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Documentation Guidelines for Mental Health Disabilities

In order for Student Access and Accommodation (SAA) to evaluate requests for accommodations and/ or auxiliary aids and to determine eligibility for services, appropriate disability related documentation is needed. The documentation submitted should include an evaluation by an appropriately licensed mental health professional and should demonstrate the current impact of the disability as it relates to the accommodations requested. The documentation should also include a description of any and all relevant functional limitations that demonstrate how the diagnosis rises to the level of disability.

A mental health disability is characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. These types of diagnosis are usually associated with significant distress or disability in social, occupational, or other important activities. Mental Health Disabilities include, but are not limited to, mood disorders, anxiety disorders, depressive disorders, eating disorders, obsessive-compulsive disorders, sleep-wake disorders and psychotic disorders.

Qualified Professional Must Complete the Documentation- Documentation must be completed by a licensed psychiatrist, psychologist, or other appropriately licensed mental health practitioner. The examiner must be trained and qualified to make a diagnosis based on the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the current International Classification of Diseases Manual (ICD). Comprehensive training and direct experience with an adolescent and adult population is essential. (Note: It is *not appropriate* for professionals to evaluate relatives or family members.)

Current Documentation- Documentation must be current, within the past 6-12 months; (determination will be made on a case-by-case basis). The documentation must be in a typewritten report on professional letterhead that bears the evaluator's name, license number, professional credentials, business location, contact information and signature.

Diagnosis – A complete DSM-V or ICD-10 diagnosis must be provided with an accompanying description of the specific symptoms that the student experiences. This diagnosis should be based upon a comprehensive clinical interview and/or psychological testing (when testing is clinically appropriate). A comprehensive clinical interview should meet mental health service provider standards of care in length (50 min.) and focus (complete developmental, familial, psychological, medical history, and/or mental status exam.)

Impact on Postsecondary Academic and Housing/Residence Life Functioning – A complete description of the impact that the student's psychological symptoms have on the student's academic and residence life functioning must be provided. Examples of academic areas impacted by the mental health disorder may include, but are not limited to, study skills, classroom behavior, test taking, organizing, memory, concentration, processing speed, and research. Examples of housing/residence life areas impacted by the mental health disorder may include, but are not limited to, sleep, social anxiety, eating meals, initiating and maintaining friendships, communication with roommates/suitemates and living environment.

Other Relevant Information to be Addressed- Documentation should provide responses to each of the following questions:

1. Does the student have a diagnosable mental health disorder and/or a certification of mental health disability? If so, what is the specific *DSM-V* classification or specific ICD-10 code? Please comment on important psychosocial and contextual considerations important to the postsecondary environment.
2. What assessment or evaluation procedures were used to make the diagnosis?
3. Is there historical data that is pertinent to the mental health disability (i.e.: medical, familial or developmental)? Please explain.
4. What major symptoms of the disorder does the student currently manifest and what is the level of severity of each symptom?
5. If medications are currently prescribed for any diagnosis, does the individual experience any substantial side effects? Please state type of medication, dosage, any adverse side effects, and the medication's current effectiveness. Does the student need accommodations to address substantial side effects? Please explain.
6. What are the current functional limitations on activities of daily living imposed by the disorder(s)?
7. What is the current prognosis? Is the condition stable, chronic, progressive, or relapsing-remitting?
8. When was the original diagnosis made? When did you first treat this individual? When did you last treat this individual? When is your next scheduled appointment? Have you treated this individual on a regular, rather than an intermittent, basis? For how long have you been treating this individual?
9. How does the diagnosis impact the individual in a postsecondary academic setting? (What are the current functional limitations)?
10. If applicable: How does the diagnosis impact the individual in a postsecondary residential setting? What are the current functional limitations on activities of daily living within this setting?
11. Are there any indications that this student may have another diagnosis? Please describe pertinent characteristics and give an explanation for your reason to suspect this secondary diagnosis.
12. Have you referred the individual for other treatment that may impact on current functional limitations?