School Shootings and Student Mental Health - What Lies Beneath the Tip of the Iceberg

William Dikel, M.D.
Independent Consulting Psychiatrist
dikel002@umn.edu
www.williamdikel.com
Once again, the nation is reeling from yet another mass killing, this time at an elementary school. Since the Columbine tragedy in 1999, there have been over thirty mass killings in the U.S., in elementary schools, high schools and universities as well as in the workplace, in churches, a movie theater, a restaurant, and in other public places.

Although these events are tragic in all settings, homicidal violence in the school setting is especially horrific, with children and adolescents often being the prime victims. Sometimes the assailants are fellow students; sometimes they are outsiders who enter the schools to commit murder.

As we try to make sense of these tragedies, our responses vary from “we need stronger gun controls” to “we need to arm teachers with automatic weapons.” Vocal members of the public take polarized positions on the gun-control issue, and provide examples to support positions at each extreme.

The media contributes to the problem with its 24/7 coverage and its intense focus on the killers and their backgrounds. This type of coverage attracts unstable individuals and increases the risk of future tragedies.

School board members, superintendents, principals and other school administrators struggle to address this issue in a meaningful way. They institute emergency plans and procedures so that students and staff are prepared to respond appropriately in a crisis. Although these are prudent and necessary measures, which undoubtedly save lives in an emergency such as a school shooting, the fortunate truth is that these events are rare.

If we examine the profiles of these killers, which often include histories of mental illness, it is easy to assume, with the benefit of hindsight, that their crimes were inevitable or predictable. This assumption is ill advised; it suggests that these murderers can be identified in advance and should be incarcerated or hospitalized. Indeed, there is public pressure to lower the threshold for involuntary commitment from imminent dangerousness to potential dangerousness. However, for every violent perpetrator of mass killings who has a history of mental health disorders and/or psychological and social stressors, there are hundreds of individuals who have similar profiles who do not become violent. Mental health professionals generally are unable to accurately predict violence other than in instances of imminent danger; and allowing commitment for the mere potential of violence would simply result in many individuals becoming
reluctant to seek needed mental health services. Although mental health disorders can lead in rare instances to mass killings, an individual who has a mental health disorder (with the exception of a paranoid delusional disorder) generally does not have an increased risk of violence.

When these mass killing tragedies occur, schools often respond by addressing the emotional needs of the community (e.g., grief counseling, therapeutic dogs) and safety concerns such as building security. Clearly, it is important for schools to have security, safety and access procedures in place. But schools and other public places would need to be turned into fortresses to keep out killers armed with automatic weapons and multiple rounds of ammunition. Clearly, there are no simple solutions to preventing these heinous, but fortunately rare, events.

These mass killings are the tip of the iceberg of a much greater problem causing daily repercussions in schools across the nation. The problem: students’ untreated mental health disorders that contribute to academic underachievement, acting out behaviors in the classroom, self-destructive and/or aggressive behaviors, poor graduation rates and costly special education interventions that often have poor outcomes.

If schools are able to address students’ mental health issues successfully, it is possible that they might prevent future violent acts. The more likely, and extremely worthwhile result, however, will be students’ improved academic performance, a reduction in behavioral incidents and significant cost savings, especially within the special education system.

WHAT CAN SCHOOLS DO TO ADDRESS STUDENTS’ MENTAL HEALTH ISSUES?

Before we formulate the appropriate role of schools in addressing student mental health concerns, we must first understand the demographics of mental health disorders in children and adolescents. Research indicates that approximately 18% of children and adolescents have a mental health disorder, and that approximately 5% are severely emotionally disturbed. The odds are, therefore, that every classroom in every school has at least one student with a mental health disorder. Of those who have a mental health disorder, only one out of five will receive any treatment, generally from a primary care physician rather than a mental health professional. The vast majority of students who have mental health disorders, even severe ones, are served within the general education system and are not receiving special education services.

If a student is receiving special education services for emotional/behavioral problems, the student generally has either been diagnosed with a mental health disorder (e.g., Attention Deficit Hyperactivity Disorder, mood disorders, anxiety disorders, autism spectrum disorders, psychotic disorders, etc.) or exhibits characteristics of one. Often, the student is receiving no mental health treatment, or is only receiving medication from a primary care physician that may not be of the correct type or dosage. This lack of appropriate treatment for the mental health disorders underlying the identified disability category leads to high cost educational services with largely poor outcomes in graduation rates, post secondary education, vocational success and involvement with the corrections system. The problem is compounded when, in the school setting, we take a behavioral approach that disregards the student’s mental health disorder (e.g.,
when a student’s distractibility is seen as “avoiding schoolwork” or mood swings are seen as a method of “seeking attention”). Mental health disorders may not be obvious.

For example, take the delinquent student who has been identified as a student with a disability under the Emotional Disturbance category, but who has underlying severe anxiety resulting from trauma. He may prefer to appear to be “bad” rather than “sick.” Because the student’s mental health disorder is not being treated effectively, we tend to see relatively poor educational outcomes. Indeed, for many students identified as emotionally disturbed with the special education system underlying disorders such as depression, bipolar mood disorder, post-traumatic stress disorder, ADHD, etc. are the major causal factor of the student’s emotional or behavioral difficulties. Behavioral interventions are not likely to be successful without accompanying clinical interventions.

We need to clarify the role of schools in addressing students’ mental health concerns. School counselors, social workers and psychologists may provide counseling services, but in general, they do not provide mental health diagnostic and treatment services.

Some schools take the approach of having their staff provide diagnostic and treatment services, whereas others are reluctant to address mental health issues at all, using the rationale that schools are educational, not clinical institutions. In this author’s opinion, both extremes are problematic.

If school staff provide diagnostic and treatment services, they need to recognize that their records containing sensitive student and family information become part of the educational record. Schools cannot get malpractice coverage, and their existing coverage may not be sufficient to protect them from liability. Schools would need to provide evening, weekend and vacation coverage for their therapists.

It is also important to recognize that when schools avoid addressing mental health issues, they continue to address them indirectly, through time-consuming visits to the principal’s office, educational failure, and one-to-one aides and other educational interventions that would have been more successful had the student been receiving effective mental health services.

In this author’s opinion, the best approach is for schools to “stay out of the mental health business” of diagnosing and treating students, but to play a crucial role in a continuum of collaborative services that includes parents, medical and mental health providers, community agencies and county services. Schools can build bridges to community mental health providers while maintaining firewalls to protect them from legal and financial liability.

**MENTAL HEALTH PROCEDURES AND GUIDELINES**

Schools can adopt mental health procedures and guidelines that assist them in building bridges to mental health services for students, while protecting themselves from liability risks. These procedures and guidelines should 1) clarify the roles of school personnel; and 2) implement an effective system that integrates the school’s work with that of mental health services providers.
1) **Clarify the roles and responsibilities of the school social workers, counselors, psychologists, nurses, teachers and administrators in their work with students who have mental health disorders.** When these roles are not clearly defined, we see overlap of activities in some areas, and major gaps in others. It is important to clarify who performs activities such as:

- Conducting educational evaluations of students who have mental health disorders;
- Providing counseling as a related service;
- Providing skills training, individually and in groups;
- Attending IEP meetings;
- Providing ongoing documentation of special education interventions and their outcomes;
- Monitoring behavioral symptoms of disorders that are being treated (e.g., inattention in a student being treated for ADHD), and documenting their nature, frequency and severity;
- Communicating, (with appropriate signed releases) the documentation of behavioral symptoms to the treating clinician;
- Obtaining (with appropriate signed releases) mental health diagnostic and treatment records from the treating clinician;
- Reviewing diagnostic and treatment records, and translating the information they contain into educational terms that result in appropriate accommodations and modifications for the student’s disability;
- Assisting teachers in understanding the nature of the student’s disorders and helping them in their work with the students;
- Communicating with parents about the student’s challenges and successes, and seeking information and suggestions from parents about interventions;
- Assisting in pre-referral mental health interventions that might prevent the need for special education services;
- Screening for mental health and chemical health disorders when appropriate; and
- Conducting a functional behavioral analysis with a recognition that the student’s behavior may be due to intrinsic causes rather than external behavioral influences.

2) **Develop effective procedures and guidelines that integrate the efforts of schools with those of outside mental health service providers.** These procedures and guidelines should:

- Clarify methodology of crisis intervention (e.g., when a student makes suicidal statements);
- Clarify the protocol for putting mental health related services on IEPs;
- Assure that mental health data generated from within the school or obtained from outside professionals is dealt with appropriately;

- Provide for inservice presentations to educational staff on mental health disorders: their manifestations, appropriate interventions in the classroom, understanding the basics of medication treatment, monitoring for effects and side effects of medication, etc.;

- Provide for collaboration with professionals outside of the school district (county social workers, probation officers, community agencies, medical and mental health clinics, etc.);

- Call for transition planning for re-entry into the school environment from psychiatric hospitals and residential facilities;

- Maximize funding streams for collaborative services, including Medicaid billing for services as appropriate;

- Address effective use of consultation (autism specialists, child psychiatrists, etc.);

- Address supervision of school mental health staff (counselors, psychologists and social workers) to assure accountability in performance of defined roles and responsibilities; and

- Establish methods of identifying baseline and outcome measures to determine the success of interventions.

**CO-LOCATING MENTAL HEALTH SERVICES WITHIN THE SCHOOL**

One way to more effectively address student’s mental health needs is to co-locate mental health professionals into the school setting, so that mental health diagnostic and treatment services are provided within the school, but not by the school. In this service model, the school district provides space within the school for a clinician, preferably from a community mental health clinic, to see students. Information about the students can only be shared if parents sign releases of information. If releases are signed, then clinicians and school staff can share information on a need to know basis. The clinician is thereby better informed in the diagnostic and treatment process, and school staff better understand the underlying symptoms that are contributing to or causing school difficulties.

Contractual relationships between the school district and the mental health provider clarify the scope of activities of each party, outline requirements for the clinic (criminal background checks, ID badges, data privacy, compliance with school policies, licensure issues, indemnification requirements, etc.) and assure that the school personnel understand their boundaries, roles and responsibilities in regard to the co-located clinicians.

This co-located services model provides access to mental health services to students who otherwise would not have meaningful access. Many parents cannot leave their workplace on a weekly basis to pick up the child at school, bring him/her to a clinic, and then return him/her to the school after the session. When necessary, the mental health services provider can contact the parent via phone during the session. Also,
parents and families can be seen at the community mental health clinic in addition to the appointments at the school.

In this model, the clinic is essentially operating a branch office located within a school. Generally, health insurance covers, or at least partially reimburses for, the mental health services. In fact, some HMOs have provided an increased reimbursement rate for school-based services, given the extra time involved in teacher consultation and other ancillary services.

The co-located services model offers an array of benefits. The clinic benefits from reduced fail and cancel rates, and a steady source of clients. County or grant funds may help cover the cost of uninsured clients. Families benefit from increased access to services. The school benefits from the reduction in the student’s symptoms that had resulted in academic and/or behavioral difficulties. The clinic is responsible for malpractice coverage, data privacy, backup coverage and psychiatric consultation, thus protecting the school from liability.

Co-located services can be very effective for both general education and special education students, and may even result in preventing the need for special education referrals for some students. The success of this model depends on the clinicians’ clinical skills and their ability to work within a school setting, and upon the school staff’s adaptation to the on-site services. It is important for the procedures and guidelines outlined above to be successfully addressed, in order for the co-located clinical services to be optimally effective.

Schools can be an effective partner with parents, medical and mental health providers, county programs and community agencies in the process of addressing students’ mental health disorders. By taking a middle path that neither ignores mental health issues, nor takes the responsibility to diagnose and treat them, schools can clearly define their roles in the process and ultimately improve educational outcomes and realize cost savings. Most importantly, the process is likely to result in greater success for vulnerable and at-risk students. There is even the possibility of preventing severe violent behavior for those “tip of the iceberg” students who have the most severe and dangerous mental health disorders.

**SUMMARY**

Mental health disorders are pervasive in the student population. It is essential for school districts to have appropriate procedures and guidelines that identify both what they should be doing, as well as clarifying services that need to be provided by other systems. With effective procedures and guidelines in place, schools can get a handle on this complex topic, and be a successful collaborative partner in the provision of services to vulnerable students.
William Dikel is a child and adolescent psychiatrist who consults nationally with school districts, attorneys and state Departments of Education to assist them in providing services to students who have mental health disorders. He provides expert testimony, inservice presentations, case consultation and program planning and development services that are focused on cost-effective interventions that result in improved educational outcomes.

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