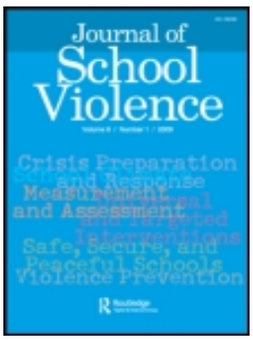

Journal of School Violence

ISSN: 1538-8220 (Print) 1538-8239 (Online) Journal homepage: http://www.tandfonline.com/loi/wjsv20

A Coordinated Mental Health Crisis Response: Lessons Learned From Three Colorado School Shootings

Franci Crepeau-Hobson , Kathryn S. Sievering , Charlotte Armstrong & Julie Stonis

To cite this article: Franci Crepeau-Hobson , Kathryn S. Sievering , Charlotte Armstrong & Julie Stonis (2012) A Coordinated Mental Health Crisis Response: Lessons Learned From Three Colorado School Shootings, Journal of School Violence, 11:3, 207-225, DOI: 10.1080/15388220.2012.682002

To link to this article: https://doi.org/10.1080/15388220.2012.682002

Accepted author version posted online: 25 Apr 2012.
Published online: 25 Apr 2012.

Journal of School Violence, 11:207–225, 2012

ISSN: 1538-8220 print/1538-8239 online
DOI: 10.1080/15388220.2012.682002

Routledge
Taylor & Francis Group

A Coordinated Mental Health Crisis Response: Lessons Learned From Three Colorado School Shootings

FRANCI CREPEAU-HOBSON
School Psychology, University of Colorado Denver, Denver, Colorado, USA

KATHRYN S. SIEVERING
Jefferson County Schools, Arvada, Colorado, USA

CHARLOTTE ARMSTRONG
Lewis-Palmer School District No. 38, Monument, Colorado, USA

JULIE STONIS
Douglas County Schools, Parker, Colorado, USA

This article describes a crisis response framework based on the authors' first-hand experience following three Colorado school shootings. During each crisis response, one or more of the authors joined school and/or district crisis teams, providing direct assistance and leadership. The authors' experiences helped guide subsequent responses and assisted teams in better meeting the impacted school's needs. Lessons learned are shared with the intent of organizing and improving school-based crisis response to extreme acts of school violence.

KEYWORDS crisis response, crisis team, crisis intervention, school shootings

In light of recent school-based acts of violence, there has been increased public, professional, and legislative interest in school crisis prevention and intervention. It has been recommended that comprehensive crisis teams be

Received November 10, 2011; accepted March 18, 2012.
Address correspondence to Franci Crepeau-Hobson, University of Colorado Denver, School Psychology, Campus Box 106, P.O. Box 173364, Denver, CO 80217-3364, USA. E-mail: franci.crepeau-hobson@ucdenver.edu

established at the school, district, and regional or community levels (Brock, Sandoval, & Lewis, 2001), and in some states policymakers have proposed legislation requiring school districts to address school violence and crisis management (Pagliocca & Nickerson, 2001). In response to media attention and increasing crisis-related needs and mandates, a variety of crisis response models and training manuals have been developed to help guide the response of crisis teams to school-based crises. These models provide a conceptual framework for crisis response and its multiple components (e.g., Brock et al., 2009). While helpful in providing a structure for developing crisis response teams and plans, these models have little empirical support for their use (Pagliocca & Nickerson, 2001). In fact, few accounts of responses to school-based crises have been published to date and most that have provide very general information. Thus, crisis responders do not have access to data that can inform their practices and help to ensure that crisis-related needs of the school community are met. The purpose of this article is to share the lessons learned of four crisis responders who have participated in the response to three school shootings in Colorado. It is hoped that our experiences can serve as a guide for future responders to facilitate more effective responses to major school-based crises.

COLORADO SOCIETY OF SCHOOL PSYCHOLOGIST STATE-WIDE CRISIS RESPONSE TEAM

The Colorado Society of School Psychologist State-Wide Crisis Response Team (CRT) was created following the shootings at Columbine High School in Littleton, Colorado in 1999 to assist Colorado schools and communities in preventing and responding to school-based crises. Since that time, CRT members have provided comprehensive school-based prevention, intervention, and postvention crisis response services and training to school personnel throughout the state of Colorado. The team is comprised of 18 school-based mental health professionals licensed by the Colorado Department of Education who live and work across the state.

The authors, members of the CRT, have all been involved in at least one of the mental health crisis responses following the three school shootings in Colorado. One of us responded to all three, participating as a district-level and/or state-level crisis team member. The first Colorado school shooting was the Columbine tragedy in 1999. The Columbine shootings resulted in the deaths of twelve students and one teacher, as well as the suicides of the two shooters. In 2006, a gunman took a classroom of students hostage at Platte Canyon High School. The assailant sexually assaulted several of the female students before killing one of them and then turning the gun on himself. Finally, in 2010, two students were shot outside of Deer Creek Middle School. Fortunately, both students survived and the shooter was arrested.

These crisis response experiences have provided us with knowledge that may be helpful to other school mental health professionals involved in crisis response. It is hoped that the information shared in this article will serve to inform future responses to school shootings and other major school-based crises. One of the most important lessons CRT members have learned is that a "one size fits all" model is not efficacious. Responders must be flexible and adjust to the unique needs of any school tragedy or crisis: the nature of the supports and services provided in each instance will be different. Initial or "core" mental health responders must consider the need for additional or alternative team members and the types, location, intensity, and duration of services and supports that will be offered. Decision-making must also take into account the closure of school or plant facilities; the overall impact of the crisis in terms of numbers of students, staff, and families affected; the size of the school and/or district; the degree to which the crisis impacted the community; the availability and accessibility of outside resources; and whether or not fatalities occurred. These factors then guide the response beginning with resources and interventions needed, the length of stay of crisis responders, length of time of school closure, extent of long-term follow-up intervention/supports, and degree of community involvement. While it is important to keep in mind flexibility and individual school and community needs given different crisis situations, there are some things that may apply across crisis situations.

Following are issues and practices we have found to be important considerations in an effective response. These are organized chronologically beginning with crisis preparedness activities such as planning and training—issues that should be addressed at the beginning of every school year in order to lay the foundation for a comprehensive crisis response. These preventative recommendations are followed by recommendations that relate to the response and recovery issues in the immediate aftermath of the crisis that need to be considered in subsequent days.

PRECRISIS PLANNING

Training

An effective response is contingent on school personnel receiving training in crisis response (Brock et al., 2009; Crepeau-Hobson & Summers, 2011). All members of our CRT are trained in the PREPaRE model (Brock et al., 2009). Many members of the CRT also have training and/or background expertise in additional models, including the National Organization for Victim Assistance model (NOVA; Young, 1998). Moreover, many CRT members are certified as PREPaRE trainers. Unfortunately, our team frequently had to work alongside other responders who lacked appropriate training—including those on school-based and district teams. This often put CRT members in the uncomfortable position of having to step in and/or voice ethical concerns.

District Crisis Response Team

Both school and district CRTs have been widely advocated in school-based crisis response (Pagliocca & Nickerson, 2001). Although turf issues may arise when multiple teams respond to a crisis (Brock et al., 2009; Crepeau-Hobson & Summers, 2011), we have found that it is possible for school-level, district-level, and outside/community-based response teams to work together in a collaborative fashion if roles are clearly defined and teams are organized functionally. Building teams are typically comprised of the school psychologist, school nurse, school counselor, administrator, teachers, and/or support staff. District-level teams are usually comprised of personnel with mental health backgrounds exclusively (i.e., school psychologists, school social workers), as well as administrators who serve in a supportive role to the on-site administrator. As noted, members of all crisis teams should have adequate training in crisis response and recovery.

In the case of a school shooting or other major school crisis, site-based crisis team members are often personally impacted and overwhelmed (Adamson & Peacock, 2007; Crepeau-Hobson & Summers, 2011) and thus in need of assistance from the district level team and/or community-based teams. In these situations, the school level team typically first requests assistance from the district team to supplement the on-site response, then they may invite community agencies and/or state teams to assist in the response efforts. However the situation unfolds, the site-based team and district level teams have a valuable role to play. These two teams are familiar with the crisis plans used in the school and district and are the backbone of an effective crisis response. Best practice is for these teams to be organized according to a basic Incident Command System (ICS) structure (U.S. Department of Homeland Security, 2004). The ICS provides a systematic structure for school districts, describes key roles and responsibilities of crisis team members, and facilitates communication with community responders (Reeves, Kanan, & Plog, 2010). Our more recent response efforts have been guided by the ICS and as a result, have been much smoother and more efficient than those crisis responses that did not follow such a conceptual framework.

Mental Health Incident Commander/Point Person

Strong, effective leadership is a key component in the effective implementation of crisis response plans (Cornell & Sheras, 1998; Fein & Isaacson, 2009; Pitcher & Poland, 1992). Having a designated mental health incident commander (MHIC) or point person from the district to lead the team(s) and make response-related decisions is critical to coordinating an effective crisis response (Drennen, 2009; Sharma, Bershad, & LeBanc, 2010). This person is responsible for determining the need for additional mental health responders (within district and/or outside), how resources/responders will be utilized, and which facilities/rooms will be used. The MHIC is also responsible for

communicating with the incident commander (typically the district superintendent), as well as the district's public information officer (PIO) so that the mental health component is considered when communications such as letters to parents are developed and disseminated. Essentially, the charge of the MHIC is to coordinate the entire response and to ensure that mental health interventions are available and provided at all levels to staff, students, and community members as needed.

MHICs must receive adequate training in crisis response. Responses led by individuals with inadequate training and expertise can lead to poor decision-making and subsequently jeopardize survivors' mental health needs. Understanding that not all students and staff will need the same level of intervention, MHICs must be prepared to identify individual, group, and/or school wide interventions.

For example, following one Colorado school shooting, the MHIC suggested offering critical incident stress debriefings to all individuals who showed up for support. Critical Incident Stress Debriefings are intended only for those individuals who have been directly exposed to a traumatic event and research findings related to its effectiveness have been inconsistent (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Fortunately, the MHIC was open to suggestions and other ideas from CRT members and a variety of developmentally appropriate services were made available to individuals impacted by the crisis.

At another response, the MHIC was a mental health professional who worked at the school where the shooting occurred. Research has demonstrated that the adults employed at the school can experience crisis reactions (Daniels, Bradley, & Hays, 2007; Nims, 2000) and this is certainly true for those in leadership positions (Fein & Isaacson, 2009). The person charged with leading the mental health side of the response was clearly impacted by the crisis at the school, but felt obligated to maintain the leadership position. This made for an uncomfortable situation for the outside responders because someone needed to step in to help ensure that the response went according to plan and that the needs of the school community were met. The approach that worked best was to be empathic to both the personal impact and the responsibility felt by the MHIC and to gently offer suggestions and to help coordinate the response. This way the MHIC continued both to be viewed as the leader and to take care of the students for whom they felt responsible while a great deal of pressure to manage the response was removed.

Knowledge of Resources

It is critical that the leaders of CRTs have an awareness of crisis response resources available in the community (LeBlanc, Krepel, Johnson, & Hermann, 2010; Poland & McCormick, 1999). For example, in Colorado,

in addition to our CRT, the state has the Colorado Crisis Education and Response Network, or CoCERN, a response team made up of a variety of trained crisis responders that can be deployed to crises and disasters statewide, including those in the school setting. Members of this team can be deployed at the request of the MHIC when the site-based resources are overwhelmed.

KEY COMPONENTS IN CRISIS RESPONSE

Reunification

Following a school tragedy, students are typically reunited with parents at an off-site location. The school that is the site of the crisis may be deemed a crime scene by law enforcement and consequently, parents must pick up their children at an alternative location, often at a nearby school. At the outset, police and emergency personnel attend to the immediate physical needs of student, staff, and community. Just as importantly, mental health staff should be available to simultaneously attend to the immediate mental health needs of those impacted. The reunification process is an important piece of the crisis response as the re-establishment of natural social support systems is often the only crisis intervention needed for many individuals (Barenbaum, Ruchkin, & Schwab-Stone, 2004) and family members are often identified as the greatest source of support following a crisis (Horowitz, McKay, & Marshall, 2005).

Reunification generally takes from 2 to 10 hours depending on the crisis. Having crisis responders available to provide support during the reunification process is critical. Logistical considerations for the reunification site include transportation from the crisis site, a roster of students who come to the reunification site, and logs to document times that students are released and to whom. It is helpful to have law enforcement on site to ensure a sense of safety and security, as well as adequate number of mental health staff members to meet immediate crisis-related needs. This is dependent on the level of impact experienced by students, staff and community. Finally, written material (i.e., an informational flyer) addressing mental health support available, typical crisis reactions, and emergency contact numbers should be on hand. These materials should be in the languages of the school and surrounding community.

Safe Haven

As noted, the re-establishment of naturally occurring social support systems is of critical importance to the healing process following a crisis. With this in mind, a location can be open to students, parents, and staff

as a forum for congregating, as well as to address immediate mental health concerns/issues. Ideally, this "safe haven" is set up the day after a major school crisis. An off-site location is typically used because the school that was the site of the crisis generally cannot be reopened immediately. In addition to allowing affected individuals to come together with social supports prior to school resuming, planning for and offering a designated gathering place for students, families, and staff aids in reaffirming physical health and safety, issues strongly related to psychological safety and recovery (Reeves et al., 2010).

There are a number of important logistical considerations for the safe haven. If an off-site location is used, it should be close in proximity to the crisis site and able to accommodate the estimated size and needs of the impacted population. It should be protected from the media and have a number of private rooms. Another, nearby school often works well in this capacity, as do other nonschool locations such as churches; however, it is important to be sensitive to cultural and religious differences in the school community when choosing the location. The safe haven should be open much of the day so parents can attend with their children. However, it is important to keep in mind the exhausting nature of this work and the impact on mental health responders and staff (Crepeau-Hobson & Summers, 2011) when scheduling safe haven hours and services. Following one school shooting, we realized too late that some CRT members were emotionally drained well before the end of their all-day shift. Subsequently, we shortened responders' shifts.

The safe haven must be staffed with adequate numbers of mental health responders. Too few and needs may go unmet; too many and responders are left standing around. Determining what is adequate should be based on an assessment of mental health needs and the types of supports to be provided. Utilizing a triage approach at this time is an effective means to approach these tasks. Psychological triage involves determining who is at risk for psychological trauma following a crisis (Brock et al., 2009; Sandoval & Brock, 2002) and is vital to estimating the number of individuals who will need mental health support and determining what services may need to be provided. Specifics related to performing psychological triage are presented next.

In our experience, most parents take the day off following a serious crisis like a school shooting so they can be with their children. About 75% of parents brought their children to the safe haven following the most recent Colorado school shooting, staying 1 to 2 hours on average. This response rate speaks to the importance of offering such a gathering place and appropriately assessing crisis-related needs. In addition, a number of community members came to the safe haven seeking reassurance and/or support, something that was completely unexpected. Knowing that these individuals may

also seek support from the school was helpful in planning for subsequent response and recovery activities.

Parent and student attendance at the safe haven should be tracked and recorded in order to identify families receiving support and any need for follow-up with individuals who attend and also for those who do not. Offering translators to parents who have difficulty comprehending and speaking English should be planned for as appropriate.

Mental Health Crisis Intervention

NOVA model

We have found it beneficial to use the NOVA model (Young, 1998) in this stage of response planning. According to this model, there are three tasks essential to reestablish precrisis levels of functioning: safety and security, ventilation and validation, and prediction and preparation. The first task is establishing safety and security, and involves connecting individuals with their loved ones and ensuring a sense of control and safety. The second task entails ventilation and validation. Ventilation involves providing individuals who have experienced a crisis to tell their story while validation normalizes their reactions and feelings. The third task of the NOVA model is prediction and preparation, where crisis responders are charged with anticipating future issues and reactions and helping individuals and the community prepare for these (Young, 1998).

These three tasks have provided the foundation for much of our response planning. However, we have found it important to include a fourth task: empathy and empowerment. We believe these two concepts are crucial. The concept of empathy has been referenced in the school-based crisis response literature only to a limited degree, generally in the context of individual crisis intervention (e.g., Brock et al., 2009). In our view, empathy can also be displayed in a broader manner by attending to the needs of staff, students and the community, anticipating what they need to increase their sense of safety and security, and responding to their venting empathically. Empathy also involves being flexible and adjusting the mental health response as needed.

Consistent with community level disaster response approaches (e.g., Hobfoll et al., 2007) as well as psychoeducational strategies (Brock et al., 2009; Hatzichristiou, Issari, Lykitsakou, Lampropoulou, & Dimitropoupou, 2011), empowerment includes activities that promote efficacy and a sense of "can do." Empowerment includes the promotion of a sense of self-worth and capability, as well the perception that others are available to provide support. This may involve providing factual information and resources. For example, following the shooting at Columbine, crisis responders developed handouts that listed all pertinent memorial information including dates, times, and locations. A number of teachers had mentioned that they were

having difficulty recalling this information when it had been presented verbally and consequently, they struggled to make plans to attend the services. The handouts provided these teachers with the information they needed to make decisions related to memorial attendance and gave them a sense of control.

Triage

A key piece of effective crisis response is determining how triage will be set up and which types of supports/interventions are to be offered. As noted, identifying the students, parents, and staff who are most impacted and in need of immediate crisis intervention is a crucial early step in mental health crisis response (Brock et al., 2009; Sandoval & Brock, 2002). Private triage rooms must be available for this purpose. Research indicates that proximity—both physical and emotional—is one of the greatest risk factors for more severe responses and subsequent posttraumatic stress disorder (Brock & Davis, 2008). It is essential that individuals who witnessed the shooting and those who are close to those directly impacted by the crisis be identified. Typically, primary witnesses are known to law enforcement, as well as to school security and administrators, and school personnel generally have a good idea of the relationships of those directly impacted. This information must be given to the MHIC and crisis responders so that they can reach out to these individuals and share information and resources. Those with closest proximity can be personally invited to the safe haven, offered support, and monitored subsequent to the immediate response. CRT members with significant crisis response experience and training should be the ones who are assigned to assist the students and families with the most significant needs.

Triage for the general school community works well if mental health crisis responders greet everyone upon entry to the safe haven and then escort individuals (or parent–child dyads or pairs of students) to triage rooms as appropriate. For example, individuals who are clearly distressed and those who have difficulty verbalizing what they need would be taken immediately to triage rooms. Once there, assessing their degree of impact and crisis-related needs can be accomplished via an interview and/or the use of a checklist. Brock and colleagues (2009) have developed a primary risk screening form that can be used for this purpose. The data from such interviews and/or checklists can be used not only to prioritize those in need of crisis intervention, but to also determine the types of services and supports needed (Brock et al., 2009). It is important to keep in mind that although psychological triage begins at the safe haven, it does not end there: triage is a dynamic process, not an event (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001) and thus continues throughout the response and recovery processes.

Mental health supports

Students with similar crisis experiences often request support as a group, so small psychoeducational groups should be offered as an option for them, as well as for others who would benefit from this approach. These groups are best led by two to three well-trained and experienced crisis responders in small rooms with homogeneous groups of six to 10 individuals. The PREPaRE model of psychoeducational groups (Brock et al., 2009) includes four basic tenets that can be helpful in planning: sharing of crisis facts; identifying and normalizing crisis reactions; identifying maladaptive crisis reactions and coping strategies; and development and promotion of healthy forms of coping and stress management.

In addition to small groups, large meeting areas should also be planned for to allow less-impacted students/ families to be together, again with the goal of fostering the re-establishment of naturally occurring support systems. This should include a mingle area, such as a hallway for students who simply want to congregate with their peers. Following a major crisis, students often want to be together and share their stories in an informal manner. This is especially true of secondary school students. We have found that high school students tend to seek each other out and cluster with their peers almost exclusively at the safe haven. Middle school students are more likely to want to be with their parents and other supportive adults in addition to their peers.

Setting up tables with construction paper and markers in this area allows students to create banners/signs/get well messages, et cetera. After one Colorado school shooting, a group of teachers provided computers for middle school students to use for journaling their thoughts and reactions. This was an opportunity for the students to express their needs and experiences in a different way. All of these services fall under the ventilation and validation and empathy and empowerment tasks.

It is also helpful to have larger open areas, such as libraries, for multiple grade levels. The developmental age of students should help guide planning for multiple grade levels. For example, following one Colorado school shooting, we had middle school students and their parents meet in the library, Grades K–3 meet in the kindergarten rooms, and Grades 4–6 meet in a large classroom. Finally, a room should be designated specifically for staff and teachers to allow these adults to share their stories and take a break from providing emotional support to students when they themselves have also been impacted by the crisis.

Stationing floating crisis responders in all areas is vital as some students and parents will not directly request intervention but will want to share their experiences. Floating crisis responders are there to listen, reflect, empathize, and provide coping suggestions and/or resources. The easier the access to support and intervention, the more likely students, parents, and staff will access and take advantage of it. Floating crisis responders also have the

responsibility to observe and take note of any students, parents, and/or staff who may be in need of follow-up and additional intervention/support.

Food

Keeping in mind safety and security issues and the importance of meeting the basic needs of individuals first, arrangements to have food brought into the safe haven—as well as the site school the day it reopens—should be made. Considerations include indentifying who will solicit donations or purchase the food, pickup or delivery, location, serving, and cleanup. Often, support and/or administrative staff will initiate and handle this process, though the mental health team may need to emphasize how important this is. It is helpful to have one person in charge of this aspect of the response. A school secretary or parent is often a logical choice. The school cafeteria staff can serve food and custodial staff can assist with set up and clean up. In our experience, students, parents, and staff really appreciate the caring gesture of being fed. In addition, this provides a way for classified school personnel to be involved and contribute to the healing process. Responders can mingle and talk informally with students, parents, and others in the food area.

Handouts

Helpful in addressing the prediction and preparation and empowerment tasks of our model, a table for handouts, information booklets, and other resources should be front and center at the Safe Haven, as well as at the site school when it reopens. Handouts should include information related to available resources, common reactions to crises, and coping. Providing information about adaptive coping promotes both a sense of self-efficacy and hope, which strengthens people's beliefs about their capabilities to manage stressful events (Benight & Harper, 2002). CRTs should have premade handouts or at least handout templates that can easily be edited to apply to the current crisis. Preparing copies of handouts prior to opening the Safe Haven is strongly recommended. These resources should be available in languages spoken by students and their families. Because translation can take some time, materials should be translated into the language(s) of the school community ahead of time as part of crisis preparedness (Brock et al., 2009). Various editable forms are available online and in various publications (e.g., Brock et al., 2009; Reeves et al., 2010). Crisis responders should be scheduled to staff the table and answer questions as they arise.

Scheduling and role assignment

Once the services to be offered have been determined, an intervention schedule needs to be developed and responders are assigned to specific roles. Consideration should be given to all supports/interventions and

phases of the response, as well as the potential impact on the responders themselves. Sometimes it makes sense to divide the days into half-day shifts in order to avoid fatigue.

CRT members should be strategically stationed throughout the setting. Responders should be at the door where the students, staff, and parents enter the building as school security or law enforcement check identification and provide an atmosphere of security and calm. This is important at both the safe haven and at the school that was the crisis site in the days immediately following the crisis. Several CRT members are needed to greet and guide guests to triage rooms and appropriate areas based on their respective crisis-related needs. Experienced mental health responders need to be available to triage individuals who come to the safe haven, to intervene with those most impacted, and to run small groups. Floating crisis responders should also be scheduled in the large group and mingle areas, as well as in the food area and at the handouts table.

As noted, planning for roles and responsibilities for the next day must also occur. Someone should be delegated to orient newly arrived CRT members the next morning and maps of the crisis site school will need to be printed. The maps should be marked with designated mental health areas. Sign-in sheets must also be developed for tracking the CRT members who are in the building and where they are. Prior to the doors opening, an orientation meeting for all CRT members is strongly encouraged. At this meeting, maps can be provided to the responders, role assignments can be made, and clarification regarding information sharing and resources can be discussed and disseminated as needed. In addition, specific CRT members should be selected to support triage rooms and lead small group crisis interventions on Day 2.

Communication among responders

Efficient communication during a crisis response is vital to overall effectiveness (Nash, 2007, as cited in LeBanc et al., 2010). If cell service is available, CRT members should share cell numbers with the MHIC and other team leaders and members as appropriate so that information can be shared via phone calls or text messaging. If there is a lack of cell service, as was the case at one Colorado school-shooting site, the CRT may need to come up with a more creative means of communication such as intercoms or walkie-talkies.

Supplies

The CRT must also consider the supplies that will be needed to support the response. Each CRT member should bring their own “go-bag” with various materials, including pens, a notepad, a flash drive with handout and parent letter templates, tissues, and bottled water. Photo identification such as a

driver's license or school or CRT badge will also be needed to gain access to the safe haven and crisis site. Other supplies such as tissues, markers, nametags, and banner paper may not be available at the site, so these materials may need to be obtained from the district or as donations. If donations are needed, consider who will solicit and pick them up and who will keep track of donors and donations so that thank you cards can be sent out after the response.

Depending on the location of the crisis, some CRT members may need to stay in the area over one or more nights. These individuals will also need to bring an overnight bag with items such as extra clothes, toiletries, and medications. Paying for food and accommodations may be necessary as well. If CRT members are being released from their regular work assignment to respond, they need to let the MHIC know their availability (i.e., number of days, hours). Outside responders who assist should check in periodically with their employer and be accessible by cell phone, if possible. Professional conduct and accountability in times of crisis should not be neglected or compromised (Young, 1998).

Communication with the public

The MHIC should be in contact with the district public information officer and contribute to the crafting of messages and information that is shared with the general public, as well as how this information will be disseminated (e.g., TV, e-mail). Communications should include acknowledgment of the tragedy, what is being done to ensure that the school is safe/being repaired (if relevant), and an explanation of the available crisis-related services offered (LeBanc et al., 2010).

A letter must be written specifically for parents of children attending the school where the crisis occurred. This letter should provide information about the crisis including support services available for students, staff, and families, when and where support can be accessed, community resources if pertinent, and emergency contact information. This type of information sharing can be very empowering and foster healing (Brock et al., 2009).

CRISIS INTERVENTION BEYOND THE SAFE HAVEN

At the end of the first day of the response, a meeting should be held with all mental health responders so that insights, unexpected events, suggestions, and plans for the next day can be shared. This is also an appropriate time for the team(s) to share their experiences. The opportunity to debrief and support each other is critical to mediating the response-related crisis reactions of CRT members (Crepeau-Hobson & Summers, 2011; Trippany, White Kress, & Wilcoxon, 2004). This meeting is also a good time for responders to make

suggestions and turn in lists of students/parents they saw, severe reactions observed, need for follow-up, and contact information to the MHIC.

Supports provided at the safe haven are offered again on the second day and beyond as appropriate, or they may be scaled back. Generally, this decision is based on triage data, but other logistical issues may come into play (e.g., when the site school is scheduled to reopen and when classes are expected to resume). These services can be offered at the school that was the site of the crisis if reopened, or at an alternative site if needed. Something we have found that worked extremely well is for the site school to have an open house the day before classes resume. The open house is a comfortable and safe way for students to return to the site of a school crisis. At one school we responded to, this was the case. The teachers at this school wore matching school t-shirts and many of them were stationed outside the front door to greet students and parents as they arrived. A hand-decorated banner signed by all the teachers was hung outside by the front door. A check-in table was set up directly inside the front door with security, a teacher, a crisis responder, and a school administrator. This visible presence was a comforting and reassuring sight for visitors. Triage activities continued as appropriate and at various levels as needed. Crisis responders were stationed throughout the school, including in common gathering areas for students and designated support rooms for students, parents, and school personnel. There were places students could go to draw or make get well cards for those who were hospitalized. Food was available for everyone, and the general feel was one of nurturance and support. Opportunities and locations for various supports and services were announced to the students and clearly marked by signs throughout the building.

When the school does reopen and classes resume, the availability and extent of mental health supports need to be determined for that context. Again, these decisions should be based on triage data. A practice we have found to be incredibly effective is the use of a classroom buddy system. Following two of the shootings in Colorado, teachers were given the option of having a mental health responder assigned to their classroom for the first day or two that classes resumed. Most of the teachers chose to have this “buddy” with them in their classroom throughout the day. The buddy helped facilitate conversations about the crisis, was available to support both the teacher and the students, provided large group/classroom interventions, offered mini breaks for classroom teachers and was able to identify those students—and teachers—who were having severe crisis reactions and escort them to where interventions were provided. Anecdotal feedback from many teachers indicated that they appreciated this type of support.

Long-Term Follow-Up and Intervention

It is essential that those individuals who are not responsive to initial supports and early intervention be monitored and provided with resources for

ongoing support (Brock et al., 2009; Crepeau-Hobson & Summers, 2011). As noted, CRT members must have an organized system of documenting who they worked with, their level of impact, and need for follow-up, as well as referral list of experienced mental health professionals and agencies. Contact with both the parents of students who struggle and with parents of students who have not yet returned to school should be made. All of this information must be shared with school-based mental health personnel to ensure follow-up after district and outside responders leave. If the school is in an isolated community with few outside resources for long-term mental health services, arrangements for bringing in mental health professionals from other communities may have to be made.

Evaluation

Probably the most challenging aspect of the crisis response process is that of evaluation. Consistently, our efforts to assess the effectiveness of the crisis response were thwarted in a variety of ways. Resistance by both building and district administration has been the biggest obstacle. This is understandable and we perceive it as coming from a cautious and caring standpoint. The resistance appears to be related to a natural desire to protect the school and district from negative perceptions from the public, a push to "move on" from the event, and/or reluctance to stir up event-related reactions and feelings following demobilization. Regardless, it is important to debrief as a team and discuss experiences as well as what worked versus what did not, and to brainstorm what could be improved (Crepeau-Hobson & Summers, 2011; Razi & Dechillo, 2005). This allows for the making of adjustments to subsequent response efforts as well as the opportunity to celebrate the work that was accomplished.

Self-Care

Research has indicated that crisis responders can experience crisis reactions (Bolnik & Brock, 2005; Crepeau-Hobson & Summers, 2011), so self-care and the opportunity to debrief are important considerations in any crisis response. As noted previously, opportunities for CRT members to debrief and to receive social support should be provided throughout the response and recovery processes.

SUMMARY, CONCLUSIONS, AND IMPLICATIONS FOR PRACTICE

Although lethal violence in schools is extremely rare, it can have a traumatic effect on the entire school community (Daniels et al., 2007). Other types of sudden, unexpected incidents such as the death of a student or teacher,

natural disasters, and suicides can also have a large-scale, negative impact on students and school personnel and fall under the umbrella of crisis (Brock et al., 2001). Thus, schools and school districts must strengthen their capacity to respond in these situations.

Our experiences responding to the three school shootings in Colorado have provided us with a wealth of knowledge that can be used to inform responses to other major school-based crises. It is hoped that the information contained in this article will complement and add to existing crisis response models and published guidelines while perhaps filling in some gaps. Following is a summary of important considerations:

- Crisis preparedness is key to an effective response. Schools and districts must have crisis teams and crisis plans in place. Teams should be organized functionally and be aligned with the National Incident Management System ICS structure. All crisis responders on these teams need training in school-based crisis response. In addition, each team should know what additional resources are available in their respective communities. Crisis plans ought to include potential reunification and safe haven sites, means for monitoring and following up with impacted individuals, and steps for evaluating the response.
- The district should have an identified MHIC or point person who assumes the lead and coordinates the response. The MHIC must have training and expertise in crisis response. This person is charged with the major decision-making regarding the mental health response including: which responders should be deployed and what services should be offered and where. This person also serves as the liaison with the incident commander and school administration. Having an MHIC is critical when outside mental health responders are called in to assist and is crucial to fostering a collaborative and coordinated response.
- Mental health crisis responders need to be included and participate in crisis-related meetings held by the school and/or district from the beginning. Consideration of the mental health impact and needs of the school community must be part of the planning and should be a priority of the response and recovery processes. Involvement in planning fosters communication between mental health personnel, crisis responders, and school and district leaders.
- Psychological triage is a critical component of the response. This should be part of both the planning for and delivery of crisis intervention services. Triage allows for estimating numbers of impacted individuals and for their identification.
- Using a framework such as the NOVA model (Young, 1998) is valuable in planning and implementing the response. The tasks of safety and security, ventilation and validation, and prediction and preparation help to inform

crisis response decision-making. We suggest also considering an additional task, empathy and empowerment, when responding and when deciding on services and supports to be offered.

- Offering a range of supports and services is key to meeting the needs of the entire school community following a major crisis. One size does not fit all and school-based crisis responders need to be flexible and prepared to think outside of the box.

This article is not intended to serve as a script to be followed exactly, but rather to provide some direction following a major school crisis. Armed with this information, solid crisis response training, and comprehensive crisis response plans, crisis responders may be better equipped to meet the needs of the school community when major crises occur in the school setting.

COMPETING INTERESTS

We confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

REFERENCES

Adamson, A. D., & Peacock, G. G. (2007). Crisis response in the public schools: A survey of school psychologists' experiences and perceptions. *Psychology in the Schools*, *44*, 749–764. doi:10.1002/pits.20263

Barenbaum, J., Ruchkin,V., & Schwab-Stone, M. (2004). The psychological aspects of children exposed to war: Practice and policy initiatives. *Journal of Child Psychology and Psychiatry*, *45*, 41–62. doi:10.1046/j.0021-9630.2003.00304.x

Benight, C. C., & Harper, M. L. (2002). Coping self-efficacy perceptions as a mediator between acute stress response and long-term distress following natural disasters. *Journal of Traumatic Stress*, *15*, 177–186. doi:10.1023/A:1015295025950

Bolnik, L., & Brock, S. E. (2005). The self-reported effects of crisis intervention work on school psychologists. *The California School Psychologist*, *7*, 117–124.

Brock, S., & Davis, J. (2008). Best practices in school crisis intervention. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology V* (Vol. 3, pp. 781–797). Bethesda, MD: National Association of School Psychologists.

Brock, S., Nickerson, A., Reeves, M., Jimerson, S., Lieberman, R., & Feinberg, T. (2009). *School crisis prevention and intervention: The PREPaRE model*. Bethesda, MD: National Association of School Psychologists.

Brock, S., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2nd ed.). New York, NY: Wiley.

Cornell, D. G., & Sheras, P. L. (1998). Common errors in school crisis response: Learning from our mistakes. *Psychology in the Schools*, *35*, 297–307. doi:10.1002/(SICI)15206807(199807)35:33.0.CO;2–K

Crepeau-Hobson, F., & Summers, L. L. (2011). The crisis response to a school-based hostage event: A case study. *Journal of School Violence*, *10*, 281–298. doi:10.1080/15388220.2011.578277

Daniels, J., Bradley, M., & Hays, M. (2007). The impact of school violence on school personnel: Implications for psychologists. Prof*essional Psychology: Research and Practice*, *38*, 652–659. doi:10.1037/0735-7028.38.6.652

Drennen, C. (2009). *The Colorado Crisis Response Education and Response Network: Protocol and guidance*. Denver, CO: Colorado Department of Human Services, Division of Behavioral Health.

Fein, A. H., & Isaacson, N. A. (2009). Echoes of Columbine: The emotional work of leaders in school shooting sites. *American Behavioral Scientist*, *52*, 1327–1346. doi:10.1177/0002764209332549

Hatzichristiou, C., Issari, P., Lykitsakou, K., Lampropoulou, A., & Dimitropoupou, P. (2011). The development of a multi-level model for crisis preparedness and intervention in the Greek educational system. *School Psychology International*, *32*, 464–486. doi:10.1177/0143034311402918

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry*, *70*, 283–315.

Horowitz, K., McKay, M., & Marshall, R. (2005). Community violence and urban families: Experiences, effects, and directions for intervention. *American Journal of Orthopsychiatry*, *75*, 356–368. doi:10.1037/0002-9432.75.3.356

LeBanc, B. H., Krepel, T. L., Johnson, B. J., & Herrman, L. V. (2010). Managing the whirlwind: Planning for and responding to a campus in crisis. In B. O. Hemphill & B. H. LaBanc (Eds.), *Enough is enough: A student affairs perspective on preparedness and response to a campus shooting* (pp. 53–82). Sterling, VA: Stylus.

Nims, D. R. (2000). Violence in our schools: A national crisis. In D. S. Sandhu & C. B. Aspy (Eds.), *Violence in American schools: A practical guide for counselors* (pp. 3–20). Alexandria, VA: American Counseling Association.

Pagliocca, P., & Nickerson, A. (2001). Legislating school crisis response: Good policy or just good politics. *Law & Policy*, *23*, 373–407. doi:10.1111/1467-9930.00117

Pitcher, G. D., & Poland, S. (1992). *Crisis intervention in the schools*. New York, NY: Guilford.

Poland, S., & McCormick, J. S. (1999). *Coping with crisis: Lessons learned*. Longmont, CO: Sopris West.

Razi, A., & Dechillo, N. (2012). High schools respond to crises. *Journal of School Violence*, *4*, 115–131. doi:10.1300/J202v04n02_07

Reeves, M., Kanan, L., & Plog, A. (2010). *Comprehensive planning for safe learning environments*. New York, NY: Taylor & Francis.

Saltzman, W., Pynoos, R., Layne, C., Steinberg, A., & Aisenberg, E. (2001). A developmental approach to trauma/grief focused group psychotherapy for youth exposed to community violence. *Journal of Child and Adolescent Group Therapy*, *11*, 43–56.

Sandoval, J., & Brock, S. (2002). School violence and disasters. In J. Sandoval (Ed.), *Handbook of crisis counseling, intervention, and prevention in the schools* (2nd ed., pp. 249–272). Mahwah, NJ: Erlbaum.

Sharma, M. M., Bershad, C., & LeBanc, D. (2010). Counseling during a campus-wide crisis. In B. O. Hemphill & B. H. LaBanc (Eds.), *Enough is enough: A student affairs perspective on preparedness and response to a campus shooting* (pp. 83–106). Sterling, VA: Stylus.

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development*, *82*, 31–37.

U.S. Department of Homeland Security. (2004). *NIMS and the Incident Command System*. Retrieved from http://www.fema.gov/txt/nims/nims_ics_position_paper.txt

van Emmerik, A., Kamphuis, J., Hulsbosch, A. M., & Emmelkam, P. (2002). Single session debriefing after psychological trauma: a meta-analysis. *Lancet*, *360*, 766–771. doi:10.1016/S0140-6736(02)09897-5

Young, M. (1998) *The community crisis response team training manual* (2nd ed.). Washington, DC: National Organization for Victim Assistance.