Briefing Notes: Mental Health Priorities

Mental Health in Schools

**Why Focus on Mental Health in Schools?**

**In southwestern CT**, the teen suicide rate is at its highest level ever, with 5 teenagers dying by suicide during the 2013-14 school year. A 2014 study of Bridgeport teens found that 23% had attempted suicide. 5 Child Guidance of Southern Fairfield County reported a 58% increase in crisis calls during July-December 2013 compared to the previous year.

* Young people spend most of their time in school. The middle and high school years are when most mental illnesses start—on average, at age 14. 1
* Almost one-quarter of high school students report symptoms of depression. 2
* Suicide is the 2nd leading cause of death in young people. 3
* In CT, Latino youth are at particular risk for suicidal ideation, as well as substance use and disordered eating patterns. 4

1National Institutes of Mental Health; 2Youth Risk Behavior Surveillance System; 3Centers for Disease Control and Prevention; 4CT Suicide Advisory Board; 5RYASAP

Too often early signs go unnoticed, leading to greater severity of symptoms. Failure to identify and meet the needs of students with mental health concerns results in disruptions to academic instruction, exacerbation of social and behavioral problems, and high rates of school exclusion due to suspension, expulsion, and even arrest. Children’s school success is associated with their wellbeing and life outcomes.

**The Role of Mental Health Promotion**

With training, teachers, administrators, and school staff who have daily interactions with this age group can be a part of prevention and early detection. Students themselves can also play a role in awareness, prevention, and peer support. Schools can further support mental health promotion by serving as a conduit of information and resources to families.

The CT legislature recommended Mental Health First Aid (MHFA) training for school resource officers, and many districts are now offering suicide prevention programs as well as training to foster social-emotional development. From 2011-2014, a SAMHSA grant under the Garrett Lee Smith program provided for mental health screenings, Question-Persuade-Refer (QPR) suicide prevention trainings, and QPR trainings-of-trainers. Mental health promotion is on the agenda of the new CT Children’s Behavioral Health Plan as well as of advocacy groups statewide, and was a primary concern of Fairfield County participants in last year’s Community Conversations on Mental Health.

**The Role of School-Based Health Centers (SBHCs)**

School-Based Health Centers (SBHCs) offer a convenient “one-stop shop” for teens to access mental health services along with primary care, immunizations, medication, and in some cases dental care. All children enrolled at the site school may use the SBHC, regardless of income or health care coverage. Focus groups show that most adolescents prefer accessing care in this setting, which is culturally and developmentally responsive, easy to access, and confidential.

**School Based Health Centers in Connecticut**

* Currently there are 84 SBHCs in Connecticut, out of more than 1100 schools statewide.
* Schools provide approximately 70-80% of mental health services received by children in Connecticut.
* 36% of students made 2-5 visits to the SBHC per year; 15% made 20 or more visits.
* 28% of all SBHC visits were to the social worker.
* More than 40,000 annual visits were made specifically for mental health needs.
* Among students served, more than 5000 had one or more identified mental health need.
* For students insured by Medicaid, each visit to the SBHC saves an estimated $35 in Medicaid costs.

*Source*: CT Association of School Based Health Centers

**School Based Health Centers Have a Record of Success**

Research has demonstrated that school-based health centers represent cost-effective investments of public resources:

* A current Issue Brief by the CT Association of School-Based Health Centers found that SBHCs are more effective than community-based services at reaching Latino and African-American males.
* A 2012 Policy Statement by the American Association of Pediatrics reported that students served by SBHCs had 85% fewer discipline referrals, 50% less absenteeism, and increased graduation and promotion rates, especially among African-American males.
* A Johns Hopkins University study found that SBHCs reduced inappropriate emergency room use, increased use of primary care, and resulted in fewer hospitalizations among regular users.
* A study of Medicaid-enrolled children served by a SBHC in Georgia found that the total annual expense per individual for the SBHC was $898.98, as compared to $2360.46 for individuals without a SBHC.
* The number of hospitalizations and emergency department visits decreased for children with SBHCs in Cincinnati schools (2.4-fold and 33.5% respectively) – with an estimated savings of nearly $1,000 per child.

**Legislative Action in 2014**

Bill ***SB415*** was introduced in 2014, and would have expanded access to a greater continuum of healthcare services, including mental health services for students at several schools, by increasing the numbers of School Based Health Centers. The bill acknowledged that enhanced access to care has been proven to improve academic outcomes and would enhance the school environment. ***The bill was not called in the Senate.***

**What Can Legislators Do?**

* Require training on social-emotional development and mental health for teachers and teachers in training.
* Support funding and policies to continue evidence-based awareness programs such as Mental Health First Aid, QPR, or Parents & Teachers as Allies to all school personnel, students, public servants, and the general public.
* Support expanding SBHCs to all middle and high schools and making their services available year-round.
* Promote early detection through mental health screenings in schools.
* Support funding for in-service training to school-based social workers and psychologists to increase evaluations and referrals to community-based systems.