The Shrink in the Classroom

Mental Health Specialists in Schools

Steven C. Schlozman

Schools have become increasingly involved in the assessment and treatment of students with psychiatric illnesses and psychological problems. Reasons for this trend include the greater number of children and adolescents with significant psychosocial problems, the shorter time allowed for inpatient and residential treatment of troubled youth, and an increasingly overburdened mental health system.

The intermingling of pedagogy with psychology does not please everyone, but educators cannot afford to ignore the psychosocial needs of their students. Students travel along their academic and emotional trajectories at the same time, and the major portion of this journey occurs at school.

The models for collaboration between schools and mental health specialists have evolved in a number of different ways. We can roughly categorize them according to traditional or nontraditional models (Bostic & Rauch, 1999).

The Traditional Approach
In the traditional model, a mental health specialist functions as an outside consultant, working with school staff instead of directly with students. The specialist consults with school staff about students with difficult behavioral problems. Psychiatrists, psychologists, and social workers all shared this consultative role. Such work requires a trusting alliance between clinician and school staff, and the clinician must take the time to familiarize him- or herself with
the organization and politics of the school.

Outside consultants may suggest appropriate treatment regimens, facilitate necessary referrals, and discuss ways to translate clinical techniques into classroom management. These consultants do not simply make formal diagnoses; they also suggest extra attention for problems that do not meet criteria for a psychiatric disorder—for example, relationships crises, parental discord, and family distress.

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Critics of the traditional model point to the limitations created by mental health specialists not spending time with the students. Consultants may appear aloof and out of touch with the culture of a school, especially when they are in the early stages of building an alliance with school staff. In addition, consultants' recommendations that school officials refer students for treatment are often frustrating because finding an available child mental health clinician is increasingly difficult in some communities. Finally, in situations where students are referred, the clinician treating the child may be reluctant to share information with teachers that could help the teachers understand and better assist a troubled student. These criticisms have led to the establishment of more school-based, nontraditional consultative models.

**The Nontraditional Approach**

Although nontraditional models vary, they generally share the common approach of bringing services into the schools. The most established model,
the school-based health clinic, grew out of concern that student health needs were largely unmet in poor urban areas. These clinics provide general medical care as well as psychiatric attention.

More than 1,200 school-based health clinics had been established in the United States by the year 2000. Some studies suggest that as many as half of all visits to these clinics are for mental health concerns (Rappaport, 2001).

In-school mental health care has several advantages. It catches young people in the setting where they encounter many of their difficulties and gives students access to services that they otherwise might not receive. In addition, clinics within schools often carry less of a stigma than outside referrals, and in-school treatment helps the empathic clinician better understand the school’s culture (Rappaport, 2001).

In-school consultation also poses potential problems. Teachers may become frustrated if students frequently visit the clinician during class time. Alternatively, teachers may come to rely on sending difficult students to the clinician to prevent classroom disruptions. Both of these problems can lead to strained relationships between schools and their in-school clinics, and such systems of care should therefore take pains to establish clear guidelines that meet the needs of both teachers and clinicians.

Perhaps the most confusing issue regarding in-school clinics is establishing whom these clinics primarily serve. Traditionally, mental health clinicians function as advocates for their patients, whereas in-school clinicians potentially have responsibilities to both students and school staff. For example, consider the student who meets weekly with an in-school clinician and in this setting reveals his concern that another student routinely cheats on tests and assignments during class. Although this situation poses no risk of imminent harm to any student, the clinician may feel uncomfortable keeping this information private, especially if he or she is part of the school community. These dilemmas
have no clear-cut answers, but they signal the great care that in-school clinics must take to define the type of relationship that exists among students, clinicians, teachers, and administrators (Rappaport, 2001).

Mental Health Collaboration
Students often approach school staff with difficult issues more readily than they would approach even their own parents or friends. Because teachers and administrators are held increasingly responsible for their students' mental health concerns, they may become bewildered and frustrated as they attempt to make sense of the complexities of behavioral issues.

The goal of mental health collaboration is to learn as much as possible from seasoned teachers who have years of experience in reaching difficult students, and then to apply this learning to what mental health specialists know about the developmental struggles of young people. As collaboration improves, schools, clinicians, and—most important—students, stand to benefit enormously.

References

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