DV-CBLC_There%27s+No+One+I+Can+Trust_2016.pdf.

[54] Vivek Sankaran *et al.*, "A Cure Worse Than the Disease? The Impact of Removal on Children and Their Families Children and Their Families," Marq. L. Rev. 102, no. 4 (2019): 1166-1167, https://repository.law.umich.edu/cgi/viewcontent.cgi?article=3055&context=articles.

Individual Solutions to Systemic Problems	
What is it?	A common response to student mental health concerns is to call for the placement of more school counselors and mental health professionals in schools. While this can be helpful for some students, it speaks to a larger context of pathologizing young people by seeing the problem as a matter of an individual "illness" rather than a collective concern requiring systemic solutions. Rather than placing any pressure on schools and school districts to become places that don't harm student mental health and instead nurture it, this framework blames and shames young people for their own experiences and places the burden on them to treat their resulting symptoms.
Examples of Federal/ State/Local Policy	The Bipartisan Safer Communities Act is the latest federal effort to increase the number of mental health professionals in schools. This program provides $1 billion in grant funding specifically to strengthen the pipeline of mental health professionals preparing for school-related service and to increase the number of mental health professionals and services in schools.[55] It makes no requirements of schools to end practices that have a harmful effect on student mental health, such as school policing.
Data & Examples of Usage	***One report on the mental health needs of Latina girls in Philadelphia highlighted the fact that over 50% felt persistently sad or hopeless and 10% had attempted suicide within the past year.[56] The report explained that the reason these young people had such high rates of depression and suicidal behavior was not because something was "wrong" with them; it was because they experienced multiple intersecting forms of harm.*** • These harms included racial/ethnic discrimination, immigration enforcement, gender-based violence, the expectation that they put others first, and lack of access to healthcare and mental health support.[57] • Though the report included access to counseling as one of many demands for mental health support, it also highlighted the limitations—and sometimes harms—of relying on counseling alone. Instead of support, young people reported they were met with judgment and shame. – One young person described that when they went to counselors, they "would come out feeling worse than I did before. They were not supportive at all. It was like I went there for no reason and I told this stranger everything that I'm going through and now I feel worse about myself. There's a lack of support. Often they don't try to help. They listen and say something that doesn't help at all."[58] – Another shared that, "I remember something happened and I went to talk to the counselor. But she was kinda judging me. That's how I felt, she was judging me. She was like, 'How did you even get to that point, you should have known better.'"[59] – One student noted that a school counselor "would try to make me feel like what I was going through was my fault."[60]

[55] "FACT SHEET: Biden-Harris Administration Announces Two New Actions to Address Youth Mental Health Crisis," The White House, July 29, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/29/fact-sheet-biden-harris-administration-announces-two-new-actions-to-address-youth-mental-health-crisis/.

[56] Noelia Rivera-Calderón *et al.*, *We Are Not Invisible: Latina Girls, Mental Health, and Philadelphia Schools*, National Women's Law Center (2019), 5, https://nwlc.org/wp-content/uploads/2019/04/We-Are-Not-Invisible-Final-Report-1.pdf.

[57] Rivera-Calderón, ibid. at 6-9.

[58] Ibid. at 13.

[59] Ibid. at 23.

[60] Ibid. at 6.

Individual Solutions to Systemic Problems	
What is it harmful?	***In our schools and in society at large, there is a perception that mental health is an individual problem rather than a community concern.*** While counseling can be helpful and should be readily available to young people who want it, the burden should not be solely on the individual to treat their "shameful" "disease"—it should be on schools to do their part to end harm they cause to young people's mental health. This harm includes, for example, all forms of school policing, school cultures that allow harassment to thrive, and cultures of learning focused only on relentless high-stakes testing. ***Quality counseling can be important, but it is not the only way to support youth mental health.*** A single-minded focus on placing counselors and other mental health professionals in our schools does not account for the reality that traditional interventions like individual counseling and medication, while very helpful for some, are not the only ways to support youth mental health. It also does not account for the reality that many young people experience harm from counselors and other mental health professionals. Young people can also thrive with practices like peer support circles, culturally grounded forms of healing, safety plans, mental health break spaces, art, music, and movement therapies, and many other modes of healing that don't always require the presence of licensed mental health professionals. Mental health is a community concern and requires many forms of community responses.

COMMON THEMES & TAKEAWAYS

- Too often, responses to youth mental health needs are carceral. They are based in policing, surveillance, confinement, and control and cause further harm to young people's mental health.
- Young people expressing mental health needs are punished much more than they are supported.
- Until schools do their part to address the ways they harm youth mental health, adding more counselors will never be enough to address the scale of the problem.

WHAT THIS MEANS FOR OUR ORGANIZING

- Abolitionist mental health means rejecting all carceral and punitive forms of mental health response.
- It means providing real, holistic support to our young people while not losing sight of who should bear the burden of change—our systems, not our young people.
- It means following the lead of our young people and communities in developing their own visions for healing and wellness outside of these carceral approaches.