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Crisis management for schools

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Crisis Management for Schools

Volume 1

Wilson K MacNeil
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Contents

Volume 1

Abstract

Initial modules review the literature on critical incidents or crises with emphasis on a school context where possible and appropriate. A widely accepted four-stage model is used as a basis for the review. In the field of crisis management, practice appears to be based mainly on clinical judgement and the related best practice literature provides valuable insights. A number of specific programs are discussed which do have some founding in research. For a range of reasons, mental health promotion in the school context is gaining attention and appears a particularly promising area that can be used effectively. A number of interventions are of questionable efficacy. Youth Suicide is considered as an issue of specific importance to schools. In module 4, a skills-based training workshop is developed around a scenario of an evolving crisis. With the intent of giving school staff the skills to undertake the multiplicity of tasks that may be required, the workshop uses evidence-based and best practice recommendations to create a coherent path through crisis situations. The following module takes this process further by creating a comprehensive, step-by-step process for producing a school crisis management plan that sets out how the Crisis Management Team will operate, the tasks it will perform and the support that will be available, Module 6 looks at school safety and the link to crisis management. Critical questions are considered in relation to the value of a safety audit to a school and to the Crisis Management process, and, whether taking actions based on an audit leads to a safer school. Finally, consideration is given to how the school can support recovery after a crisis. Practical actions are identified for immediate and ongoing actions based on particular models where there is some supportive evidence as to effectiveness. Limitations are noted, particularly that much of the research is based on disasters and focuses on Post Traumatic Stress Disorder.

I gratefully acknowledge the support and guidance of my supervisor, Professor Keith Topping, and thank him for his continuing encouragement. I must also acknowledge the support of my wife, Maria, and of my family.

I, Wilson Kerr MacNeil, declare that I am the author of this thesis; that, unless otherwise stated, all references cited have been consulted; that this is my own work; and, that it has not been previously accepted for a higher degree.

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University of Dundee **D. Ed. Psych.**

Modules 2 and 3

Literature Review

Crisis management with particular reference to schools

Introduction to Response 10,580 words
Recovery to Conclusion 10231 words

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Abstract

The literature in relation to critical incidents or crises is reviewed, with emphasis on a school context where possible and appropriate. A widely accepted four-stage model, described by many writers (e.g., Paton, 1992), is used as a basis for the review. In the field of crisis management, practice in the main appears to be based on clinical judgement of "what works" and the related best practice literature provides valuable insights. A number of specific programs are discussed which do have some founding in research. For a range of reasons, mental health promotion in the school context is gaining attention and appears a particularly promising area that can be used effectively in schools. Youth Suicide is considered as an issue of specific importance to schools. A number of authors have cast doubt on the efficacy of certain types of intervention following a crisis. Debriefing has been subject to criticism and, in a highly polarised and ongoing debate, long-term outcomes from this kind of intervention are viewed as questionable. To date, there has been very little published research that looks at management and response to crisis within schools. There is a need for empirical study of all facets of crises as they impact on children and schools, ranging from the fundamental issue of whether having a Crisis Management Plan leads to better outcomes, to how best to address the socio-emotional needs of children after a trauma.

Introduction

This paper considers the literature in relation to crises or critical incidents with emphasis on a school context where possible and appropriate. An extensive review of published works on school crisis intervention was conducted to provide a background of information about current theories, concerns, needs, and practical applications. This is a best-evidence synthesis or integrative review that focuses on the current state of knowledge in crises that relate to schools and looks at some broader issues where there is a lack of school level information.

There is an extensive body of literature in relation to the varying aspects of crisis situations and the associated management tasks. The scale of events ranges from the macro, with profound effects impacting across the world, to the micro with effects remaining within very limited boundaries. In this review, the intention is to identify practices that can be supported as relevant and useful to those crises that may impact on schools, these being considered as generally nearer to the micro than the macro.

Electronic databases were used as an initial starting point to identify relevant literature. Searching on PsychINFO, PsychArticles, PubMED and Web of Science using search terms such as crisis, school and crisis, school and suicide, trauma, youth and suicide, PTSD (Post Traumatic Stress Disorder) and school, (all with 'and' as a Boolean operative) and on the phrases 'critical incident', 'school crisis' and 'school crises' was used to identify relevant publications. Similar searches were run on the Google search engine to identify relevant web sites. A range of books by noted writers in the field were also accessed in relation to both content and to explore citations. Other areas covered in the review relate to practices in

themes such as Youth Suicide Prevention and Mental Health Promotion, where programs have already been introduced into Australian schools, and to consider the relevance to a crisis management model that embraces prevention and mitigation. Youth Suicide Prevention and Mental Health Promotion are significant research areas in their own right. The intention in considering such areas is not to extensively review relevant literature but rather to indicate how these fit into the prevailing model of crisis management and highlight the relevance to schools.

It is hoped that the review will clarify the basis for many of the practices advocated for schools in crisis management, lead to appropriate changes that are informed by research, identify areas where research is needed and serve as a basis for school psychologists to pursue informed work with schools in training and intervention.

Definitions

Events that cause severe emotional and social distress may occur at any time and without warning. Such occurrences have been variously called Traumatic Incidents, Critical Incidents, Crises, Disasters and Emergencies. Whatever the terminology, there is a clear need, arguably a legal obligation under 'duty of care' (Tronc, 1992), for all schools to establish a Crisis Management Plan. There are a number of writers who describe a crisis management process for schools e.g. Sorenson (1989), Pitcher and Poland (1992) and Whitla (1994). Pitcher and Poland (1992) provide an analysis of 40 years of crisis intervention, an overview of techniques applicable within the school environment and recommendations for approaches and necessary components in establishing a comprehensive, preventive school crisis intervention program.

Raphael (1986, page 6) has identified characteristics of "crises", in that they involve:

- rapid time sequences;
- an overwhelming of the usual coping responses of individuals and communities;
- severe disruption, at least temporarily, to the functioning of individuals or communities; and
- perceptions of threat and helplessness and a turning to others for help.

Flannery and Everly (2000), in trying to clarify some of the terms that are often used interchangeably, define a crisis as a response condition where:

- psychological homeostasis has been disrupted;
- the individual's usual coping mechanisms have failed to re-establish homeostasis; and,
- the distress engendered by the crisis has yielded some evidence of functional impairment.

Flannery and Everly (2000) propose that if a crisis is a response, then the stressor event requires a different name and suggest the use of "critical incident", a term that they note is frequently confused with the term crisis. Contrary to the crisis response, a critical incident may be thought of as any stressor event that has the potential to lead to a crisis response in many individuals. The critical incident is the stimulus that leads to the crisis response.

Brock, Sandoval and Lewis (1996, page 14), offering a definition applicable to schools, suggest that crises are sudden, unexpected events that have an

'emergency quality' and have the potential to impact on the entire school community.

In schools, a crisis might be considered as any situation faced by staff or students that causes them to experience unusually strong emotional reactions which may have the potential to interfere with their ability to perform at the scene or later. Crises tend to be far outside of the normal experience of those involved and indeed of most of the population. Accordingly, the individual has little by way of guideline from past experience on how to deal with the event or the reactions to it. Children have even less experience to draw on than adults and usually have a more restricted repertoire of coping responses. Sense of control and self-efficacy are likely to be reduced. Children are likely to be looking to those adults who usually provide support, guidance, direction and leadership to continue to fulfil these roles. Problems can arise from a single highly traumatic event or from several less severe but emotionally taxing events spread over time. Exposure to crises can also trigger normal but strong or heightened reactions and responses. These should decrease in duration and intensity over time. Best practice models suggest that appropriate support may minimise the duration and intensity of such reactions. Some individuals, both school staff and school children, may require more support over a longer time than others.

Background

In recent years, schools in Australia and across the world have been increasingly required to respond to traumatic incidents impacting on the school and its community. Such events may be natural and/or human-made (with other terms such as industrial, technological, complex emergencies being used to describe

those that are human-made). Along with a marked increase in those crises whose origins are human-made, there has emerged a societal expectation that schools will be involved in the management of such situations when there is impact on school children. Although the frequency and severity of school crises have increased dramatically with, for example, Australian youth suicide rates trebling over a thirty year period (from one in 20 male deaths in the 15-19 age range in 1966 to one in 7 in 1987 [Mason, 1989]), many school psychologists and administrators still lack training in crisis intervention or in how to recognise and make effective decisions under conditions of stress and in the absence of sufficient information, time and resources. For example, in Western Australia there are two training courses at University level for school psychologists neither of which give any attention to crisis management. In the United States, the National Association of School Psychologists as recently as July 2000 added Crisis Intervention to their accreditation standards (National Association of School Psychologists, 2000). Poland (1995) notes that few schools have been prepared to manage a crisis and little emphasis has been placed on prevention activities. Though such critical incidents may not be a new phenomenon to schools, the role of the school and often the nature of the incident are new.

The identification of the effective elements of crisis management is fundamental. Practice appears in the main to be based on clinical judgement as to what works and what does not. The clinical judgement of those with significant experience in crisis management should not be under-estimated yet opportunities should be taken to research the effectiveness of practice, to clarify the standards of practice used in interventions, and to evaluate outcomes over time at a range of levels from individual through to the broader community.

There are significant difficulties involved in research into crisis situation. Some of these relate to the unpredictable nature of such events, the ethical constraints associated with research and the difficulty of measuring socio-emotional upheaval and recovery in the short and long term with adequate reliability and validity. The difficulty of persuading those actively dealing with crisis situations that there is a place for researchers may prove an even more challenging task.

Previous Reviews

In order to gain an understanding of the school psychologist's role in crisis intervention, Allen, Marston and Lamb (2001) reviewed a number of school psychology journal publications over a 31-year period, from 1970 to 2000. Abstracts from the following school psychology journals were coded to determine the type of articles that were published on crisis-related topics over the 31-year period: School Psychology International, School Psychology Review, Psychology in the Schools, School Psychology Quarterly, and Journal of School Psychology.

This study's main limitation is that it drew from a very narrow list of journals, apparently only those that had "School" and "Psychology" in the title. Searching on PsychINFO, PsychArticles, PubMED and Web of Science using search terms such as crisis, school and crisis, school and suicide, youth and suicide, PTSD (Post Traumatic Stress Disorder) and school, (all with 'and' as a Boolean operative) and on the phrases 'critical incident' and 'school crisis' gave relevant results from almost 30 additional journals, many published books and dissertations. There were clearly a number of significant journals that were

omitted from the Allen, Marston and Lamb (2001) review including: Suicide and Life Threatening Behaviour; Pediatrics; American Journal of Psychiatry; Journal of the American Academy of Child and Adolescent Psychiatry; Developmental Psychology; Journal of Emergency Mental Health; New England Journal of Medicine; Death Studies; and, Crisis: Journal of Crisis Intervention and Suicide.

Allen, Marston and Lamb (2001) included as crisis topics in their coding: suicide, grief and death, aggression/violence, Post Traumatic Stress Disorder (PTSD) and school phobia, dealing with the media during a crisis, natural disasters, development of crisis plans and crisis teams, abuse (physical and sexual), gangs, drugs/addiction, critical illness (Cancer and AIDS were the primary subjects under this category.), incidents involving guns and weapons, and "other" crisis situations (e.g. war, crisis in general, etc.). Approximately 4%, (215 from 5298), of the school psychology journal articles published over the 31 years dealt with these listed crisis topics.

Allen, Marston and Lamb (2001) used a very broad sweep in determining what would be included, failing to offer a definition of a crisis. Operational definitions of a crisis and of their sub-groupings would have given their review more clarity and usefulness, allowing, for example, comparison to other published research. If a narrower definition were used in line with the parameters laid out earlier in this review (Flannery and Everly, 2000; Raphael, 1986), then the elements considered would be: suicide, grief and death, development of crisis plans and crisis teams, incidents involving guns and weapons, critical illness, and natural disasters. These kinds of events would likely meet the criteria for the definitions proposed by Flannery and Everly (2000) and Raphael (1986). Aggression/violence, Post

Traumatic Stress Disorder and school phobia, abuse (physical and sexual), gangs, drugs/addiction, and "other" crisis situations might, at least without further clarification, fail to meet the criteria for consideration as a crisis. Assuming an equal distribution of research to areas, then this narrows the field to 62 articles from 5298 - just over 1%. Allen, Marston and Lamb (2001) further found that almost half of all articles involved research although they did not say how this was defined other than to comment that this might be contingent upon the heavy emphasis for data collection and empirical study in journal publication. Around 0.5% of articles published in School Psychology journals over this 31-year span involved 'research' into crisis situations as considered in this review. In broad terms, this equates to one research article per year. Although this study by Allen, Marston and Lamb (2001) could, at best, only be considered as a representative sample it does suggest that published works in the field are heavily weighted towards the anecdotal and best practice rather than research.

The PPRR Model

Within this review, the Prevention, Preparation, Response, Recovery model (PPRR) is used as a framework from which to consider the research, both because it is widespread in usage and because it is notable in considering Prevention as a necessary first step in a crisis management strategy. Some authors refer to Mitigation rather than Prevention (e.g. Tierney, 1989) but in spite of having clearly different meanings, these elements appear to involve essentially the same actions.

PPRR may have had its origins in the work of Caplan (1964) who described three levels of crisis intervention:

1. Primary Intervention which consists of activities devoted to preventing a crisis from occurring (this would equate to Prevention in the PPRR model);
2. Secondary Intervention or the steps taken in the immediate aftermath of a crisis to minimise the effects and keep the crisis from escalating (this would equate to Response); and
3. Tertiary Intervention which involves providing long-term follow-up assistance to those who have experienced a severe crisis (this would equate to Recovery).

There are other models of crisis management, perhaps the most well known being Critical Incident Stress Management (Mitchell & Everly 1995) where a key element, "debriefing", has become the centre of heated controversy as to its effectiveness. This will be considered later in the review.

PPRR has also come under recent criticism. The PPRR model anticipates crises and outlines a sequential planning and implementation of actions before, during and after an event. Crondstedt (2002) suggests that this kind of comprehensive emergency management model has lost relevance to modern risk management. Crondstedt sees PPRR as a model that cannot be adapted to the way emergency management has evolved or is evolving. Because PPRR has an almost pervasive acceptance as the operational model of choice, Crondstedt's views will be given some attention.

Crondstedt (2002) identifies comprehensive emergency management as originating from work by the United States' State Governors' Association in 1978.

It has since been adopted as ‘best practice’ in many jurisdictions in Australia, the United States and Asia. He identifies two broad rationales for the PPRR model. First, PPRR has been represented as the sequence or phases of emergency incidents and therefore describes the events that occur before, during and after an event. Second, the model has been used to categorise a menu of available emergency management strategies. Crondstedt notes that within the emergency management community, there has been a general policy move associated with two key issues: the shift from an internal, agency focus to a community centred focus and a shift away from delivering a limited range of services (usually response based) to more intelligent resource allocation based on risk, business-like management and outcome based performance.

Crondstedt (2002) argues that with this shift there has been a concentration on the best practice models of resource allocation and maximising return on investment. He notes that the PPRR approach was developed nearly 25 years ago, well before risk management as we know it today, was developed. Although PPRR has found a place in the new methodology, the fit is not neat and has inherent problems.

First, the PPRR model sets up artificial barriers between the four elements: Prevention, Preparation, Response and Recovery - and therefore implies a clear delineation between the elements. Crondstedt (2002) believes this leads to unnecessary discussion and concentration of effort at categorising actions into one of the elements. He suggests that much of the debate derives from arguing the appropriate category for action, rather than the appropriateness or otherwise of the specific action. An example might be in considering whether psychological

debriefing is a Response action or a Recovery action rather than considering whether such debriefing is even appropriate or useful.

Second, in all circumstances the four categories appear to be given equal weight and imply that there must always be strategies that fall under each element. This forced weighting does not recognise that a risk management approach may not reveal strategies that fit neatly, if at all, under all elements.

Third, the elements assume a sequential consideration of the PPRR process and that they must be considered and implemented in the same order all the time. This assumes that the actions are inextricably linked to the emergency cycle and that therefore actions follow the same order. A Risk Management model does not make this assumption and leads to the selection of the most appropriate actions, regardless of order and categorisation. Whitla (1994), though an advocate of PPRR, also offers criticism of the apparently linear nature of the PPRR model, stressing that it is inadequate as a model for a comprehensive, school planning process. Whitla (1994) argues that in the planning of emergency management procedures for a school, the Preparation phase should be commenced only after a thorough investigation of all the implications for the school of the other phases, Prevention, Response and Recovery. Using the model in this way is intended to encourage schools to focus on the ongoing process of planning and not merely on the product, especially not on a product that is simply a list of what should be done and by whom. Yet the criticisms are not just related to the apparently linear nature of the PPRR process and the ease with which it can become bureaucratised, but rather how emergency management has moved on to a more flexible and adaptive model where appropriate treatments are more important than the process.

Fourth, in Crondstedt's argument, the elements appear biased towards action-based procedures whereas there may be softer options involving social dimensions. The PPRR model tends to relate to activity and physical actions which may be a carry over from the emergency management paradigm that focused on the hazard rather than the situational vulnerability. Emergency Risk Management now focuses on the interaction between the community and the hazard within the particular context. Such consideration goes well beyond the physical hazard and includes socio-economic and psychological vulnerability factors such as income, perceptions, networks, support groups and the like, factors do not easily lend themselves to categorisation within the PPRR framework.

Crondstedt (2002) offers an alternative approach. He advocates using risk management methodology to guide the selection, application and review of risk treatments without the use of the PPRR model to categorise treatments. The selection of treatments should be based on criteria founded on efficiency, effectiveness and economy. Efficiency provides the basis for cost/benefit comparisons across treatments; effectiveness provides the basis for impact on risk level and risk criteria set up in the context; and economy is used as a basis for assessing resource implications for possible treatment selections. He asserts that unconstrained thinking about possible treatments is critical in deriving innovative, new and possibly better ways of treating risk. Questions to test the appropriateness of treatments might include:

- What will the impact of the treatment be on the assessed risk and how will it meet the risk criteria established at the context stage?
- What is the cost/benefit ratio?

- What is its total cost?
- How acceptable will the treatment be in the light of the environment in which it will be implemented and monitored (organisational/political)?

Crondstedt's (2002) approach follows that given by Helm (1996) who pointed out that the risk management cycle provided an overlay on the emergency/disaster management process with the PPRR model being an appropriate reference during the risk treatment phase. Importantly, Helm went on to describe models for identifying the acceptability of risk. Risk is tolerable only if risk reduction is impracticable or if its cost is grossly disproportionate to the improvement gained. All proposed risk treatments should be subject to a costs and benefits analysis.

Crondstedt makes a strong argument yet the PPRR model provides a simple, easily understood framework, (an important consideration in schools where few would likely have emergency management training), that has been widely adopted in emergency management throughout the world.

Prevention

Prevention can be considered as taking steps to identify and then eliminate or reduce sources of risk. The use of the term Mitigation, either instead of or in conjunction with Prevention, serves to convey an additional focus on reducing any potential impact from a crisis when it is accepted that risk cannot be entirely removed.

Many kinds of risks and hazards are obvious and predictable regardless of the setting. Fire, for example, would be considered a risk factor in most kinds of

building. Steps can be taken to reduce the risks associated with fire, for example, by reducing or removing readily combustible materials, having extinguishers and alarms in place, and having comprehensive and practiced evacuation procedures.

Risk can be identified and reduced in other areas and in other ways. In Western Australia, Youth Suicide Prevention became a high priority in the late 1980's when there was a State Government sponsored response to the dramatic rise in the incidence of young people taking their lives. The age specific rate of suicide among youth in Western Australia increased from 6.1 in 1970 to 16.3 per 100,000 in 1989. In 1980, 1 in 10 deaths among Western Australian males aged 15-24 was due to suicide by 1989 this proportion had increased to 1 in 5. (Silburn, Zubrick, Hayward & Reidpath, 1991). The Western Australian State strategy gave particular attention to schools and, using a public health model, aimed to have skills available at the school-level to identify and intervene with high-risk students. The key objectives for the strategy were:

- the early identification of students at risk of suicide or self-harm;
- appropriate intervention using best practice guidelines to reduce risk;
- the provision of sound, effective management based on an established crisis management plan that specifically addressed suicide in the event of a completed suicide or serious self-harm, to reduce the potential for contagion and facilitate a healthy resolution of issues; and,
- to promote primary prevention of youth suicide by enhancing mental health and well-being (WA Youth Suicide Advisory Committee, 1998). Formal evaluation has been planned for this program but the outcome measures are not available at this point although coronial data does appear to show a

plateau of suicide in the school-age population (Hillman, Silburn, Zubrick & Nguyen, 2000).

Recognition that such 'last minute' interventions carry their own degree of risk has led to consideration and implementation of a number of programs, considered later in this review, that seek to intervene earlier, before any crisis is apparent. As a behaviour, suicide is usually an individual event, perhaps the last act in a life path filled with despair, hopelessness and loss, accompanied by a belief that nothing can be changed. To prevent suicide, intervention should presumably occur well before a person begins to consider suicide as an option. But at what point should this intervention occur, how early does this have to be, and what should be the focus of actions? The majority of literature on suicide prevention has focused on the individual and intervention at times of crisis. This puts immense pressure on families and professionals who, after a death, focus on the central questions: "Should we have known? Could we have stopped him/her?" Given that suicide is an unpredictable behaviour, the answer to these questions is usually "No", and focusing just on or around the time of crisis may be simply too little, too late.

To understand how and when to intervene effectively in relation to self-harm and suicidal behaviours, some understanding of causation is needed. Many writers have detailed the possible explanations for suicidal behaviour. In the United Kingdom, Scotland's National Framework for the Prevention of Suicide and Deliberate Self-harm in Scotland Consultation (2001) lists as follows.

Societal risk conditions

- Availability of, and easy access to, lethal methods for suicide
- Irresponsible (factual) reporting and (fictional) representation of suicidal

behaviour in the mass media

- Socio-demographic change, including marital breakdown/divorce, later marriage
- Adverse labour market conditions, including insecurity of employment
- Adverse economic conditions, including level of unemployment and business confidence
- Social attitudes to suicidal behaviour

Psychosocial environment

- Impoverished social capital (low level of social cohesion, social integration and trust in the community)
- High level of social exclusion (e.g. neighbourhood poverty/deprivation)
- Impaired community capacities, resources and resilience

Individual risk factors

- Inadequate social support (low levels of practical, emotional, financial and other forms of assistance from family, friends and neighbours)
- Socio demographic characteristics (e.g. age (young-mid aged adult), (male) gender, marital status (non-married), (lower) socio-economic status and (certain types of occupation)
- Serious mental illness
- Substance misuse
- Previous deliberate self-harm
- Recent discharge from psychiatric hospital, in particular following detention under mental
- health legislation
- Experience of abuse (sexual and physical)
- Low educational qualifications, poor life skills and interpersonal skills

- ❖ Life crises, especially interpersonal loss

Quality of services

- ❖ Inadequate prevention and treatment responses by health services (primary and secondary care)
- ❖ Inadequate prevention and treatment responses by other services (e.g. welfare, social work and housing).

In Australia, recent focus has been on reduction of individual and accumulated 'risk factors' (Beautrais, 1998). These biological, family, community or societal characteristics, which have been shown to be associated with suicidal behaviours, are often built into pathways that may tell something about where to intervene (Davis, Martin, Kosky & O'Hanlon, 2000). For example, it is known that people with a mental illness, particularly depression or a psychosis, are vulnerable to feelings of hopelessness. At times of stress or isolation, such as the few days after leaving hospital, they may feel life is not worth living. This places a special responsibility on Mental Health or Community Services to provide adequate supports. A different example concerns when a certain group is at increased risk, for example, young people who are severely abused or young people known to be abusing large quantities of illicit drugs. Here there is a responsibility for society to provide adequate services to ensure such people get back on track and never get to the point of thinking about suicide as an option. At another level, it is known that a societal issue such as unemployment, can be important in making men particularly feel they can never measure up to expectations. Here it may take the whole community and some changes in national policy to change the risk factor and reduce its impact (Commonwealth of Australia, 2000).

Review of the Australian National Youth Suicide Prevention Strategy (NYSPS, 1994-1998) shows that more than 70 programs were spread across the whole prevention spectrum (Mitchell, 2001). It can be argued that the resulting increased skills of professionals, the improved awareness in the community, and the improvements in accessibility of services have begun to show up in the figures. The reduction in young male deaths from 1997 to 1999 was 25%, and it was the first time for many years that a reduction had occurred over two years but there was no sustained reduction in Australia's loss through suicide at any time in the 20th century.

Zenere and Lazarus (1997) studied a comprehensive suicide prevention and intervention program in a large, urban, multicultural school district. The program was developed and implemented by the Florida Public School Department of Crisis Management. The program was systematically disseminated and, at the time of the report, had been sustained for 6 years in all secondary schools in urban/suburban counties that had an average of approximately 130,000 school-age youth. The program aimed to prepare schools and communities to identify, respond to, and obtain help for at-risk youth as well as other health topics such as coping and self-efficacy. The program was comprehensive in that it promoted linkages among school and community services and included school-based crisis teams; community crisis response capability; administrative polices and procedures; and training for school personnel, parents, students, and to a lesser extent, community gatekeepers.

The curriculum component was delivered to grades pre-kindergarten through 12 by the "To Reach Ultimate Success Together" (TRUST) programme. The pre-

kindergarten to grade five programme involved a drug education curriculum that stressed themes relevant to making healthy and positive choices (e.g. self-awareness development, communication skills enhancement, decision-making skills, drug information, and development of positive alternatives). The curriculum provided to grades 6 to 12 addressed more developmentally appropriate themes for those age groups, with the topic of youth suicide not formally introduced until the 10th grade in a mandatory "Life Management Skills" class. A three-tiered approach of prevention, intervention and postvention services was used in a multi-faceted program involving teachers, parents and students.

Zenere and Lazarus (1997) describe how students were tracked over a five-year period. Evaluation of the program consisted of analysis of hotline data which included 2,698 incidents of suicidal ideation, 699 suicide attempts, and 23 completed suicides of Dade County Public School students during the first five years of the program. From 1980 to 1984 there were a total of 145 students who killed themselves. Between 1980 and 1988 (prior to the program's implementation) there was an average of 12.9 student suicides per year, with 19 occurring in 1988. It was found that although suicide ideation (thinking about suicide) remained stable, the rate of attempts and completions was dramatically reduced. Number of completed suicides dropped by 63% from an average of 12.9 per year (1980-1988) to 4.6 per year (1989-1994). Suicide attempts decreased from 87 per 100,000 students (1989-1990) to 31 per 100,000 (1993-1994). Follow-up compared suicide rates with state and national suicide rates for the time periods prior to and after program implementation. The follow-up found a reduction in youth suicide rates subsequent to the dissemination of the programs

that did not occur at the state or national levels for the same time periods. There were two additional noteworthy findings associated with this program. First, no student who expressed ideation or attempts, and, therefore, received intervention, later went on to complete suicide. It was only those students who never came to the attention of crisis team members that later took their own lives. Second, there was no significant reduction in self-reported suicidal ideation among students for this period of time. Thus, changes in self-reported ideation may not predict suicide completion rates.

Zenere and Lazarus (1997) used a before and after study without a non-intervention control group which was a weakness in the design. In the absence of any meaningful comparison group, the premise that the program had a direct impact on suicidal behaviour cannot be accepted. Other changes (e.g., accessibility or quality of health care, other curricula within the school, community based programs, alcohol/drug use patterns) occurring during the same period may account better or more directly for the decline in suicidal behaviour. Although these data cannot be conclusively linked to the program, taken together, they meet some epidemiological criteria for supporting the possibility of causal relationships including consistency of findings across studies, temporal sequence of exposure and outcome, and logical plausibility of the relationship.

Mental Health Promotion

Suicide is behaviour. It is hard to stop a suicide either when it is impulsive or once someone has made a final decision to take his or her life. Mental health promotion programs may provide a chance to reduce the long-term, intergenerational burden of suicide. Universal, preventive interventions target the general population or a

whole population group that has not been identified on the basis of individual risk. Because universal programs are positive, proactive and provided independent of risk status, the potential for stigmatising individuals is minimised and they may be more readily accepted and adopted. This blanket approach increases the likelihood that all at-risk persons will be "inoculated" by the prevention activity, but on a mass level it is difficult to control how much "prevention dose" each person receives. The mass approach, simply because it has to target more people, may also be more expensive than the alternatives. Any prevention strategy should clearly outweigh the costs and risks of implementing that strategy. This requirement is true for all three types of prevention strategies, but the burden of showing this positive balance is greatest for the universal group because the costs are often high and the risks can easily be overlooked.

The other kinds of prevention strategies are referred to as "Selective" and “Indicated.” Selective prevention strategies are targeted at specific subgroups who are known or thought to be at elevated risk for suicidal behavior. "Selective" strategies tend to address the risk factor(s) defining the subgroup at risk, directly or indirectly. A direct strategy might involve intervening to lower depression severity for a subgroup of young people who qualified for a diagnosis of major depression. An indirect strategy might involve offering support and education to a gay/lesbian/bisexual youth who was thought to be at risk by virtue of his/her sexual orientation and/or the environmental response to his/her lifestyle.

Indicated prevention strategies are targeted at individuals known or suspected to be at high risk for suicide. This approach presumes that tools exist for identifying individuals at high risk with good sensitivity and specificity, i.e., few "false positive" or "false negatives".

Evidence suggests that young men with high self esteem, a sense of purpose, resilience, interpersonal skills, support from parents, family and community, a commitment to life and a connectedness to friends never consider suicide (Martin, 2002). In order to reach this point, there has to be support for family life, school life, and community life. Young people have to be supported and helped to find meaning in the transition to adulthood. In particular, resilience and connectedness may be key factors (Resnick, Bearman, Blum, Bauman, Harris, Jones, Tabor, Beunning, Sieving, Shew, Ireland, Bearinger, and Udry, 1997).

Schools are being encouraged to promote positive mental health. (World Health Organisation, 1984, 1994; Commonwealth of Australia, 1996). Australian programs such as MindMatters (Curriculum Corporation, 2000), the Resourceful Adolescent Program (Shochet, Holland & Whitefield, 2000) and Aussie Optimism (Hart, 1998; Quayle, Dziurawiec, Roberts, Kane, & Ebsworthy, 2001; Roberts, Kane, Thomson, Bishop & Hart, 2003) are research-based and target positive mental health at different levels of the school population. MindMatters describes a health promoting school as one that takes action and places priority on creating an environment that will have the best possible impact on the health of students, teachers and school community members; and which recognises the interaction and connection between its curriculum, policies, practices and partnerships.

The latter two programs build on Seligman's (1995) work on optimism and the notion of 'psychological immunisation' of young people against mental health problems. Seligman examined and designed an intervention program around 'potentially modifiable risk factors.' The Penn Prevention Program, a precursor to

the Australian programs, identified an approach to altering the cognitive distortions and improving the coping skills in at-risk youth (Gillham, Reivich, Jaycox & Seligman, 1995).

Zubrick, Siburn, Gurrn, Teoh, Shepherd, Carlton and Lawrence (1997) state: "Different school contexts are associated with different patterns of problem behaviour in students." "It remains to be seen if the higher rates of problems reported in some school contexts constitute a mental health risk for students attending such schools." Are schools in fact a mental health hazard? In terms of Occupational Safety and Health or Helm's (1996) costs and benefits analysis, it would seem to make more sense to remove the hazard than to try to ameliorate the effects!

Research on the Aussie Optimism program (Quayle, Dziurawiec, Roberts, Kane & Ebsworthy. 2001), which is aimed at young people identified as being at risk of depression, indicates that it has had some success in reducing depression and increasing self-esteem. Quayle, Dziurawiec, Roberts, Kane and Ebsworthy. (2001) studied the short-term effectiveness of an Optimism and Life-skills program, an adapted version of the Penn Depression Prevention Program (Jaycox, Reivich, Gillham & Seligman. 1994) in a universal school-based context, for preventing depression in preadolescents. A randomised, controlled trial was conducted with students about to make their transition to high school in a private girls' school. All seventh grade girls (n=70) attending a private girls school in a high socioeconomic suburb of Perth, Western Australia, were invited to take part in the study. Informed consent to participate was obtained from 47 of the girls and their parents, a response rate of 67%. The girls were aged between 11 and 12

years and were all completing their last year of primary school. Twenty-four students were randomly assigned to the intervention condition, and 23 to the wait-list control condition. The intervention condition comprised two groups of 12 participants. The intervention was targeted at the cognitive and social risk and protective factors for depression, and included active skills training. Self- report questionnaires were used to assess the program's effect on depressive and lonely symptoms, attributional style and self-worth at post-test and six-month follow-up. To fit the conditions of the Western Australian school term the program was adapted to eight, 80-minute weekly sessions (10 hours, 40 minutes). The language was modified to make it more relevant for young Australians.

There were fewer depressive symptoms and more positive self-worth in the intervention group compared to the control group at six-month follow-up. There was no significant difference in depressive symptoms between the groups at post-test, with both intervention and control group students reporting a reduction in depressive symptomatology. The authors suggest possible explanation for the program's lack of immediate impact with latency effects, low-symptomatic groups (floor effects) considered along with a number of methodological limitations such as high attrition, less than optimal attendance, small sample size and limited outcome measures.

Roberts, Kane, Thomson, Bishop and Hart (2003), in a larger scale study of the same project, investigated the effectiveness of a targeted depression prevention program in a randomised controlled trial conducted under normal service delivery conditions in 18 rural schools in Western Australia. The two-phased study, screening and intervention, was conducted to evaluate a prevention program

aimed at reducing depressive and anxious symptoms in rural school children. Fifty-one per cent (n=369) of the available 720, 7th-grade students from 18 rural primary schools consented to participate in the screening phase, and 341 children aged 11–13 years completed the Child Depression Inventory (CDI; Kovacs, 1992). Trained research assistants who were blind to the condition read the CDI aloud to students in class groups. For the intervention phase, participating children in each class were rank ordered using their CDI scores, and 13 children with the highest scores from each class were invited to participate. In classes with 13 or fewer students, all children were invited. Sixty-one per cent (n=208) of children with CDI scores ranging from 1 to 37 (m=11.01, sd=8.30) were invited to participate in the intervention phase. Parental consent was provided for the participation of 194 children (93%). Pairs of schools matched for geographical location, school size, distance from the nearest regional town, and socioeconomic status were randomly assigned to intervention or control conditions prior to pre-intervention. The final sample consisted of 189 children: 90 children (46 girls) in the intervention group and 99 children (48 girls) in the control group. Children with elevated depression were selected. Nine primary schools (n=90) were randomly assigned to receive the program, and 9 control schools (n=99) received their usual health education classes. Children completed questionnaires on depression, anxiety, explanatory style, and social skills. Parents completed the Child Behavior Checklist (Achenbach, 1991). Children and parents completed the pre-intervention assessments halfway through the 7th grade. The child assessments were read aloud to small groups during school time, whereas parents were sent the CBCL and demographic questionnaire to complete and return in prepaid envelopes. Post-intervention assessments were conducted in the same manner at the end of the school year. At the 6-month follow-up in 8th grade,

questionnaires were mailed separately to parents and children. They were instructed to complete the questionnaires independently and mail their responses in separate prepaid envelope.

The results show that intervention effects were found for anxiety, internalising, and externalising problems at post-intervention and that effects for anxiety were maintained at follow-up. The results relating to the primary outcome variable, depressive symptoms, were contrary to predictions with no significant differences between intervention and control groups at post-intervention or follow-up. No intervention effects were found for depression. Intervention group children reported less anxiety than the control group after the program and at 6-month follow-up and more optimistic explanations at post-intervention. Intervention group parents reported fewer child internalizing and externalizing symptoms at post-intervention only. The results contrast with Jaycox, Reivich, Gillham and Seligman (1994), who found reductions in depressive symptoms at post-intervention. Both the Quayle, Dziurawiec, Roberts, Kane and Ebsworthy (2001) and Jaycox, Reivich, Gillham and Seligman (1994) studies found group differences at 6-month follow-up.

Shochet, Dadds, Holland, Whitefield, Harnett, and Osgarby, (2001) evaluated an 11-session, fully manualised, resilience building program (The Resourceful Adolescent Program. Shochet, Holland & Whitefield, 1998), based upon Cognitive Behavioural Therapy principles and interpersonal theories of depression. This universal school-based program was evaluated in a controlled trial using two cohorts, 260 adolescents, of year 9 secondary students from one school. The two cohorts experienced the program in different years to prevent

contamination from the active treatment group to the comparison group. All adolescents were assessed at pre-intervention, post-intervention and eight-month follow-up using a range of measures of depression and hopelessness including the Child Depression Inventory (CDI; Kovacs, 1992), the Reynolds Adolescent Scale (RADS; Reynolds, 1987) and the Beck Hopelessness Scale (BHS; Beck & Steer, 1988). The results indicated that students assessed as being at moderate and high risk for depression reported significant decreases in depressive and hopelessness symptoms compared with the control group, at post-test and eight-month follow-up. An unexplained finding was that intervention effects were found on the BHI and the CDI but not on the RDI. The program also appeared to benefit those who were initially considered 'healthy' This program is particularly important because it was run during school time and designed to fit the constraints of the usual school term and lesson time. The use of only self-report measures of depression was a constraint of the study. Running the program in a single school was another methodological limitation with potential confounding variables from cohort and time effects.

"Resilience is the ability of rebounding or springing back after adversity or hard times. It is the ability to bungy-jump through life. It is as if the person has an elasticised rope around their middle so that when they meet pitfalls in their lives they are able to bounce back out of them" (Fuller, 1999). Young people who are resilient often have stronger connections to school, family and peers, and young people with these links are less likely to develop mental health problems. Enhancing resilience in young people develops their ability to cope with change and challenge. Research indicates that the factors that promote resilience in young

people include family connectedness, peer connectedness and fitting-in at school. (Fuller, McGraw & Goodyear, 1998)

In terms of this Prevention section, the benefits should be twofold. First young people should be less likely to develop the kind of mental health problems that can lead to crisis situations such as suicide. Secondly, when facing a potential crisis, the young person should be able to cope with the challenge more successfully.

Resnick, Bearman, Blum, Bauman, Harris, Jones, Tabor, Beunning, Sieving, Shew, Ireland, Bearinger, and Udry (1997) indicate that the main risks to adolescent health in the Unites States are the health risk behaviours and choices made by the adolescents. Some children who are at high risk for health compromising behaviours successfully negotiate adolescence, avoiding the behaviours that predispose them to negative health outcomes; while others, relatively advantaged in relation to health compromising behaviours, sustain significant morbidity. Caring and connectedness to others, particularly parents and school, were found to be important protective factors that apply across major risk areas. Those who were academically at-risk were at high risk in other ways too. The “full-service school’ is advocated as a means of delivering educational, social and health services for community planning and action to address the needs of distressed young engaging in health compromising behaviour.

A critical and an as yet unanswered question for the whole mental health promotion argument is whether resilience will lead to better outcomes in crisis

situations which, by definition, are those which overwhelm the individual's usual coping mechanisms.

The complexity of evaluating training and intervention at the school level is obviously enormous. In reality, it may never be possible to have research that affirms the effectiveness of any single element of intervention, particularly in an area such as youth suicide prevention.

Preparation

This phase involves planning, training, education and practice.

Eaves (2001) states that traumatic events and subsequent crises within the school setting can have a devastating effect on students, faculty, staff, and parents. Crises compromise the most important mission of the school, learning. It is proposed that school crisis response plans should be a mandatory aspect of effective, educational planning and administration. The potential of a number of factors including how trauma might influence learning, the kinds of crises that may be faced by schools, school liability in crisis prevention and intervention, and advantages of a crisis response plan are explored.

Poland (1997) feels that schools can improve their management of school crisis situations through advance planning and constantly evolving crisis plans Poland stresses the importance of the leadership of school crisis team in addressing areas such as school crisis history, gaining administrative support for planning, and organization of school crisis response.

Disaster sociologists have proposed many disaster classification systems (e.g. Barton 1989). A basic principle of disaster theory is that disasters are defined not in terms of the nature or magnitude of the event or the extent off the resulting damage, but rather according to the degree of social disruption caused. In order to determine the degree of social disruption brought on by a crisis, it is necessary to know something about the pre-crisis state of the community (Britton, 1986). According to this contention, the severity of the effect of a crisis on a school will be significantly affected by its pre-crisis state as well as the nature of the presenting crisis situation. Preparation for crisis management in schools should therefore include a review of the pre-crisis social climate of the school and a consideration of the current level of social stability.

Paton (1992) outlines a comprehensive process in leading to an effective crisis management plan. For schools, this involves:

- Commitment of Administration
- Resistance to plan development being addressed before beginning the planning process
- The plan being developed in a consultative, participative manner to ensure its realism and the commitment to act
- Those individuals and agencies who will be involved in implementation being involved in plan development
- The plan being accompanied by a commitment of resources
- The plan focusing on realistic events
- A risk assessment being undertaken to aid the planning process
- The plan addressing events involving multiple casualties/fatalities

- ❖ The plan and the training program it stimulates focussing on those common key characteristics and common key problems of trauma events and tasks
- ❖ Procedures being adapted from applications used for 'routine' emergencies
- ❖ Organisational leaders being aware of: liability issues, response plans, their role during and after the incident, and, the support resources available
- ❖ The plan should address and define the tasks and responsibilities of all positions and all organisations likely to become involved
- ❖ The plan should identify positions of responsibility rather than people
- ❖ The plan should be based on appropriate expectations of how people are likely to act/react.

Paton (1992) outlines a process that would likely produce a comprehensive plan with ultimately well-trained staff. Intuitively, it makes sense that to manage large-scale crises such as the 11 September 2001 terrorist attacks on the World Trade Centre and the Pentagon, a coordinated response plan is essential. But key questions remain unanswered for those whose work generally involves the smaller scale crises that may impact on schools. For example, in relation to implementation, is it 'better' to have a good plan badly enacted or to have no plan at all with a flexible and sensitive school administration responding on an ad hoc basis? Does having a plan really produce better outcomes?

Crisis management plans for schools are recommended by many writers (e.g., Pitcher & Poland, 1992; Brock, Sandoval & Lewis, 1996; Western Australian Youth Suicide Advisory Committee, 1998; United States Department of Education, 2003) with a high degree of consistency in relation to the recommended components and content. Yet it appears that there has been no

assessment and evaluation of the application or effectiveness of either the individual elements or of crisis plans as a whole. For example, crisis drills are one of the components often cited as an important element of the Preparation phase but some have cautioned that these may create unnecessary anxiety or cause children to be more fearful of a possible crisis (Kramen, Kelley & Howard, 1999; Missouri Department of Elementary and Secondary Education and Department of Public Health, 1999). Tronc (1992) has argued that there is a legal obligation for schools to have Crisis Plans under "Duty of Care" but there is no apparent research base to support their effectiveness or even to confirm that components of any plan, such as crisis drills, do no harm.

Crisis Management Teams are widely advocated (Paton, 1992; Pitcher & Poland, 1992) yet there is no research which indicates whether certain members are more effective than others, for example, whether a school psychologist is more effective than a Deputy Principal, or whether particular combinations of members are more effective than others.

Ganz (1997), focussing on the effects of violence, argues that schools can no longer look solely to outside agencies, social institutions or other resources to deal with emotional and psychological trauma within the school and its community. Ganz contends that discussions and actions should involve the confirmation of the presence of trauma within the school venue; that this trauma is impacted by a variety of influences including culture; and the ambivalence on the part of school staff as to the role of the school in responding to violence.

Brock (2000) describes a case study of efforts to initiate, implement, and continue a school district crisis intervention policy. The change environment and barriers to this school change effort are identified. Policy developer actions and other factors that helped to overcome barriers are discussed. Among the important lessons learned was that a necessary change (such as a crisis intervention policy) will eventually come to be viewed as essential by the school community. Brock concluded that planners should anticipate this and be prepared to respond quickly when the time is right. People are more interested in preparing for potential crises when the there is there is some kind of proximity, whether it be temporal, physical or emotional, to a real event.

Riley and McDaniel (2000) discuss the role of the school psychologists and counsellors in prevention, intervention, and crisis response. They conclude that understanding the role-played should lead to appropriate professional development that will ensure that all professionals involved have the necessary skills at every level of crisis management.

Cornell and Sheras (1998) use case studies to support the assertion that the qualities of leadership, teamwork, and responsibility are essential ingredients of successful crisis management. The qualities of effective teams are described in the Gatekeeper Training Manual, (Western Australian Youth Suicide Advisory Committee, 1998):

- Integration of government/non-government, medical/non-medical representatives
- Clearly identified client group
- Clear, negotiated vision that is shared, valued and attainable

- Written, operational policy with clear statement of aims, objectives and functions of the team so member's responsibilities and accountability are clear
- Negotiated best practice model to be used for intervention
- Team coordinator responsibilities defined by team
- Democratic and collaborative leadership through identified team coordinator
- Non-judgemental communication that identifies problems and generates action strategies
- An expectation of high standards
- Recognition of supervision/training needs for team members and action to achieve these
- Provision of support for team members
- Conflict resolution process in place for team and for issues between team and other agencies
- Provision of support and professional development to assist other community professionals who are involved with the same client group
- Continuity of care, assisted by integration of services.

The Preparation phase of crisis management covers multiple elements. The possible interconnections and co-dependences of these elements, which range from policy to school-based program, remain unclear and largely unexplored. The widely accepted and published strategies for this Preparation phase appear to be largely based on best practice, clinical judgement or personal preference rather than a systematic accumulation of evidence.

Response

Response involves prompt implementation of effective actions and the mobilisation of appropriate resources. The response phase might be considered as having three objectives: developing options based on the information gathered, selecting the appropriate responses and implementing these. Developing options is based on a focussing-in on the problem and a determination of the level of response required. Selecting a response also requires that account be taken of community culture and values and the values of those directly affected by the problem. Although in school-based crisis situations there is often a commonality of values, this should not be assumed as always being the case. Consideration must be given to the people and financial resources required and how the response might serve to reduce the effects of the crisis. Implementing the response requires a clear view of the tasks required to carry it out, staff to see that it happens, timelines to accomplish the tasks and a determination whether there will be any ongoing or follow-up assessment to gauge the effectiveness of the response. The task is to select the responses that seem most likely to be practical, effective and cost-efficient for the crisis within the prevailing context.

Newgass and Schonfeld (2000) note that a school-based crisis intervention team composed predominantly of school-based staff is ideally suited to coordinate crisis prevention activities and to provide intervention services to students at the time of a crisis. Crondstedt (2002) argues for a move from such an internal focus to a community-centred approach. Johnson (2000) considers that while community based crisis response teams offer needed resources to schools impacted by crisis, they are often not asked to help. Johnson cites factors such as unfamiliarity with school organization, culture, and procedures as limiting the

usefulness of community based teams and that key differences in school versus community team precepts, decision-making, and strategic paradigms render team coordination difficult. If representatives of agencies external to the school are involved in the planning process, it is more likely that their services can be accessed at the time of a crisis for the mutual benefit of the students and the community. The absence of any empirical evidence in regard to the most effective composition of school-based crisis teams has been noted earlier.

Klingman (1993) focused on the school-based intervention used by a mental health team to enhance the school as a social support system, so that it may better adjust to the taxing demands of the crisis. The preventive intervention aims to keep stress within manageable limits on the assumption that the crisis will prove less intense and there will be a better chance of adaptive responding by the adults and children involved

Underwood and Dunne-Maxim (2000) note the importance of acknowledging the event when a school community experiences the sudden traumatic death of a student or faculty member. Wraith (1991) outlines a case study where failing to give attention and pushing an event “under the carpet” had serious, long-term, negative effects on a whole community. Pitcher and Poland (1992) found negative effects sustained from childhood through to adulthood when traumatised children were encouraged to go home and forget about an incident. (These findings are described more fully later in this review.)

In their study of critical incident stress in Victorian State Emergency Services volunteers. Werner, Bates, Bell, Murdoch and Robinson (1992) identified six

factors associated with a critical incident that increased the difficulty for workers of coping:

- the involvement of children or young people;
- the worker's first experience with death or multiple deaths;
- the goriness or enormity of the incident;
- being unprepared for the incident;
- the presence of multiple deaths or injuries; and
- an existing association with the victim or their family.

Critical incidents in schools generally involve at least one of these factors, the involvement of children or young people. Incidents involving events such as death, serious illness and abduction within the school population are likely to be particularly stressful for the school and for the professionals supporting individuals and groups within the school.

Eileen (2000) reviews suicide and attempted suicide during adolescence. Regardless of whether the suicide attempt culminates in death or an unsuccessful attempt, the school should be prepared for the impact on the adolescent group and staff. Friends and family members can become the unwilling and vicarious victims of the suicide attempt. A rapid and assertive emergency mental health response to any given suicide or attempt is recommended.

Media coverage of a suicide can be a causal factor in suicide 'contagion' or 'clusters.' (Pirkis & Blood, 2001). According to the American Foundation for Suicide Prevention (2003), after a film or news story on suicide, suicide rates tend to show an increase and there are documented accounts of individuals suiciding shortly after viewing or reading media coverage of a suicide. A well-known

instance of this kind of contagion was investigated to consider a possible association between the broadcast of an episode of the BBC television drama "Casualty" and changes in presentation to general hospitals for deliberate self poisoning including changes in the substances taken. (Hawton, Simkin, Deeks, O'Connor, Keen, Altman, Philo & Bulstrode, 1999). The storyline to the episode included a serious overdose of Paracetamol providing the opportunity to conduct a large scale prospective study of any possible effects on subsequent suicidal behaviour. This study found that portrayal of self-poisoning in a popular television drama was associated with a short-lived increase (17% and 9% in the first and second weeks after the broadcast) in presentation of self-poisoning patients to general hospitals. Choice of substance taken in overdose was also influenced by the broadcast. Two effects may apply. One is the modelling effect where a vulnerable individual identifies with someone, their situation or circumstances and their suicidal behaviour, and imitates the behaviour. This is sometimes called a copycat effect. The second is a normalizing effect where suicidal behaviour is seen as a normal and therefore acceptable response to despair or crisis resulting in a general acceptance of suicide as an option.

Although there has been no specific studies on the effects on young children of fictitious depictions of suicide on television, research in Canada (Mishara, 1999; Normand & Mishara, 1992) indicated that half of children aged from 5 to 7 years reported seeing at least one suicide on television, and all of the older children could report on at least one such incident and usually several deaths by suicide in television programs. These studies found that conversations with older children, television depictions of suicide and the occasional depiction of suicide in films were the primary sources of information on suicide for children of all ages. The

exception to this was among the small number of children who had experienced a death by suicide in their own family.

A number of studies have implicated the media in the emotional distress of children and their families (Pfefferbaum, 1998). Pfefferbaum, Seale, Brandt, Edward, Pfefferbaum, Doughty and Rainwater (2003) examined indirect, interpersonal exposure to the 1995 Oklahoma City bombing. Exposure to broadcast and print media in the aftermath of the explosion were studied in relation to emotional reactions and posttraumatic stress reactions to the coverage in children distant from the explosion. A survey was administered to 88 students in the 6th-grade of the public middle school in a community 100 miles from Oklahoma City 2 years after the bombing. Many children reported indirect interpersonal exposure and most reported bomb-related media exposure. Print media exposure was more strongly associated with enduring posttraumatic stress symptomatology than broadcast exposure. Indirect interpersonal exposure and the interaction of media exposure with emotional reaction to media coverage in the aftermath of the explosion each predicted ongoing posttraumatic stress. Results suggest that children may have lingering reactions to highly publicized terrorist incidents. This kind of research might be more revealing if carried out as a longitudinal study with the initial measurements taken soon after an event and with a systematic attempt to gauge, the degree, the kind (e.g. video footage, spoken commentary, printed word, newspaper pictures etc) of the exposure across different media.

Brent, Bridge, Perper and Cannobbio (1996) followed-up 166 friends of 26 adolescent suicide victims over a three-year period with an unexposed community

control group comparison. Assessment of current and past psychiatric symptomatology using the Schedule for Affective Disorders and Schizophrenia for School-Age Children, Epidemiologic and Present Episode versions (Chambers, Puig-Antich & Hirsch, 1985; Orvaschel, Puig-Antich, Chambers, Tabrizi, Johnson, 1982). Using a semi-structured interview, there were no significant differences found in exposure to life stressors between groups over the follow-up period. Brent, Bridge, Perper and Cannobbio (1996) found that exposure to suicide did not increase risk of suicidal behaviour with similar incidents of attempts in both groups. The exposed group showed a higher rate of any psychiatric disorder ($p<0.0001$), as well as major depression ($p<0.0001$), generalized anxiety disorder ($p=0.04$), and PTSD ($p=0.001$). Those exposed to suicide continued to show high current rates of depression, anxiety and PTSD symptomatology although the differences in the incidence rates of depression and anxiety between exposed and control youths converged after approximately 18 months. The incidence of PTSD was increased both initially and during the last half of follow-up. A question left unanswered is whether these symptoms left to develop over a longer period still would result in suicidal behaviour. Depression is a known high risk factor for suicide. Unfortunately, the social network of the victims was not comprehensively explored, an important factor, as some studies have shown that exposed peers who were not close friends may be at greater risk to imitative suicidal behaviour (e.g., Gould, Forman and Kleinman 1994).

Recovery

The recovery phase involves providing support and counselling services for significant groups and individuals to assist recovery of individuals and communities.

Shneidman (1981) coined the term postvention, in contrast to prevention, to describe the sorts of actions taken after a suicide largely to help survivors such as family, friends, and co-workers. Postvention was seen as a natural extension to the established suicide prevention field partly because there will always be some base level of suicide even when highly effective suicide prevention programs exist and partly because the survivors of a suicide can also be viewed as victims in need of assistance in dealing with their grief and other reactions. Postvention is often used to describe the process put in place following a completed suicide to support the bereaved and those at risk in order to reduce the potential for contagion. There is a trend to use the term in the broader context of crisis management. Komar (1994) examined techniques for postventions to handle adolescent school crises. Komar proposed a two-component structure to an effective postvention: the presence of a pre-existing crisis management team in the school, and the availability of a postvention team that can provide grief counselling and lethality assessment. This proposition of two independent teams contrasts with the more usual single team where counselling and assessment would simple be seen as two of the strategies available as vehicles to recovery.

Underwood and Dunne-Maxim (2000) discuss a postvention model that emphasises the involvement of the entire community in the resolution of grief and other issues after the death of one of its members, rather than delegating the entire responsibility to the school. This model of community involvement would fit with Cronstedt's view that PPRR is an outdated concept (2002).

Shaw, Applegate, Tanner, Perez, Rothe, Campo-Bowen and Lahey (1995) make the distinction between "event trauma" associated with a sudden unexpected event and "process trauma" related to the multitude of secondary adversities associated with the event. Process trauma occurs with the displacement, relocation, property loss, and unemployment that may follow a traumatic event; with the family and social dysfunction evidenced in increased divorce rates, child abuse, disruptive behaviour, and school absenteeism; and with the depletion of resources, the erosion of support, and the emergence of conflict between survivors and responders (Pfefferbaum, 1998).

Perhaps the most often studied risk factor for negative outcomes following disaster events is the severity of the exposure to the event (i.e. extent of life threat, loss, and injury). The literature examining the role of exposure to severe life threat or the death of others is definitive. Regardless of the traumatic stressor, be it war or other combat, physical abuse, sexual assault, or natural disaster, 'dose-response' is a strong predictor of who will likely be most affected. The greater the perceived life threat, and the greater the sensory exposure, i.e. the more an individual sees distressing sights, smells distressing odours, hear distressing sounds, or is physically injured, the more likely posttraumatic stress will manifest (Holloway & Fullerton, 1994; Jones, 1985; Ursano & McCarroll, 1990; Young, Ford, Ruzek, Friedman & Gusman, 1998).

When schools are required to respond to a crisis, the best practice literature generally follows a 'medical model' of screening and referral (Poland & McCormick, 1999). Attention is given to physical and emotional needs. Research in other areas of disaster service delivery suggests that there may be more useful

ways to assist in recovery. Baisden and Quarantelli (1981) completed a three-year comprehensive investigation of studies which involved, interviews, symptom checklists, case studies, longitudinal data collection from both published and unpublished reports on disaster services provided to eight communities. They found that long-lasting emotional problems rarely occurred, that problems in daily living were common and that in a crisis most people did not approach those identified as mental health workers. Baisden and Quarantelli (1981) concluded that a social service delivery model that employs outreach efforts to homes and schools and which assists with problems in daily living was more effective than the medical model.

When a crisis occurs, the emotions experienced are generally very strong and often difficult to resolve. When school personnel and students are involved, the impact of a death or crisis can be significantly debilitating both to the individuals and to normal school routine. A significant question is to the extent schools should accept responsibility for alleviating some of the grief, pain and fears that are often present following such a crisis, and indeed, whether there is sound psychological practice to underpin any intervention.

It has become common to offer support to “process”, to systematically assist those affected in examining their feelings in order to help minimise trauma and begin healing. Processing is generally viewed as not being a complex therapeutic technique but rather a way of talking that facilitates discussion about a crisis by those affected. For children, having this opportunity to talk about what happened in a critical incident can be very important to their recovery. In one incident, a busload of children was kidnapped, transferred to darkened vans and ultimately

shut in a container buried in the desert. After three days, the children managed to dig their way out and escape. The children were told by well-meaning adults to go home and forget about the incident (Sandall, 1986). Five years after this incident, it was found that every one of these children had clinical symptoms of depression, anxiety or fears about the world. Later investigation found that some of these continued to experience problems in their adult lives (Pitcher & Poland, 1992). This is an unusual incident, not simply because of the bizarre nature of the event, but also because of the active suppression of any discussion.

In another incident where discussion was suppressed, Wraith (1991) described involvement several years after an incident in which a number of school children were killed and others were injured, some seriously. At the time of the incident, there was an overriding need for every aspect of the event to be pushed under the carpet. The matter was not spoken of in the small community and the death of the children was given no attention. Wraith was presented with a situation in which the community was divided around management and care of its children. Years on, there were children who were still having nightmares about the incident, who were refusing to travel in buses, who had school refusal dating from the incident. The community was divided, angry and hurting, with a range of detrimental mal-adaptations. These kinds of anecdotal reports can be enlightening but it is clear that there is a need for empirical research that considers the best ways to help children cope with trauma.

Debriefing

In recent years, post-trauma crisis intervention, and particularly the area of Debriefing, has been a contentious area. Debriefing has two principal intentions.

The first is to reduce the psychological distress that is found after traumatic incidents. The second, related intention is to prevent the development of psychiatric disorder, usually posttraumatic stress disorder (PTSD). This debate has polarised into for and against yet even the middle ground is controversial. Internationally, debriefing is now routinely offered following a range of occurrences including to the victims of mass disasters and to individuals involved in traumatic incidents in the workplace. Debriefing is usually offered on a voluntary basis, but there are instances, such as debriefing of bank employees in both the UK and Australia, or in some UK police forces, who are victims of trauma, when it can be compulsory. The assumption of such policies is that debriefing can prevent the onset of PTSD. There are concerns to reduce or remove the threat of litigation concerning the development of PTSD.

Critical Incident Stress Debriefing (CISD) was developed by Mitchell (1983) to meet the requirements of both disaster and general emergency service workers for assistance with emotional and psychological aspects of their support work. Mitchell found that stress in emergency response workers could be greatly reduced by using the Critical Incident Stress Debriefing process. Debriefing involves promoting some form of emotional processing/catharsis or ventilation by encouraging recollection / ventilation / reworking of the traumatic event. Mitchell (1983) operationalised it in seven stages:

1. Introduction (where the rules, process and goals are outlined)
2. The facts (clarification of what the participants, saw, did, heard)
3. Thoughts and impressions (the participants' first thoughts and impressions of the event)
4. Emotional Reactions (exploration of individual's reactions)

5. Normalisation (assessment of physical and psychological reactions)

6. Planning for the future (educating participants about possible stress reactions)

7. Disengagement (information provided for follow-up)

The process is usually undertaken two to three days after the event. What has become apparent is that this process is not always followed when a debriefing intervention is initiated after a critical incident.

From 30 October to 1 November 2001, a workshop was held (in Virginia, United States of America) in which 58 disaster mental health experts from six countries were invited to address the impact of early psychological interventions for victims/survivors of mass violence and disaster to identify both best practice and gaps in knowledge (National Institute for Mental Health [NIMH], 2002). A number of areas of agreement were reached including:

- A sensible working principle in the immediate post-incident phase is to expect normal recovery;
- Presuming clinically significant disorder in the early post-incident phase is inappropriate, except when there is a pre-existing condition;
- Participation of survivors of mass violence in early intervention sessions, whether administered to a group or individually, should be voluntary; and
- The term "debriefing" should be used only to describe operational debriefings. Although operational debriefings can be described as "early interventions," they are done primarily for reasons other than preventing or reducing mental disorders.

In the process of gathering information for the consensus workshop, a literature review was undertaken of early intervention but a lack of well-designed studies led to a broadening of the area considered to early and later interventions for trauma related symptoms from a variety of stressors. Unfortunately, this lack of specificity, particularly in regard to the victim groups and the severity and nature of the incidents, (which included dog-bite, rape, assault, motor vehicle accident, burns, bereavement, non-injured victims of terrorist attack, bank robbery, combat-induced PTSD, earthquake and sexual abuse), the timing and type of interventions, made it difficult to draw other than the broadest of conclusions. A full literature review was not published with the consensus workshop findings; rather, a simple summary table was appended giving basic information, strengths and weaknesses for each study. No clarification was given as to how each conclusion was informed by research or which particular articles considered in the literature review related to particular conclusions. Nevertheless, in considering best practice, it was thought that:

- Early, brief and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents, and children;
- There is no evidence that eye movement desensitization and reprocessing (EMDR) as an early mental health intervention, following mass violence and disasters, is a treatment of choice over other approaches;
- Selected cognitive behavioural approaches may help reduce incidence, duration, and severity of acute stress disorder, post-traumatic stress disorder, and depression in survivors;
- Early interventions in the form of single one-on-one recitals of events and emotions evoked by a traumatic event do not consistently reduce

risks of later post-traumatic stress disorder or related adjustment difficulties; and

- Other practices that may have captured public interest have not been proven effective and some may do harm.

The NIMH workshop participants (2002) recognised that debriefing has become a commonplace term with a range of meaning. Paton (1992) identified four types of debriefing: the on-scene debrief, post-incident defusing, educational debriefing and psychological debriefing. It is psychological debriefing that has gained most interest and which is most often meant when debriefing is cited. Paton (1992) describes psychological debriefing as having the primary goal of management of post-trauma consequences and assessment by human service workers. Secondary goals include: Provision of support from other group members and from those running the psychological debriefing; discussion of the events; complete understanding of the event by all participants; listening to the information from other participants; acknowledging the normalcy of post-trauma consequences; providing information on post-trauma coping skills; contracting for recovery with the peer-support group; assessment by human service workers of all participants and determination of the need for follow-up services; follow-up to observe whether any long-term consequences are evident; and planning for further intervention.

The NIMH consensus workshop also produced guidance on best practice based, current research evidence concluding that there was limited, acceptable evidence to definitively confirm or refute the effectiveness of any early psychological intervention following mass violence or disaster. The caveats described earlier in

relation to conclusions drawn from the literature review apply here also. Although drawing on diverse types of trauma, and apparently making some generalisations from one type of trauma to another, the following consensus conclusions were reached:

- There is some acceptable evidence for the effectiveness of early, brief, and focused psychotherapeutic intervention (provided on an individual or a group basis) for reducing distress in bereaved spouses, parents, and children;
- There is some acceptable evidence that selected cognitive behavioural approaches may help reduce incidence, duration, and severity of Acute Stress Disorder, Post Traumatic Stress Disorder and depression in trauma survivors (e.g., victims of accidents, rape, and crime); and
- There is some acceptable evidence suggesting that early intervention in the form of a single one-on-one recital of events and expression of emotions evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties. Some survivors (e.g., those with high arousal) may be put at heightened risk for adverse outcomes as a result of such early interventions.

Rose, Bisson and Wessely (2003), in an update to their earlier article published as a Cochrane Review (initially published as Wessely, Rose & Bisson, 1999), reviewed a number of studies of psychological debriefing. Using a comprehensive search strategy, 30 studies were initially considered for inclusion in the review. Studies were included if they were randomised or quasi-randomised trials; participants were aged above 16 and exposed to a traumatic event with

intervention within 4 weeks; and, the type of intervention was any brief, single session, psychological intervention that involved some reworking/reliving/recollection of the trauma and the subsequent emotional reactions. Studies were excluded if the crisis intervention service was for psychiatric patients and/or their families; where the debriefing was of research participants; where counselling was used in perinatal grief support/bereavement; where the intervention was for the treatment of PTSD; where the intervention was aimed at an individual; and, where the intervention was aimed at children. Accordingly, 11 studies met the inclusion criteria. The methodological quality of the included studies was considered variable. The reviewed trials were heterogeneous. Only six trials used a similar intervention. In the quantitative findings from the included trials, there was no evidence that psychological debriefing reduced the risk of developing PTSD. Adverse effects were reported in the two trials with the longest follow-up, one involving victims in a Burns Unit and the other involving Road Traffic Accident (RTA) victims at a Hospital Casualty ward. Follow-up at three years for the RTA victims showed that there were significantly worse outcomes for the intervention group when there had been initial high scores on the Impact of Events scale (IES: Horowitz, Wilner & Alvarez, 1979).

Rose, Bisson and Wessely (2003) concluded that although finding that data quality was generally poor, there was no current evidence for psychological debriefing as a useful treatment for prevention of post traumatic stress disorder and that compulsory debriefing of trauma victims should cease. In considering why treatments may have failed, they postulated that; the interventions might be too short; the follow-up might be too short; that the vagaries of randomisation

caused an imbalance in the pre-test groupings; that the timing of the intervention was wrong; and, that a culture change in which people are more aware of the principles underlying debriefing has made it unnecessary.

Rose, Bisson and Wessely (2003) also gave consideration to why some treatments had adverse effects. Debriefing may carry benefits in terms of the management of traumatic incidents rather than mitigating trauma symptoms. There is the possibility of "secondary traumatisation". Debriefing involves intense imaginal exposure to a traumatic incident within a short time of the event. It is possible that in some individuals this serves as a further trauma, exacerbating their symptoms without assisting in emotional processing. Another possible adverse reaction to psychological debriefing could be hypothesised in those with a sense of shame as a reaction to the traumatic event. While there is no direct evidence that shame is implicated in the onset or course of PTSD, there is some evidence that it is of predictive importance (Andrews, Brewin, Rose and Kirk, 2000). Those with a sense of shame might be more likely to experience some exacerbation of distressing symptoms when undertaking a verbal exposure to the event, particularly when the shame and/or the underlying reasons remain undisclosed.

It is also possible that debriefing may pathologise normal reactions and may increase the expectancy of developing psychological symptoms in those who would otherwise not have done so. A very similar argument, drawing heated debate, has been put forward in relation to PTSD (Summerfield, 2001) but that will not be explored within this review. A further problem is that debriefing focuses on the single trauma. Even if all the victims of a disaster were exposed to a uniform event, they are not uniform in other respects. Focusing attention on the

single traumatic event may divert attention away from other important psychosocial factors that differ between victims. The Rose, Bisson and Wessely (2003) meta-analysis had a number of shortcomings. There were relatively few trials included in the study, the range of trauma events varied considerably, all interventions were one-off events, there was no standardised format to the debriefing interventions, the period between the trauma event and the intervention was long, interventions were with individuals as opposed to groups, and there were a wide variety of outcome measures. Mitchell (2003) has questioned the independence of the Rose, Bisson and Wessely (2003) Cochrane Review in that two of its authors were primary investigators in two negative studies contained in the review and thus compromise independence.

Deahl (2003), in a commentary appended to the Cochrane Review, points out that conducting a methodologically rigorous randomised control trial of group debriefing would be extremely difficult given that group trauma generally only occurs in unpredictable and often chaotic circumstances such as war or disaster. Deahl argues that regardless of whether or not debriefing works, many individuals find it helpful. Deahl questions whether it can therefore be ethically justifiable to employ "non-intervention" controls denying individuals short-term support whatever the long-term outcome. Yet ethical considerations can be adequately overcome in the testing of other unproven treatments. Deahl fails to make a case as to why this should be a particular problem when psychological debriefing is subject to scrutiny. Deale does not give consideration to the negative outcomes cited in the Cochrane review, that some of those who experienced debriefing were adversely affected by the interventions. Surely continuing to offer as helpful, a treatment that is apparently noxious would be considered unethical.

Everly and Mitchell (2000) attempted to provide some definitions to the area in reviewing the terms and concepts that underlie the field of crisis intervention. They found that much of the interpretation of the terms and concepts was at odds with the principles, prescriptions and protocols regarding clinical use: the same words were being used to describe different things. Their review found that many crisis intervention practices, including their Critical Incident Stress Debriefing model (CISD), proved to be highly clinically effective yet this conclusion was not based on empirical evidence. They suggested that research should focus on who does psychological debriefing to whom and in what circumstances.

Everly was a participant in the NIMH consensus workshop (2002) and the report includes his dissenting opinion in relation to psychological debriefing. Everly makes the valid point that conclusions regarding its effectiveness must be anchored to an operational definition of the term itself. Everly reiterated the Deahl argument (2003) that in the randomised controlled trials, pre-test groups were not equivalent. Everly also challenged the basis of the Cochrane Review argument (Wessely, Rose & Bisson, 1999; Rose, Bisson and Wessely, 2003) citing a number of grounds wherein the studies included differed from the CISD method, using medical patients as opposed to those physically healthy and in using one-on-one counselling as opposed to the more standard small-group intervention used in CISD yet this argument loses some of its weight as neither evidence nor opinion is offered as to why this might make a difference to the effectiveness of the CISD process. For example, Everly's case would be supported if there were evidence that hearing others' accounts of their experiences and reactions aids in the normalising process for other participants in the group and that this can't happen

in individual debriefing reactions. Everly cites supportive evidence from two studies identified in the consensus workshop's literature review. In the first study, Campbell and Hill (2001) studied the collective trauma of bank employees who had been subjected to robberies. Victims were randomly assigned to either immediate (less than 10 hours) or delayed (up to 48 hours) post-event debriefing. The number and severity of PTSD symptoms did not differ immediately after debriefing but were lower for the immediate group at 2, 4 and 14 days follow-up. This study, which was really evaluating the effects of the timing of the intervention, had a number of flaws, most notably the lack of a comparison treatment group. The second study cited involved soldiers who had been acting as peacekeepers in Bosnia (Deahl, Srinivison, Jones, Thomas, Neblett, & Jolly, 2000) where initial assessment took place prior to intervention after a 6-month tour of duty. The intervention group also received an Operational Stress Training Package. The control group had assessment only. The control and intervention groups differed at assessment with the control group being higher on anxiety and on the Impact of Events Scale (Horowitz, Wilner & Alvarez, 1979). At 1-year, follow-up, the intervention group had lower scores in measures of alcohol abuse and a broad range of psychological problems and symptoms of psychopathology. Again, there were methodological flaws in this study with poorly controlled randomisation, no definition of target symptoms, no measures of use of the training package and lack of a comparison intervention group most notable

Everly also cites Deahl's comments (2003) on the difficulty and ethical constraints of using randomised controlled trials but fails to acknowledge that randomised trials have been conducted although methodological failings persist or that these same ethical constraints do not prevent other sound research into life-

threatening conditions. Finally, Everly makes the important point that evidence-based practice pertaining to mass violence or disasters should reflect research that has direct applicability to these kinds of situations: disasters are not all the same.

Flannery and Everly (2000) reviewed crisis intervention procedures within a Critical Incident Stress Debriefing context. They claim mounting empirical evidence that this approach provided the tools for prevention and effective treatment. They provide few details of the selected studies but concede that randomised experimental designs are still lacking and are needed. Flannery and Everly (2000) indicate that the Cochrane Review (Wessely, Rose & Bisson, 1999; Rose, Bisson & Wessely, 2003) had not reviewed this model in their meta-analysis and further felt that much of the negative findings were based on practices that were not in keeping with the recommended implementation of CISD. Flannery and Everly (2000) cite the Deahl, Srinivison, Jones, Thomas, Neblett, and Jolly (2000) study as the only randomised investigation of the CISD model and claim it as compelling, supportive evidence of the effectiveness of the CISD model of debriefing but give no mention of the previously described methodological shortcomings of this study.

Everly and Mitchell (2000) have proposed a newer model in which CISD is but one stage of an encompassing Critical Incident Stress Management (CISM) model. CISM comprises of seven core elements:

- pre-crisis preparation of both individuals and organisations;
- large-scale demobilisation procedures for use after mass disasters;
- individual crisis counselling;
- small group de-fusing to assist in symptom reduction;

- ❖ CISD, a longer group discussion to help bring about psychological closure
- ❖ family crisis intervention; and
- ❖ follow-up procedures including possible referral for psychological assessment or treatment

Devilly and Cotton (2003) take issue with whether CISD and CISM are in fact different noting that in claiming evidential support for CISM, Everly and Mitchell (2000) cite studies that only evaluate CISD. Devilly and Cotton (2003) further question an apparent attempt at historical revisionism wherein Everly and Mitchell (2000) claim that CISD was never intended by its originator, Mitchell, to be a stand-alone treatment but was always intended to be part of a CISM program. Devilly and Cotton (2003) note that the term CISM did not enter the literature until 1995, 12 years after Mitchell's original formulation of CISD (Mitchell, 1983).

Devilly and Cotton (2003) also offer criticism of a recent review of CISM by Everly, Flannery and Eyler (2002) in which the authors offer a meta-analysis of 8 studies that are claimed to assess interventions consistent with the CISM model. Devilly and Cotton (2003) point out that the review offers no operational definition of the required elements for a process to qualify as CISM. Studies were included if they were viewed as consistent with the CISM formulation. Of particular note is that Mitchell and Everly, the originators of CISD and CISM, authored six of the eight included studies. This is somewhat ironic given that Mitchell (2003) has questioned the independence of the Rose, Bisson and Wessely (2003) Cochrane Review as two of its authors were primary investigators in two negative studies contained in that review. Devilly and Cotton note that of the other

two studies, one was aimed at treating rather than preventing PTSD and that CISM is never explicitly mentioned. The last of the eight studies could not be readily accessed by Devilly and Cotton as, they state, it was a presentation at an International Critical Incident Stress Foundation conference. This same study by Richards (2001) has been published elsewhere however.

Richards (2001) conducted a prospective field trail that compared two post-trauma support systems, CISD versus CISM, with two groups of employee victims of armed robbery in an organisation that initially used CISD as stand-alone for 16 months before moving to an integrated CISM model. The CISM model described by Richards involved: a system of pre-raid training, CISD, and additional individual repeat assessment and advice sessions, one-month post-raid. The model of CISM used differs significantly from the 7-stage model described by Everly and Mitchell (2000) and this would support the Devilly and Cotton's (2003) contention that there was no operational definition of the required elements for a process to qualify as CISM in the Everly, Flannery and Eyler (2002) meta-analysis. The Richards study had 225 participants in the CISD alone intervention and 299 in the CISM intervention with no differences between the groups in age, gender or employee status although the samples were predominantly female, (91% and 88% respectively). Obviously given the size of the groups, the participants had been subjected to different robbery situations. The only clarification of this given is that all participants had been directly confronted by raider(s), no firearms were discharged, there were no physical injuries and none of the incidents involved hostage taking. No information was given in areas such as whether participants experienced single or multiple traumas, single or multiple assailants, whether alone or part of a group, the weapons faced or the perceived

degree of threat. Accordingly, the homogeneity of the groups must be questioned. Morbidity as measured on a range of scales was found to be equivalent at day-3 and one-month follow-up for CISD and CISM groups. Richards (2001) reports significantly less morbidity for the CISM group at 3-month and 12-month follow-up. Richards notes that the study is limited by its non-randomised field trail methodology, the lack of a no-intervention control, the before and after nature of the study (i.e., the consequent possibility that other changes could have been responsible for the effects demonstrated in the study) and the loss of participants, and accordingly data, over time. With the Richards study (2001) also shown to be fundamentally flawed, it is clear that the Everly, Flannery and Eyler (2002) meta-analysis fails to make the case for either CISD or CISM as effective interventions.

Devilly and Cotton (2003) suggest that Depression is of much higher likelihood than post traumatic stress disorder for those who have been through a traumatic event. Creamer, Burgess and McFarlane (2001) in reporting findings from the Australian National Survey of Mental Health and Well-being, give an estimated 12-month PTSD rate of 1.3% in the community with 64% of males and 49% of females having experienced one or more traumatic events. Of those who had experienced any trauma, fewer than 2% of men and 3% of women met criteria for PTSD over the preceding 12 months with lifetime prevalence for the whole community estimated at 7.8%. PTSD is far from a certainty following a trauma. Not only should CISD and CISM be evaluated for effectiveness in preventing PTSD but CISD, CISM and a range of other interventions should be evaluated for their potential effects on other post-trauma symptoms such as anxiety and depression.

An interesting findings replicated in a number of studies on psychological debriefing is that participants typically report high satisfaction ratings following such interventions (eg, Richards, 2001; Mitchell, 2003). It may be that this is an effect on employee morale, a sign of employer support for the victim rather than the intervention having a direct effect on distress or other symptomatology.

A number of alternative interventions such as cognitive behavioural therapy have supportive evidence for post-trauma effectiveness. Citing Devilly (2002), Devilly and Cotton (2003) suggest that early intervention be differentiated from psychological debriefing. Early intervention provides 'restorative treatment' to individuals who request psychological help following a trauma and who have a clinically significant presentation, this being an active attempt to treat present pathology as opposed to purportedly preventative role of CISD or CISM. Intervention for Acute Stress Disorder, which usually manifests within 4 weeks of a trauma and lasts from 2 days to 4 weeks, would be an example of early intervention.

A confounding factor for the debate on psychological debriefing is that this has now become a business. CISD and CISM have almost become a franchise and it seems that many people's livelihoods depend on selling training to receptive organisations. Mitchell (Australian Broadcasting Corporation, 2003) said in a recent interview, "Every time they attack us, guess what happens? We've had the busiest year this year in training people to do this stuff, than we ever have in history." Yet it also appears that Mitchell has lost control of the model and that psychological debriefing has become a generic, operational model. Mitchell further said, "I have gone up against people who have violated the standards,

we've explained what this is repeatedly." It seems clear that those involved in running a business should not be involved in the evaluation of its effectiveness.

The effects of traumatic events are not always bad. People also show a number of positive responses in the aftermath of a crisis. Resilience is probably the most common observation after all disasters. Although many survivors of the 1974 tornado in Xenia, Ohio, experienced psychological distress, the majority described positive outcomes learning that they could handle crises effectively, and felt that they were better off for having met this type of challenge (Quarantelli, 1985). Crisis may also bring a community closer together or reorient an individual to new priorities, goals or values. This concept has been referred to as 'posttraumatic growth' by some authors (eg. Calhoun, 2000), and is similar to the 'benefited response' reported in the war or combat related trauma literature (Ursano, Grieger, & McCarroll, 1996).

Conclusion

Some General Comments

One might well agree with the following: "The research on what works in school-based crisis planning is in its infancy. While a growing body of research and literature is available on crisis management for schools, there is little hard evidence to quantify best practices" (United States Department of Education, 2003). Much of current practice is based on clinical judgement. Clinical judgment is, and will remain, a significant asset in guiding all aspects of the prevention and the management of critical events at school and in the context of the broader community. A number of current practices are being questioned as to

effectiveness and, as yet, are unproven.

For the present, the Prevention/Mitigation, Preparation, Response, Recovery model remains as a key planning-framework yet it is essential that it be viewed as a continuous and flexible planning process and not simply as a set of rigid procedures, a commitment to extensive manuals and a state of permanent 'readiness'. Practitioners in the allied field of risk management have questioned the continued relevance of PPRR model and their arguments appear to have some merit. PPRR is very heavily focussed on physical hazards with actions often revolving around safety audits. The risk management philosophy does not seek to deny the importance of physical hazards but rather sees these as but part of a larger picture that includes social, cultural, economic and psychological factors which can carry not only their own risks but also serve as confounding factors to those identified physical hazards. Risk management also puts a strong emphasis on costs and benefits.

Although there is no supportive evidence for the value or effectiveness of crisis plans in schools, it would seem a wise course for schools to continue such preparations given that the legal view may well be that not having such a plan is a failure of the duty of care owed by schools to students (Tronc, 1992). It might also be prudent for schools to ensure that these plans are flexible and open to change during the course of a crisis.

There are considerable problems in evaluating interventions in relation to youth suicide prevention that relate to the complexity of the issues involved. A key finding from research in youth suicide is that close friends of those who complete

suicide are at heightened risk for depression for up to 18 months after the death. Depression is a known risk factor for suicide. A number of specific programs such as Aussie Optimism (Quayle, Dziurawiec, Roberts, Kane, & Ebsworthy, 2001; Roberts, Kane, Thomson, Bishop & Hart, 2003) and the Resourceful Adolescent Program (Shochet, Holland & Whitefield, 2000) are research-based and have proven efficacy as early interventions for preventing anxiety and depression. With depression also a heightened risk for those who have experienced a trauma, it may be that that programs such as Aussie Optimism and the Resourceful Adolescent Program can be used as effective interventions after a crisis. It is likely that the promotion of Mental Health and social and emotional competence will be given increasing attention in schools.

Debriefing remains an area of intense controversy with studies in this area characterised by a range of methodological shortcomings such as small sample size, absence of randomisation, absence of control group, varying degrees of trauma, low response rates, confounding variables being ignored, sample bias, low response rates, lack of uniformity of intervention and timing variables At this point, there is no empirical support for the use of psychological debriefing or of Critical Incident Stress Debriefing, at either the individual or group levels, as interventions that prevent post traumatic stress disorder. There appears to be no research examining either psychological debriefing or Critical Incident Stress Debriefing involving children. Accordingly, any ‘routine’ use of these with school children or school staffs is contraindicated. In general, very little sound research has been conducted with children after any kind of crisis situation.

Some Implications for Future Research

Although many aspects of crisis management do not readily adapt to randomised, controlled experimentation, there are enormous opportunities to validate current practice by research investigations that use a range of techniques and measures. Schools already collect significant amounts of information that reflect on the social climate: attendance records for staff and school children, reasons for absence due to sickness, examination and assignment results, enrolment and transfer data will all reflect the pre and post-trauma state of the school. There are opportunities that extend beyond the easily collected and readily available data. Schools are in a position to gather information from individuals and groups over an extended period of time. Areas such as social and emotional competence, the inter-relationship with academic success, how adaptive coping eases the impact of the stressful event and protects against the immediate damaging effects of stress or trauma are areas that could be investigated within the school context although establishing reliable measures would be a challenge. There would be significant value in looking at coping behaviour over time as a trauma or stressful incident unfolds, in considering whether post-trauma is an effective time to introduce programs designed to prevent depression and anxiety in children and in considering whether these would be more useful than any interventions aimed at preventing post traumatic stress disorder.

If crisis planning and intervention for schools are to be informed by research, the first step would be for current practices to be subjected to systematic study of efficacy. Again using the commonly advocated PPRR model as a framework,

current practices can be used as a basis for identifying initial research areas and posing questions that may inform action.

Prevention

Youth Suicide Prevention has become a significant area of prevention activity in schools in Australia. In Western Australia, a schools strategy has been in place for over 13 years. Research into the effectiveness of this strategy (and suicide prevention programs in general) is complicated by issues such as a multi-factorial aetiology, ethical constraints and the difficulties of tracking change in what are relatively low numbers of deaths, typically 18 youth suicides per year in Western Australia (Western Australian Youth Suicide Advisory Committee, 1998). With such low numbers, evaluating the effectiveness of any program within a single school would require consideration of other behaviours such as self-harm and depression which are risk factors to suicide. The prevention of suicidal behavior does not lend itself readily to the randomised controlled studies that form the basis of evidence-based research. The ethical dilemma of not providing a service when help is available and the low base rate of suicide both mitigate against such an approach. Comprehensive studies such as that of Zenere and Lazarus (1997) into a wide-ranging school suicide prevention and intervention program appear to be rare. Intervention programs might be considered ‘high risk’ in that they could easily make the situation worse. Accordingly, it would seem advisable to focus research on attempting to reduce accumulated risk factors, those biological, family, community or societal characteristics which have been shown to be associated with suicidal behaviours (Beautrais, 1998) and use knowledge acquired from this as the building blocks for comprehensive prevention and intervention programs.

Preparation

The importance of having crisis management plans and crisis management teams are two of the fundamental tenets widely advocated in the best practice literature. If plans are to be mandated as some have argued, (Tronc, 1992; Eaves, 2001) then it is vital that they can be shown to be effective and lead to better outcomes for those involved. Research into the effectiveness of crisis plans could operate at a number of levels and need not be constrained by the need to wait for a crisis to occur. The judicious use of simulations or drills may be a way to allow some insights if suitable outcome measures can be developed. Simulations and drills might also be evaluated in terms of whether they produce not only a better state of preparedness but better outcomes when a crisis presents. A difficulty is that many schools already have plans in place but this might be overcome by using those who are untrained in the school's procedures to make it possible to compare whether an effective response is more likely when a plan is in place. This would have value as any crisis plan should remain functional when alternate personnel are fulfilling the key roles. Particular combinations of school personnel making-up the crisis team (eg, the Principal, deputy principal, school psychologist), whether particular professional roles are best suited to particular crisis team roles (eg, school psychologist as counsellor or media liaison), whether there are optimal combinations of crisis team roles (eg, family liaison, medical liaison, intervention support) could be evaluated for effectiveness.

Response

When a plan is in place, a key question is whether or to what degree the plan is followed during an actual crisis. A plan should not be a constraint to effective

action but it would seem important to know whether the efforts put into planning are justified by observable benefits when the plan is enacted. Is the plan a help or a hindrance? Are some parts of a plan more useful or successful than others? Following from this, do team members fulfil their roles as designated? How much freedom do individuals have to adapt their roles or make decisions without consultation? Does the team operate effectively and efficiently? Is information shared effectively? Are there tasks that are not allocated or that have been allocated yet are not performed? Most importantly, how can such questions be answered? The debate on psychological debriefing has shown how essential it is to establish that widely accepted practices have a founding in theory and/or systematic research.

There are a number of other practices in relation to crisis response that must be questioned. For example, the model of modern risk management advocated by Crondstedt (2002) emphasises the interaction between the community and the hazard within a particular context. This brings to bear questions on how the community should be involved, not only in planning but also in response. Some writers have advocated reliance on the resources available within the organisation, ie, the school (eg, Caplan, 1964; Newgass and Schonfeld, 2000) while others consider that response is more effective when the community is involved (Johnson, 2000; Crondstedt, 2002). Factors such as unfamiliarity with school organization, culture, and procedures have previously been discussed as having potential for limiting the usefulness of community based teams and that key differences in school versus community team precepts, decision-making, and strategic paradigms render team coordination difficult. While it is easy to foresee the potential for problems when there is an interaction of multiple agencies

unfamiliar with one another's work and organisation, it is possible that these same factors of school versus community team precepts, decision-making, and strategic paradigms might have a positive effect on planning and response processes, bringing new ideas and innovative methods into the school.

Recovery

It is common practice in crisis response to give considerable attention to meeting demands for information either about the crisis or possible reactions. Typically this is done either by telephone or informational handouts (Pitcher & Poland, 1992; Western Australian Youth Suicide Advisory Committee, 1998). While there is a growing body of evidence that documents children's reactions to traumatic events (eg Brent, Bridge, Perper and Cannobbio, 1996; Poland & McCormick, 1999), there is no evidence to support the usefulness of such information when provided after a crisis. Although providing this kind of information may seem to make sense, a number of questions do arise. For example, does this kind of informational handout accurately reflect research findings, is the information age-appropriate, does it promote effective support, intervention or self-care, and perhaps most importantly, is it read by the recipients? Additionally, there has been no research investigating which are the most effective methods of delivering information after a crisis. It may well be that the efforts put into such handouts are a waste of resources that could be better targeted elsewhere.

An area of crisis management in schools that appears to be overlooked in any research relates to school personnel's continuing responsibility to care for large numbers of children or young people during a crisis event. Undoubtedly, school personnel carry an added burden of responsibility during a crisis. It has been noted

earlier in the review that, in the midst of crisis, children are likely to be looking to those adults who usually provide support, guidance, direction and leadership to continue to fulfil these roles. A number of issues arise from these relationships. Are school personnel more vulnerable to ongoing psychological trauma as a consequence of having to care for groups of children during a crisis? Do school personnel neglect their own well being during a crisis while attending to the needs of children? How can school personnel be best prepared to support children in crisis situations? How can the needs of school personnel be met? Although the potential effects of crisis work on school personnel have been acknowledged (Pitcher &Poland, 1992), at present there appear to be few answers to any of these questions from either the best practice or research literature. Although the coping strategies used by emergency and health services personnel involved in crisis situations has been subject to some attention (Dyregrov & Mitchell, 1992), given the very different nature of roles and responsibilities, it is open to question whether strategies such as emotional suppression and distancing could be recommended as either realistic or effective for use by school personnel.

It is common in the best practice literature to suggest that when schools are required to respond to a crisis, a ‘medical model’ of screening and referral be employed (Poland & McCormick, 1999). Baisden and Quarantelli (1981) concluded that a social service delivery model, that employs outreach efforts to homes and schools and which assists with the more frequently found problems in daily living, was more effective than the medical model. As yet, it remains unknown whether such a model would be effective in assisting school staff, students and the broader school community in recovering from disaster by

attending to the broad range of daily living tasks and not those simply associated with teaching and learning.

Given the limited state of research-based knowledge relating to school crises, it is difficult to make any substantive recommendations for actions that can be based on meaningful research. What is clear is that there is a need for broad-ranging research into every facet of the crisis management process as it impacts on schools and the broader school community.

Some Implications for Professional Action

At the present, there is limited knowledge gained from research that informs school-based crisis management. While such a sound research base will likely be established in coming years, professional will have to continue to rely on best practice models. Yet, even meeting what seems a relatively simple standard of best practice can be vastly more complex than it might appear. Practice may often be driven by policy direction from department or school and/or by legislative requirements.

Many education systems and individual schools have chosen to extend the traditional disciplinary role of the school towards areas of policy and strategy that look at violence prevention and creating a safe school environment. In some areas, technological measures such as video cameras or metal detectors may be used in order to fulfil what is almost a policing function. The more traditional approach, which will likely continue to hold relevance for many schools, focuses on activities and programs across the school such as violence prevention curricula, efforts to improve social climate and the promotion of skills development within

the individual. Crisis management can be seen as either an additional component to these policing and prevention strategies or as an overarching approach. This kind of global view might embrace the elements of policing and prevention in the broadest sense together with other traditional crisis management fundamentals such as planning, managing crises as they occur, intervention during critical incidents and recovery strategies.

Policy direction can have major implications for every level of professional action. In some instances, public policy relating to crises in schools has been extended into legislative action. In New York State, a task force was established to investigate and report to the Governor on "a practical plan to address the growing trend of violence and disruptive conduct in our schools and promote a safe learning environment." (New York State Center for Safe Schools, [NYSCSS], 2001). To address issues of school safety and violence prevention, the Safe Schools Against Violence in Education Act (SAVE) was later passed by the New York State Legislature and became law when signed by Governor George E. Pataki on July 24, 2000. (New York State Center for Safe Schools, [NYSCSS], 2001). A task force, established by the governor to investigate and report on practical plans to address the growing trend to violence and disruptive behaviour in schools and to promote a safe learning environment, informed the legislation. Within two weeks of establishing the task force and in the wake of the Columbine High school killings that had occurred just 4 days earlier, the governor proposed a comprehensive school safety law, Project SAVE, encompassing policing, education and crisis management functions (New York [State], Office of the Governor, 1999). Project SAVE which guides the actions of schools in all aspects

of crisis management has a number of fundamental flaws, often ignoring both best practice and available empirical evidence.

Project SAVE legislation provided an outline for the development composition and role of district and building-level safety teams and safety plans (New York [State], Commissioner of Education. 2001). The safety teams mandated are in fact planning committees rather than teams that carry out management, response and intervention tasks. The legislation also prescribes the composition of the teams that carry out management tasks and the development of the district and individual school's crisis plans. The emergency response team includes school personnel, local law enforcement officials and/or representatives from emergency response agencies. Duties of this team are also mandated and include planning and implementing safety components, securing a crime a scene, evacuation of buildings, defining a chain of command and establishing a communication system. Project SAVE mandates another team, the post-incident response team, comprising appropriate school and medical personnel, mental health counsellors and others who can assist the school community in coping. Contrary to established best practice, these statutory teams focus on safety and violence giving only brief attention to other kinds of crisis and the mental health aspects of crisis management. The aftermath of the Columbine shootings may have been instrumental in leading the task force to focus on the more extraordinary kind of event rather than the more 'routine' kind of crisis faced by schools. The New York task force also specifically cited strategies such as debriefing where there is as yet no supportive empirical evidence and crisis drills where, as discussed earlier in the review, there are concerns that these may heighten anxieties in some children.

Project SAVE presents a number of dilemmas for practitioners in New York State in that legislative requirements demand actions that are not in keeping with sound, research-based professional practice. The lesson from this is that practitioners must be mindful of policy and legal requirements wherever they might work and be able to balance these against ethical demands. Ethical professional practice may not be a neat fit with policy or law. But even when legislation doesn't get it right, it still has significant power to add to schools' commitment to prevent and respond to crises.

In the area of policy, a school or organisation's crisis management policy should be updated regularly and should be consistent with developments in research and/or best practice where there is an absence of empirical information. The school may have to look externally for expertise in this field but follow a collaborative approach as advocated earlier in this review.

Following a crisis event, it is important to provide access to immediate practical help and social support. Given the unproven efficacy of much of the support commonly available after a crisis, it is important that participation of those involved is voluntary. As discussed earlier, a social service delivery model that employs outreach efforts to homes and schools and which assists with problems in daily living may be an effective way to provide assistance to students, staff and families. Following particular kinds of trauma events such as fire and flood, aid agencies or government departments may provide some supports. If outreach social support is to be the preferred option for schools, some thought needs to be given in relation to how daily living needs can be both identified and addressed.

Although some daily living needs may be fairly general others may well be situation specific. If children or young people have been involved in a fatal bus accident for example, some needs might revolve around transport issues with just getting to and from school perhaps being a problem. School crisis management teams need to identify what might be helpful and what they can reasonably provide.

Employers have a duty of care to staff in relation to their workplace health and safety. Employee assistance programs may be available to some school staffs. Providing support from appropriately qualified personnel is an important sign of employer support for the victim and may be also be an opportunity to screen or monitor for early signs in those who may go on to develop ASD or PTSD. The findings from debriefing studies that, even when debriefing is shown to be ineffective in the aim of preventing occurrence of PTSD, the participants report high satisfaction ratings with the intervention (Richards, 2001; Mitchell, 2003). Early interventions should focus on social and emotional support rather than clinical intervention and the possible pathologising of normal reactions. Monitoring of those involved should continue for a time to allow for identification of those whose reactions may indicate a need for more help, for example those with symptoms of depression or PTSD. It is important to facilitate access to early psychological intervention for those individuals who report persistent distress or other symptoms.

Provide factual information as it becomes available. People need to know what has happened and what is being done in response. For schools this means that relevant information on an incident should be disseminated via a range of media

(for example, letters to parents, telephone statements, radio or television interviews) to those who need to know. Best practice literature commonly lists typical reactions to trauma and suggested ways to assist those involved (eg, Poland & McCormick, 1999) but as yet the effectiveness of this is unproven. Devilly and Cotton (2003) differentiate between education about possible reactions and the normalising of reactions that are already reported by victims and they suggest that the latter is more appropriate.

Following the implementation of a crisis management plan, it is important to review actions of individuals and the organisation as a whole. The aim of this is to identify areas where improvements can be made to the response. Should individual or organisational failings be identified, the stress under which individuals operate during a crisis should be remembered. Care should be taken to avoid blame and the possibility of compounding post-crisis distress.

An important question for practitioners is whether present-day crises are developing with new and qualitatively different characteristics. In an increasingly complex and connected world, there appears to be a growing concern with the critical dependencies that may be created, as evidenced by the terrorist attacks on the World Trade Center and Pentagon and the consequent impact on air travel, tourism, business and many aspects of the global economy. These terrorist attacks on the USA are also different in that they have no readily identifiable closure. People are left wondering when and where the next attack will come, what form it will take and whether authorities are prepared. Although schools are not generally dealing with crises of such magnitude, crisis management teams in schools are being asked to prepare for a range of new and unpredictable contingencies such as

bioterrorism ((United States Department of Education, 2003) which creates a climate of uncertainty, unpreparedness and feelings of not being in control. With a need for crisis teams to respond to new and different contingencies, it becomes increasingly important to have practice that is informed by research.

Earlier in the review, drills and simulations were discussed (and some reservations noted) as being recommended in the best practice literature and as a possible research avenue. Simulations can take much time and effort to prepare yet readily produce unrealistic responses when the crisis management team is operating under critical observation. It may prove difficult to get commitment from key management personnel to participate although their role would be vital in a real crisis.

It is probably fair to assume that those involved in crisis management in schools are used to making decisions. But how many decision makers have training and experience of making effective decisions while under stress and in unpredictable situations where there may be limited information, time and resources? The psychological preparation of crisis management team members appears as an area that requires attention. The interaction of individuals in such situations where stress, fatigue and even fear can create an emotionally charged atmosphere would likely be a new experience to most school crisis management teams. It may be that expertise from other areas such as Police, Fire and Emergency and the military, where these situations may be more familiar, can help inform training programs for school personnel.

How to best effect training is a critical question for practitioners. Robert and Lajtha (2002) suggest that a change of mindset might be needed to provide the basis for modern crisis management. Robert and Lajtha (2002) feel it is important to move away from the negative perception of crisis management. Robert and Lajtha (2002) are not simply arguing that crisis should be seen as learning opportunities but rather promoting the positive attributes that investment in crisis management training can bring to management flexibility, teamwork, organisational resilience and strategy. Robert and Lajtha (2002) advocate strategies to get the top administrators involved, to reverse their priorities. Perhaps of most interest in the absence of research evidence, Robert and Lajtha (2002) suggest challenging accepted practices and ideas.

A Final Word

Table 1 presents a practice summary based on best practice models and available research evidence. Hopefully, this summary will become outdated in a very short time as research informs practice. It appears that there is a growing interest in crisis management in general and wide support for considering the particular issues that relate to schools. Schools will readily accept the researcher during a crisis situation when the researcher is already part of the school's crisis management team. School psychologists are perfectly positioned to take on such research.

Table 1. Crisis management for schools- a practice summary based on available research and current best practice

Have a Crisis Management Plan involving Prevention/mitigation, Preparation, Response, Recovery or other comprehensive emergency management model. Seek help in crisis planning if these skills are not available in the school.	Best practice.
Prevention/mitigation. Remove or reduce risks. Try to reduce the impact of events when risks can't be entirely removed. Consider realistic events and look beyond the physical hazard to areas such as socio-economic and psychological vulnerabilities.	Best practice.
• Promote positive mental health using a range of Universal, Indicated and Selected programs such the Resourceful Adolescent Program, Aussie Optimism and MindMatters.	Research based.
• Address Youth Suicide and its prevention within the plan, recognising that crises relating to such events require a different kind of response.	Best practice and research based.
Preparation. Consult and involve school and community-based individuals or groups in participative planning. If you plan to call on someone to aid in response, involve them in planning.	Best practice.
• assign roles in the crisis management team based on the school's resources and needs. Consider the qualities needed for an effective team able to function under stress and pressure.	Best practice.
• use drills and practices with caution so as not to raise anxieties while ensuring that any legislative requirements relating to fire and evacuation procedures are fully met.	Best practice.
Response. Implement plans and mobilise resources. Develop options based on the information gathered, select and implement the appropriate responses.	Best practice.
• The crisis management team and other responders may be entirely school-based or may also involve community supports.	Best practice.
• Identify those in need of support. Provide appropriate levels of support and opportunities to talk. Remember to support those in crisis management roles and to take care of yourself.	Best practice.
• Work with the media towards balanced coverage that presents the school's support strategies. Alert the media to guidelines on coverage of suicide so as to avoid contagion and copycat effects.	Best practice and research based.
• Implement appropriate Postvention when suicide is involved.	Research based.

Recovery. Provide support and counselling services for significant groups and individuals.	Best practice.
• Avoid any form of psychological debriefing.	Research based.
• Provide ongoing support and counselling where necessary.	Research based.
• Be aware of children's possible reactions to traumatic events and be cautious in any interventions with children.	Research and best practice.
• Consider implementing programs to prevent depression or other post trauma conditions.	Research based.
Review the effectiveness of the crisis management plan and make any changes.	Best practice.

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Modules 4

Crisis Management Planning: a workshop for schools

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Introduction

In the growing body of literature on Crisis Management in schools, there is frequent mention of the need to develop plans and other management resources before a crisis occurs (eg Rowling, 2003; Dwyer & Jimerson, 2002). If a school is to act upon the fundamental premise that a crisis is not the time to be exploring how to respond effectively, then planning becomes a task of not only putting together procedures but also of investigating what is known about the best ways for schools to take action. The intent behind this document is to assist schools by providing such a knowledge base to support the planning process. Although there is still but limited research on Crisis Management Planning for schools, the evidence base is growing and, where there is an absence of evidence, there is a considerable body of best-practice information that can offer useful guidance (eg, Brock, Lazarus & Jimerson, 2002).

This document is intended as a support to a skills-based training workshop for school staff. It is not intended to be a manual for running the workshop nor as a manual for Crisis Management Planning in schools although it will likely be useful in this regard. There is now a wide range of manuals that address Crisis Management Planning (eg, Department of Education, Virginia, 2002; Department of Education, Tasmania, 2002) yet these typically fail to make any substantive link to either the evolving evidence or the best practice base. Indeed in many facets of such manuals, it appears to be common to present information as fact with no reference to any supporting literature. Within this document, a comprehensive approach will be taken to planning with direct reference to available evidence and best practice literature. While not a manual as such, it is hoped that many elements of the document will give school staff members the

knowledge and skills base for Crisis Management Planning, be of direct assistance in reviewing and implementing processes and may have elements that serve as components within a school's overall Crisis Management Plan.

Aims and Objectives

This workshop aims to develop knowledge and skills in establishing contingency plans for managing traumatic incidents occurring in the context of school activities and in the school community. Some emphasis will be given to meeting student and staff needs at the classroom level. The workshop is based around an evolving scenario of a crisis situation that would be applicable to many schools (see Appendix 1). This document provides support information for use and consideration during the workshop.

On completion of the workshop, participants will be able to:

- Demonstrate an awareness and have an understanding of the research and best-practice bases of crisis management planning in relation to schools;
- Critically evaluate the current status of their school in terms of crisis planning;
- Demonstrate knowledge and skills to facilitate planning;
- Demonstrate an increased awareness of the value of developing an effective plan;
- Participate in the development of a school policy on crisis management planning;

- ❖ Demonstrate an awareness of the need for the involvement of community resources in planning; and
- ❖ Demonstrate knowledge and skills to facilitate and implement effective response in a post-trauma situation.

What is a Crisis?

Events that cause severe emotional and social distress may occur at any time and without warning. Such occurrences have been variously called Traumatic Events, Critical Incidents, Crises, Disasters, Emergencies and a number of combinations of these and other terms. Crisis theorists differentiate crises into developmental and situational categories (Brock, 2002). Developmental crises are associated with movement from one stage of life to another, from childhood to adolescence for example. Situational crises are more unpredictable and have the potential to impact on large numbers of people.

Flannery and Everly (2000), in trying to clarify some of the terms that are often used interchangeably, define a crisis as a response condition where:

- ❖ psychological homeostasis has been disrupted;
- ❖ the individual's usual coping mechanisms have failed to re-establish homeostasis; and,
- ❖ the distress engendered by the crisis has yielded some evidence of functional impairment.

Flannery and Everly (2000) propose that if a crisis is a response, then the stressor event requires a different name and suggest the use of "critical incident", a term that they note is frequently confused with the term crisis. Contrary to the crisis

response, a critical incident may be thought of as any stressor event that has the potential to lead to a crisis response in many individuals. The critical incident is the stimulus that leads to the crisis response. Brock (2002) puts a similar proposition but uses the terms “crisis event” and “crisis state” respectively.

Characteristics of a Crisis

It is an interesting exercise to look at the how different authors characterise a crisis and to consider which elements might be considered as defining or essential.

Raphael (1986) has identified characteristics of a crisis in that they involve:

- rapid time sequences
- an overwhelming of the usual coping responses of individuals and communities
- severe disruption, at least temporarily, to the functioning of individuals and communities; and
- perceptions of threat and helplessness and a turning to others for help.

Brock (2002) cites these characteristics:

- extremely negative;
- uncontrollable;
- depersonalising;
- sudden and unexpected; and,
- potential for large scale impact.

Although providing a listing that is similar in many respects, some additional characteristics are cited by the Department of Education, Victoria (1997). Traumatic events:

- are extremely dangerous or distressing;
- are sudden or unexpected providing no opportunity to prepare for them;
- disrupt a person's sense of control of events around them;
- disrupt a person's beliefs and assumptions about the world, people and work;
- challenge the belief that the world is a fair and equitable place;
- challenge the belief that events can be understood; and,
- include elements of physical or emotional loss or risk.

In spite of the efforts of Flannery and Everly (2000) and Brock (2002), there is as yet no agreement on common terminology or definitions in the field of crisis management nor is there any agreement on what characterises a crisis.

Crises In School

Brock, Sandoval and Lewis (1996, page 14) suggest that for schools, crises are sudden, unexpected events that have an 'emergency quality' and have the potential to impact on the entire school community. Brock (2002) further suggests that for schools, crises are typically situational rather than developmental.

A crisis in school might be considered as any situation faced by staff or students that causes them to experience unusually strong emotional reactions which may have the potential to interfere with their ability to function then or later. Crises

tend to be outside of normal experience and the individual has little by way of guidelines based on past experience about how to deal with the event or the reaction to it.

Children have less experience to draw on than adults and accordingly usually have a more restricted repertoire of coping responses. Sense of control and self-efficacy are reduced. Children will be looking to those adults who usually provide support, guidance, direction and leadership to continue to fulfil these roles. The way that parents and other important adults react in a crisis has a major influence on the way that children react (Doll & Lyon, 1998). If parents are also traumatised or overwhelmed by the events, their children are much more likely to develop long-term symptoms (Norris, Friedman & Watson, 2002)

Problems can arise from a single highly traumatic event or from several less severe but emotionally taxing events spread over time. Exposure to crises can trigger normal, but strong, reactions and responses. These should decrease in duration and intensity over time. Appropriate support may minimise the duration and intensity of such reactions (Norris, Friedman & Watson, 2002). Some individuals may require more support over a longer time than others. This applies to both students and staff. These issues are considered in more detail later.

Schools have a set of unique characteristics that can impact on the development and management of a crisis situation.

- A crisis in school violates expectations - School is safe!
- Staff must continue to care for large numbers of students during any crisis.
- Staff have a ‘duty of care’, a responsibility enshrined in common law.

- There is an expectation of care from students, parents and the community.
- A crisis occurring in the school will likely bring many parents to the scene.
- There is an organisational responsibility to staff and students.

What is Crisis Management Planning?

Crisis Management Planning is a comprehensive approach that aims to reduce risks, mitigate the impact of a critical incident and support recovery. The Prevention, Preparation, Response, Recovery model (PPRR) is widely advocated as a framework from which to formulate a Crisis Management Plan (for example Paton, 1992) and is used in this instance. The PPRR model anticipates crises and outlines a sequential planning and implementation of actions before, during and after an event. The first two levels, Prevention and Preparation, are enacted prior to any crisis. The latter two levels, Response and Recovery, are concerned with post trauma events and the effective implementation of previously established contingency plans. There are other models of crisis management, perhaps the most well known being Critical Incident Stress Management (Mitchell & Everly 1995). A key element of Critical Incident Stress Management, "debriefing", has become the centre of heated controversy as to its effectiveness and this will be considered later.

There have been some criticisms of the PPRR model that are important to recognise before using this model as a basis for Crisis Management Planning in schools. Crondstedt (2002) argues that PPRR sets up artificial barriers between its four elements- Prevention, Preparation, Response and Recovery - and therefore implies a clear delineation between the stages. This may leads to unnecessary

discussion and concentration of effort at categorising actions into one of the four elements rather than evaluating the appropriateness or otherwise of any action. A second criticism from Crondstedt is that regardless of the circumstance, the four categories appear to be given equal weight and carry the implication that there must always be strategies for each of these stages. This forced weighting does not recognise that not all strategies will fit neatly, if at all, under these elements. Third, the elements assume a sequential consideration of the PPRR process and that they must be considered and implemented in the same order all the time. This presumes that the actions are inextricably linked to the emergency cycle and that therefore actions follow the same order. Crondstedt's point is that the most appropriate actions should be selected regardless of order and categorisation. Whitla (1994) argues that in the planning of crisis management procedures for a school, the Preparation phase should be commenced only after a thorough investigation of all the implications for the school of the other phases, Prevention, Response and Recovery. Whitla contends that using the model in this way encourages schools to focus on the ongoing process of planning and not merely on the product, especially not on a product that is simply a list of what should be done and by whom- the process is considered to be as important as the plan. Fourth, in Crondstedt's (2002) argument, the elements appear biased towards action-based procedures whereas there may be softer options involving social dimensions. The PPRR model tends to relate to activity and physical actions, focussing on the hazard rather than the situational vulnerability rather than the interaction between the community and the hazard within the particular context. Such consideration of the potential interactions goes well beyond the physical hazard and includes socio-economic and psychological vulnerability factors such

as income, perceptions, networks, support groups and the like, factors do not easily lend themselves to categorisation within the PPRR framework.

Why have a Crisis Management Plan?

At this time, there is no research evidence that indicates that having a Crisis Management Plan leads to better (or worse) outcomes for the school, students, parents, staff or community. In spite of this, there are a number of significant reasons why schools are advised to have a plan.

- There may be legislative or organisational requirements for the school to have a Crisis Management Plan.
- Not having a Crisis Management Plan for the school may be viewed as a failure of 'duty of care' (Tronc, 1992).
- In spite of the lack of evidence for effectiveness, Crisis Management Plans for schools receive widespread endorsement in the 'best practice' literature. (For example, Poland & McCormick, 1999; United States Dept of Education, 2003.)

The potential benefits include the following.

- A plan allows the school to anticipate potential crises, to take steps to reduce the likelihood of these occurring and to mitigate potential effects.
- The school can take time to plan actions, allocate responsibilities and identify concerns in the absence of those pressures that are typically associated with a crisis.
- A plan allows for a consistent set of responses regardless of which staff members take responsibility for implementation.

- The plan can give those managing the crisis some authority to take actions when it is not possible to consult with the school's Principal or designate.
- The plan provides a clear indication to the school community of the level of commitment of the school to managing crises situations.
- Everyone is agreed on the common goal of helping students, staff and families
- The school maintains an appropriate degree of control throughout the crisis.
- The needs of everyone and every group within the school community are considered.
- A rapid, cohesive and coordinated response occurs.
- The broader school community acknowledges and approves assistance.
- The school recognises and expresses appropriate concern and provides appropriate support.

The Planning Process

There are a number of key factors that underpin the planning process (Paton, 1992). Although some may seem self-evident, failing to give attention to these can seriously undermine the ultimate effectiveness of the Crisis Management Plan. The undernoted list is adapted to school factors from Paton's (1992) inventory of general organisational factors.

- Commitment of the School Administration and the Educational Organisation is vital.
- Resistance to plan development should be addressed before beginning the planning process.

- ❖ The plan should be developed in a consultative, participative manner to ensure its realism and the commitment to act.
- ❖ Those individuals and agencies who will be involved in implementation should be involved in plan development.
- ❖ The plan should be accompanied by a commitment of resources.
- ❖ The plan should focus on realistic events.
- ❖ Give attention to situations where outside agencies or emergency services will have responsibility for management of the crisis site. Learn the roles and responsibilities these agencies will assume and how they will interact with school staff and how information will be conveyed to the community.
- ❖ The plan should consider the diverse needs of children and staff.
- ❖ A comprehensive risk assessment can aid the planning process.
- ❖ The plan should focus on events involving multiple casualties/fatalities.
- ❖ The plan and the training program it stimulates should focus on those common key characteristics and common key problems of trauma events and tasks.
- ❖ Procedures should be adapted from applications used for 'routine' emergencies.
- ❖ Organisational leaders should be aware of:
    - liability issues;
    - the need to keep comprehensive records;
    - their own role(s) during and after the incident; and
    - the management requirements for the support personnel and resources available.
- ❖ The plan should address and define the tasks and responsibilities of all positions and all organisations likely to become involved.

- There should be agreement between the school and any external individual or organisation likely to become involved on the roles to be played and tasks to be undertaken.
- The plan should identify positions of responsibility or roles within the Crisis Management Team rather than people.
- The plan should be based on appropriate and realistic expectations of how people are likely to act or react in a crisis situation.

The Prevention/Mitigation and Preparation Phases.

These first two steps typically only occur before (rather than during) a crisis. Mitigation is sometimes used alongside Prevention (eg, United States Department of Education, 2003) and some authors refer to Mitigation rather than Prevention (eg, Tierney, 1989; McManus, 2003). In spite of having clearly different meanings, Prevention and/or Mitigation can appear to involve essentially the same actions and processes. The use of the term Mitigation may serve to convey an additional focus on reducing any potential impact from a crisis when it is accepted that risk cannot be entirely removed. In some situations, Mitigation may also be seen as a subset of the Response and Recovery action phases where the usage conveys the possibility of reducing the effects of a trauma on individuals, groups or communities. Whitla (1994) argues the Preparation phase should be commenced only after a thorough investigation of all the implications for the school of the other phases, Prevention, Response and Recovery.

Step one: Prevention and Mitigation

This involves taking steps to reduce or eliminate sources of risk. The use of the term Mitigation, either instead of or in conjunction with Prevention, serves to convey an additional focus on reducing any potential impact from a crisis when it is accepted that risk either cannot be entirely removed or where the costs outweigh the potential gains. Hazards created by natural events and by humans/technology should be addressed. Brock (2002) classifies crisis events as follows:

- Severe illness and injury (eg, life-threatening illness, road traffic accidents, suicide attempts, assaults)
- Violent and/or unexpected deaths (eg, fatal illness or accident, murder, suicide)
- Threatened death and/or injury (eg, robbery, mugging, rape, child and spouse abuse, kidnap)
- Acts of war (eg, invasion, terrorism, hijacking, hostage-taking)
- Natural disasters (eg, Flood, fire hurricane, cyclone, avalanche, earthquake)
- Man-made/industrial disasters (eg, aeroplane crash, nuclear accident, exposure to toxic agents, industrial accident).

Many kinds of risks and hazards are obvious and predictable regardless of the setting. Reducing or eliminating sources of risk may involve very simple actions such as ensuring that the school bus is regularly serviced or assigning staff on playground duty to areas where students may be vulnerable to assault or abduction. More involved actions might be in areas such as reviewing the school's use of particular forms of energy for heating or cooking, the servicing history of

appliances and equipment, the handling and storage requirements of chemicals, and whether proximity to dangerous industry is a factor. Consideration should be given to the costs and benefits involved in addressing any potential hazard in order to prioritise proposed actions. A hazard assessment will identify those common characteristics of potential dangers that will serve as a basis for planning. The organisational focus should be in attempting to minimise risk and ensuring that the school is as well prepared as possible for any eventualities.

Promote resilience and other aspects of positive mental health

Schools are being encouraged to promote positive mental health (World Health Organisation, 1994; Commonwealth of Australia, 1996). Australian programs such as MindMatters (Curriculum Corporation, 2000), the Resourceful Adolescent Program (Shochet, Holland, & Whitefield, 1998) and Aussie Optimism (Roberts, Kane, Thomson, Bishop, & Hart, 2003) are research-based and target positive mental health at different levels of the school population. Findings from this and other research indicate that schools can have a significant impact in promoting resilience and mental health and thus limit the onset, severity and duration of at-risk behaviours in children and adolescents.

Young people who are resilient often have stronger connections to school, family and peers, and young people with these links are less likely to develop mental health problems. Research indicates that the factors that promote resilience in young people include family connectedness, peer connectedness and fitting-in at school (Fuller, McGraw & Goodyear, 1998). Enhancing resilience in young people develops their ability to cope with challenge and change. The benefits should be twofold with young people less likely to develop the kind of mental

health problems that can lead to crisis situations and, when facing a potential crisis, the young person should be able to cope with the challenge more successfully. Caring and connectedness to others, particularly parents and school, have been found to be important protective factors that apply across major risk areas. The "full-service school' has been advocated as a means of delivering educational, social and health services for community planning and action to address the needs of distressed young engaging in health compromising behaviour (Resnick, Bearman, Blum, Bauman, Harris, Jones, Tabor, Beunning, Sieving, Shew, Ireland, Bearinger, & Udry, 1997).

An interesting finding from research into crisis situations is that resilience and coping are often enhanced in those who experience a crisis. Successfully coming through a crisis can be strengthening for both individuals and communities. Disaster can bring a community closer together (Centre for Mental Health and NSW Institute of Psychiatry, 2000).

The School Climate

A basic principle of disaster theory is that disasters are defined not in terms of the nature or magnitude of the event or the extent of the resulting damage, but according to the degree of social disruption caused (Barton, 1989). In order to determine the degree of social disruption brought on by a crisis, it is necessary to know something about the pre-crisis state of the community. According to this contention, the severity of the effect of a crisis on a school will be significantly affected by its pre-crisis state as well as the nature of the presenting crisis situation. Preparation for crisis management in schools should therefore include a

review of the pre-crisis social climate of the school and a consideration of the current level of social stability.

Another aspect of the school climate concerns safety. In an educational setting where there is a climate of safety, adults and students respect each other. Students having a positive connection to at least one adult in the school promote this climate. In such a climate, students can develop the capacity to talk and openly share their concerns. They try to help friends and fellow students who are in distress, bringing serious concerns to the attention of adults. Problems can be raised and addressed before they become serious.

Fein, Vossekuil, Pollack, Borum, Modzeleski & Reddy, (2002) identify the major components and tasks for creating a safe school climate. These include:

- assessment of the school's emotional climate;
- emphasis on the importance of listening in schools;
- adoption of a strong, but caring stance against the code of silence;
- prevention of, and intervention in, bullying;
- involvement of all members of the school community in planning, creating, and sustaining a school culture of safety and respect;
- development of trusting relationships between each student and at least one adult at school; and
- creation of mechanisms for developing and sustaining safe school climates.

Link with agencies

It is important to know of plans that are already in place in the community to address potential hazards, for example, fire, flood or chemical spill. Contact with

local emergency services may be helpful in both this regard and in gaining an understanding of their role in crises that may affect the school. Linking with other support agencies is particularly important if the school intends to call on any external services in a typical response to a crisis. For example, if school psychologists are likely to be brought in to assist in the school's management of a crisis then a representative from that service should be involved throughout the planning process. Roles and responsibilities should be clarified and agreed before the plan is prepared.

Checklist for Prevention and Mitigation

The aims are to take steps to reduce or eliminate sources of risk and whenever possible to reduce the impact of a potential event. Take a broad perspective in considering risks. The checklist is not all-inclusive but considers a number of key elements, not specific hazards. Some elements of this checklist are adapted from that of the United States Department of Education, (2003).

- ❖ Make contact and collaborate with community emergency services to identify local hazards.
- ❖ Review the last safety or risk management audit or initiate a new assessment to examine school buildings, grounds, vehicles and other resources.
- ❖ Identify natural and human or technological hazards but retain the focus on realistic events.
- ❖ Consider off-site excursions and other activities that may pose risks.
- ❖ Identify whether there are risks that are particular to staff or to students.
- ❖ Are there procedures in place to manage visitors in the school during an evacuation, lock-down or other crisis event?

- ❖ Determine who is or will have ongoing responsibility for overseeing behaviour management and safety strategies in school.
- ❖ Encourage staff to provide input and feedback into the crisis planning process.
- ❖ Consider the impact of legislative or organisational requirements to the school's planning process.
- ❖ Review the information gathered from any previous incidents.
- ❖ Determine the major problems in school and the community
- ❖ Consider whether there are potential problems in regard to student aggression and violence.
- ❖ Determine whether there are problems or situational vulnerabilities in the community that might impact on the school and assess how the school addresses these (eg. socio-economic and psychological vulnerability factors such as income, employment, housing, drug use, community perceptions, networks, support groups).
- ❖ Conduct an assessment to determine how these problems and any others may impact on the school's vulnerability to certain crises.

Step two: Preparation

This involves planning, training, education and response drills or simulations when appropriate. The aim should be to have a plan that is flexible and readily adapted to a range of crises situations. It is important to ensure that any plan is not rigid or locked-in to only those potential crises that the school has anticipated. Paton (1992) notes that effective plans may provide benefits to the organisation. For schools, these would be factors such as:

- The development of a policy statement (see Appendix 2);
- A tangible illustration that the school is concerned about the well-being of students and staff;
- More effective response to crisis situations including an earlier return to normal activities;
- A reduction in the severity and duration of post-trauma problems;
- Enhanced commitment and staff morale; and
- The development of a supportive organisational climate.

The Crisis Management Team

Crisis Management Teams are widely advocated in the literature (eg, Paton, 1992; Pitcher & Poland, 1992). As yet, there is no research that indicates whether certain team members are more effective than others, for example, whether a School Psychologist is more effective than a Deputy Principal, or whether particular combinations of team members are more effective than others. Although there is considerable variation between schools and between individuals who occupy the same job in different schools, it is possible to outline the kinds of tasks that personnel may carry out in response to a crisis. It is important in planning that tasks are designated to roles in the Crisis Management Team, not to individuals. This permits the plan and the team to continue to be effective should an individual team member be unavailable.

The size of the school's Crisis Management Team will depend on the size of the school, the availability of human resources, the delegated roles and the likelihood of particular events impacting on the school. The Team could include the

Principal, one or two Deputy or Assistant Principals, the School Psychologist or counsellor, a class teacher and the school priest or chaplain. Others who might be involved are the school nurse, social worker, the caretaker or grounds person and administrative support personnel. Some smaller schools may include community members as part of the team.

If outside agencies are to be involved in crisis response, then their input should be sought at the planning stage. It is open to the school to decide whether a representative from the external agency should also be on the Crisis Management Team. There is no consensus in the best practice literature on whether external individuals or agencies should be involved in either the school's Crisis Management Team or in any response role.

Administrators

Administrators have a major role to play. Their leadership roles are demanding and multi-dimensional involving information gathering, dissemination, liaison with school-based and community personnel, provision of support in response to the needs of students, staff and parents.

Principal

The Principal will usually fulfil the role of Team Leader. Tasks generally associated with this role include over-seeing information dissemination to staff, visiting bereaved families, all media contact, task delegation and the requests for involvement of outside agencies.

Other Team Members

In planning, a major component of the work of the Team will be in assigning roles and the associated tasks. Checklists of tasks that must be considered can be helpful in this. A number of tasks may not appear on such checklists and planning must lead into role definition with respect to these. In planning for example, a decision must be made on whether draft information and handouts should be prepared for parents on how to help their children after a particular event. Dependent on this decision, tasks might be either to prepare or to adapt handouts so that they will reflect the incident. Some elements of role definition will be relatively easy and will reflect the particular expertise of the team member.

Teachers

The classroom teacher has a vital role to play outside of the Management Team. Key tasks include providing information and support to students, identifying those who may need more assistance and those who may be at risk. It may be that teachers are also included in the team as a matter of course. There might be certain circumstances in which a teacher will be co-opted onto the Team. Be alert for situations where it would place an unacceptably high level of stress on a teacher to be part of the Crisis Management Team for example, when a student from that teacher's class had been killed in the incident.

Other Personnel

Do not overlook the role that non-teaching personnel can have in assisting towards a positive outcome in post-crisis circumstance. Their support roles will likely include parent and student contact, telephone enquiries, ancillary

coordination to ensure the continued routine functioning of the school and as a general, sympathetic listener.

Possible Roles in a School Crisis Management Team and the associated tasks

Some of these roles and the associated tasks will be relevant to every crisis and some will only apply in particular situations. It may be that one individual will fill multiple roles. Roles should be filled and tasks allocated only when necessary to effectively manage the presenting crisis. Some of these roles and tasks have been adapted from Poland and McCormick (1999).

Team Leader -usually, the Principal.

- Initial verification of the facts.
- Enactment of the Crisis Management Plan and summoning of the Crisis Management Team.
- Delegation of any incident-specific tasks to team members.
- Approval and authorisation of information dissemination.
- Record keeping.
- Organisational communication.
- Requests to external agencies for assistance.
- Visiting any bereaved families.
- Being available and visible to the school community.

Communication- A Deputy or Assistant Principal, a public relations or media officer.

- Preparation and update of a ‘fact sheet’.

- Preparation of factual information sheets for staff, students, families, the media and other callers to the school.
- Management of media enquiries and information updates. The Principal may also be required to talk with the media.

Security - A Deputy or Assistant Principal with caretaker or grounds person.

- Control access to school grounds.
- Secure a possible crime site and any evidence until the police arrive.
- Monitor sign in/sign out of visitors to the school.
- Monitor check-out arrangements for parents removing children from school.
- Authorise identification for external support personnel.

Parent/Family/Community Liaison- A Deputy or Assistant Principal, a teacher.

- Telephone contact to parents or family of those immediately involved.
- Advise parents of any known injuries.
- Arrange area for parents coming to the school.
- Plan and arrange any meetings with parents on individual and group basis. (As this may be a difficult and sensitive task, it may be in conjunction with Principal and Counselling support staff.)

Medical - A Deputy or Assistant Principal, school nurse or a teacher.

- Provide and direct first aid efforts- endeavour to save life.
- Record details of injury to those involved and where they are taken. Convey this information to Parent/Family/Community Liaison.
- Support medical personnel called to incident.
- Accompany injured to hospital if incident on school site.

- If possible, attend hospital or medical facility if incident is off school site.
- If attending the hospital, maintain liaison with Crisis Management Team.

Counselling - School Psychologist, counsellor or social worker

- Provide support to students, staff and families.
- Provide specialist advice to the Principal and other members of the Crisis Management Team.
- Provide specialist information documents for teachers and parents on the effects of crisis situations and supporting children after a crisis.
- Manage external agencies providing counselling support.
- Manage records of who has been seen by whom and follow-up where necessary.
- Monitor the stresses on the Crisis Management Team and other staff involved in the school's response.

Staff Welfare- Deputy or Assistant Principal, School Psychologist

- Identify staff who may be particularly affected by the event.
- Identify staff who may need support in giving news to students.
- Allocation of support personnel and other resources to staff.
- Monitor staff closely involved in the incident.
- Monitor the welfare of the Crisis Management Team.
- Ensure follow-up and appropriate support to all staff.

Other Helpers

When a crisis becomes public, there may well be a range of individuals or groups who offer assistance to the school. Some of these may be genuinely helpful,

others may well not be. A degree of caution is needed before accepting any outside help so that there can be some assurance of real benefit to the school. Be aware of any legislative of organisational requirements relating to who may provide services in schools, for example, a police clearance may be needed by some organisations.

Training

Training is an important element that is easily overlooked. Time and resources should be allocated to ensure that all staff in the school have a copy of the school's crisis management plan, a clear understanding of what may occur and what may be expected at the individual level.

Crisis drills and simulations are commonly cited in the best practice literature (eg, Brock, Sandoval & Lewis, 1996) as ways of ensuring that procedures are in place and that the school can implement these effectively. This can be beneficial in testing how the general nature of the school's Crisis Management Plan meets the specific requirements of a particular situation. The simulation can indicate whether the Plan is sufficiently flexible or too rigid, whether there is enough direction or too little, whether there is enough freedom for individuals to act or whether too much is referred upwards for decision. Caution should be exercised with drills or simulations as it has been suggested that these may heighten student anxieties and perception of threat (Kramen, Kelley & Howard, 1999).

Schools should ensure that all legislative or organisational requirements are met in relation to drills. Fire drills and building evacuations, for example, are often required by law.

Checklist for Preparedness

To aid in establishing the Crisis Management Plan and enhancing the school's state of effective preparedness, consider the items on the following checklist. (Some elements of this checklist are adapted from that of the United States Department of Education, 2003).

- ❖ Determine what crisis or other emergency plans already exist in the school, district and community and review how the school's crisis planning fits in with these.
- ❖ Identify all stakeholders involved in crisis planning and response.
- ❖ Involve those who may be part of your school response in order to ensure a common understanding of responsibilities.
- ❖ Develop a process for documenting actions and information flow during a crisis.
- ❖ Develop procedures for communicating with staff, students, families, emergency services and the media both during and outside of the school's normal hours.
- ❖ Develop communication procedures for when normal communication capability is disrupted.
- ❖ Develop draft documentation appropriate to some of the identified risks for the school.
- ❖ Establish procedures to account for students, staff and any visitors to the school during a crisis.

- ❖ Gather information about the school facility such as maps and the location of fire hydrants and electricity and gas shut-off points.
- ❖ Identify the necessary equipment that needs to be assembled to assist staff in a crisis.
- ❖ Identify the human resources that can be called upon to fulfil roles in the crisis management team or who may be called on to support the school.
- ❖ Ensure all staff and students know which staff members are qualified in first aid. Remember that students may also hold first aid qualifications and be prepared to assist in a crisis. (Students should not be asked to assist if there is any element of risk, danger or if distressed by the event.)
- ❖ Ensure all staff and students know where to access safety and first aid equipment.
- ❖ Identify areas or rooms within the school for Crisis actions, eg. for counselling, for parents to gather etc.
- ❖ Identify alternate facilities should the crisis mean that school is not available.

The Response and Recovery Phases

Prevention/Mitigation and Preparation typically occur before any crisis develops and are purely planning phases. Response and Recovery are not only planning phases but also might be considered as the action phases that occur during and after any crisis. Earlier, reference was made to Crondstedt's (2002) view that PPRR is shackled by its linear nature and an apparent need to have actions equally distributed in all categories. Accordingly, it is important to note that there can be considerable overlap between the Response and Recovery phases. A strong case

might be made that Recovery effectively begins from the first moments of Response (see, for example, Department of Education, Employment and Training, State of Victoria, 1997.)

Step three: Response

This involves the prompt implementation of effective actions and the mobilisation of effective resources. The aim is to have an organised and rapid response that lessens the psychological and social impact such as to aid recovery. It looks to individual and system levels. The response phase might be viewed as having three objectives: developing options based on the information gathered, selecting the appropriate responses and implementing these.

Developing options is based on a focussing-in on the problem and a determination of the level of response required. Selecting a response also requires that account be taken of the culture and values of the community and the values of those directly affected by the problem. Although in school-based crisis situations there is often a commonality of values, this should not be assumed as always being the case. Consideration must be given to the people and other resources required and how the response might operate to reduce the effects of the crisis. Implementing the response requires a clear view of the tasks required to carry it out, the human and other resources to see that it happens, timelines for implementing each action and decision-making on whether there will be any ongoing or follow-up assessment to gauge the effectiveness of the response. The aim is to select the actions that seem most likely to be practical, effective and cost-efficient for the crisis. Response should involve immediate through to long term commitments

where there may be overlap with the Recovery phase. Issues to consider include the level of response required for the particular incident, the need for involvement of outside agencies and the likely level of disruption to normal school routine.

Part of implementing the plan involves Crisis Management Team members fulfilling the roles and responsibilities outlined earlier in this document. This will not be re-iterated here.

People Who May Be Affected By Crisis

Although used as a shorthand throughout this document, avoid describing those affected by the crisis as victims. While this may appear common, it carries negative connotations that may serve to perpetuate feelings of helplessness and have adverse outcomes, such as preventing those affected from seeking help. Levels shown below do not necessarily reflect the severity of the event's impact on the individual. This mapping shows the ripple effects from a crisis and illustrates how a seemingly localised event can reach out into the community. (Adapted from Centre for Mental Health and NSW Institute of Psychiatry, 2000).

Level 1 Direct Exposure

Those who suffer the full intensity of trauma including injuries eg, students, teachers

Level 2 Family/Personal

Those who are grieving for the dead, injured and affected eg, families, teachers, girlfriend/boyfriend

Level 3 Occupational

Those who become involved by virtue of their job or expertise eg, administration and office staff, first-aiders, psychologists emergency services personnel

Level 4 School Community

Those in the school community affected but not directly involved eg. other teachers, students, parents who share the loss and grief

Level 5 Community

Others in the general community affected but not directly involved eg. those with unresolved trauma or grief experience for whom stress is a trigger

Level 6 People Indirectly Involved

Those who could have been direct victims but for circumstance or who are in some way indirectly or vicariously involved

Task Checklists

This set of checklists is intended as a guide. Although fairly comprehensive, it is not all-inclusive and it is not a chronology of what to do and when. Checklists should be adapted to take account of the school's particular situation and resources. Published checklists tend to be more limited than those provided below but can be found in many resource manuals (eg, Western Australian Youth Suicide Advisory Committee,1998; Department of Education, Employment and Training, State of Victoria, 1997). The checklist should be revisited regularly during a crisis. Some actions may occur multiple times and at different stages.

Some tasks are listed in more than one of the checklists. Actions should be associated with particular roles within the Crisis Management Team.

Task Checklist- Immediate to within first 24 hours

- ❖ Gather and confirm information (see Appendix 3).
- ❖ Is there a need for immediate contact to the police or emergency services?
- ❖ Is the school or crisis site safe? Is an evacuation or a lock-down required?
- ❖ Endeavour to save life. Provide first aid to the injured without putting anyone at increased risk.
- ❖ Decide on the level of response required.
- ❖ Call together the school Crisis Management Team.
- ❖ Enact the school Crisis Management Plan.
- ❖ Will the school or an external agency (eg, police or fire service) be managing the crisis site?
- ❖ Liaise with police and other emergency service to confirm information and establish the 'what' and 'when' of information the school may release.
- ❖ Has contact been made with families of those involved? Arrange to visit or meet as soon as possible particularly with those who are bereaved. Remember this may involve families of both staff and students.
- ❖ Prepare or adapt information release for groups in the school community.
- ❖ Inform staff.
- ❖ Support distressed staff.
- ❖ Decide on means of information transfer to students.
- ❖ Give staff guidelines on the role they can play with students.
- ❖ Can a telephone line be kept free for essential calls? Are mobile telephones available?

- Do staff members at an off-site crisis have mobile telephones?
- How will the school handle enquiries?
- Do front desk staff have an accurate written statement to use for incoming calls?
- Who will deal with media enquiries?
- Start keeping a written record of events
- Provide support facilities for distressed students. Who will deal with most affected students?
- Do outside agencies and/or organisational administrators need to be contacted?
- Establish a support centre within the school and ensure it is staffed at all times.
- Prepare for any parents who may arrive at the school.
- Have an area available to parents. Make a staff member available to provide support and information.
- Prepare checkout arrangements for parents who wish to take a child home.
- Are there siblings? In this school or other schools?
- Do other schools need to be informed?
- Is parental or next-of-kin permission required for some kinds of information release?
- Do the most critically involved school helping personnel have support?
- Have arrangements been made to sustain staff providing support off campus, eg those attending hospital with students
- Have arrangements been made for staff members who may want to stay after normal school hours?

- ❖ Are Crisis Management Team members maintaining regular contact/meetings?
- ❖ Who will attend to victims' desks and personal belongings?
- ❖ Who will attend the funeral?
- ❖ Will the school hold its own memorial service or create a memorial to victims?
- ❖ Remember that there may be deaths subsequent to the initial fatalities
- ❖ Has some follow-up been considered for the most critically involved school helping personnel?
- ❖ What follow-up is planned for the next day?
- ❖ Arrange relief teaching.
- ❖ Arrange that the Crisis Management Team meet at the end of the day.
- ❖ Clarify the expectations on and of staff who are still actively involved at the end of the day, eg at the hospital.
- ❖ Arrange how overnight developments will be monitored and managed.

Task Checklist- Medium Term

- ❖ Who will attend to victims' desks and personal belongings?
- ❖ Who will attend the funeral?
- ❖ Will the school hold its own memorial service or create a memorial to victims?
- ❖ Remember that there may be deaths subsequent to the initial fatalities.
- ❖ Does the school need a continuing presence at the hospital or off-campus crisis site?
- ❖ What level of support has been considered for the most critically involved school helping personnel?

- What follow-up is planned for the next week?
- Continue to monitor reactions within the school community and provide support.
- Return school as far as possible to regular routine.
- Consider whether particular events have to be cancelled or postponed (eg, graduation ceremonies, school ball).
- Consider whether there is a need and expectation of other actions (eg, mass or other religious ceremony, flowers at the site of a fatality, condolence notice in the newspaper).
- Update staff and students with new information.
- Consider giving advice to staff, students and parents on media enquiries.
- Keep parents informed.
- Consider preparation of school community for funeral and burial arrangements.
- Maintain contact and support to families of victims.
- Monitor those in caregiver roles.
- Keep note of expressions of sympathy, condolences and offers of help for later response.
- Arrange for relief teachers.

Task Checklist- Long Term

- Will the school hold a memorial service or create a memorial to the victims?
- Has support been considered/offered for the critically involved school helping personnel?
- What follow-up has been planned for the most affected or at-risk students once things quieten down?

- Will the school do anything to mark the anniversary date? Will there be a watch for troubled or distressed students?
- Be aware of unforeseen anniversaries eg, birthdays of victims.
- A coronial inquest may take place some considerable time after the event. Students and staff may need time spent to understand the process. The inquest may cause some re-living of the events with consequent renewed distress.
- Establish when Crisis Management Team will reconvene to review the response made and make any necessary amendments to the Crisis Management Plan.
- Continue liaison with outside agencies.
- If liability is an issue, be prepared for legal proceedings.
- Remember that those who have had special roles to play (eg, the Crisis Management Team, the secretary dealing with all telephone enquiries), also need attention given to their wellbeing. It may also be helpful to publicly acknowledge those who have taken on a task outside of their usual responsibilities.

Media Contact

With advances in communication technology, the media often have early notice of a traumatic event. There can be no denying that such events are newsworthy but media representation can be intrusive and can cause a number of problems in terms of management and response which can be heightened if schools have no experience in handling the media. Possible problems include:

- ❖ Insensitive media coverage may further traumatise victims through being repeatedly exposed to the event.
- ❖ Issues may be simplified or distorted. Victims may then do the same to their behaviours and emotions, feeling that these are not sufficiently serious to warrant seeking timely help.
- ❖ Events may be exaggerated, participants glorified or vilified.
- ❖ Information given may be misrepresented.
- ❖ Increased demand on already pressured organisational resources.

A crucial part of the Crisis Management Plan is to recognise that the media can play a positive role in relation to a number of issues. Areas that can be helpful include:

- ❖ Dissemination of information on reactions to trauma in relation to different victim groups.
- ❖ Advising of details of support services and where they can be reached.
- ❖ Rapid dissemination of information relating to, for example, evacuation procedures, where children have been moved, emergency contact.
- ❖ Reduction in the number of enquiries from the community.

Remember that other agencies, notably emergency services, will also have a role in media liaison. There may be a need for some negotiation over how such contacts can be managed so as to ensure a consistency of content.

Media Guidelines

The Crisis Management Plan should specifically address the following:

- ❖ Identification of a single media spokesperson, usually the Principal as coordinator of the team.
- ❖ The preparation of a media statement with updates if required
- ❖ When possible, dealing with the media directly on how the event will be covered
- ❖ The setting of "ground rules" for interaction. School can determine whether media enter the school grounds, where filming might occur and who they can and cannot interview

Remember that journalists are just doing their jobs. Information can be obtained from other sources such as the police. Being cooperative, while setting boundaries, can stifle rumour and speculation. Try to anticipate the information that the media might want, eg, the number affected, the extent of injury or damage, response and support facility.

Do

- ❖ Advise school personnel of the media procedures.
- ❖ Advise students of the media procedure and their rights and responsibilities if approached for interview. Parents should also be told of the advice given to students.
- ❖ Protect confidential information (check identity if the nature of the question seems inappropriate).
- ❖ Consult with the bereaved families and the families of the injured to assure them that confidential information is being protected.
- ❖ Ensure a consistency of information and keep to the facts. Seek police advice if appropriate.

- ❖ Remember that there may be liability issues. Ensure there is no accusation of blame or acceptance of fault at this stage.
- ❖ Cooperate with the media and seek their cooperation.

Don't

- ❖ Give out personal information.
- ❖ Supply photographs of the victims.
- ❖ Speculate or give credence to unfounded theory.
- ❖ Create heroes or glorify the deceased.
- ❖ Forget that media interest may extend beyond the event. Funerals, memorial services and coronial enquiry may all receive attention.

Step four: Recovery

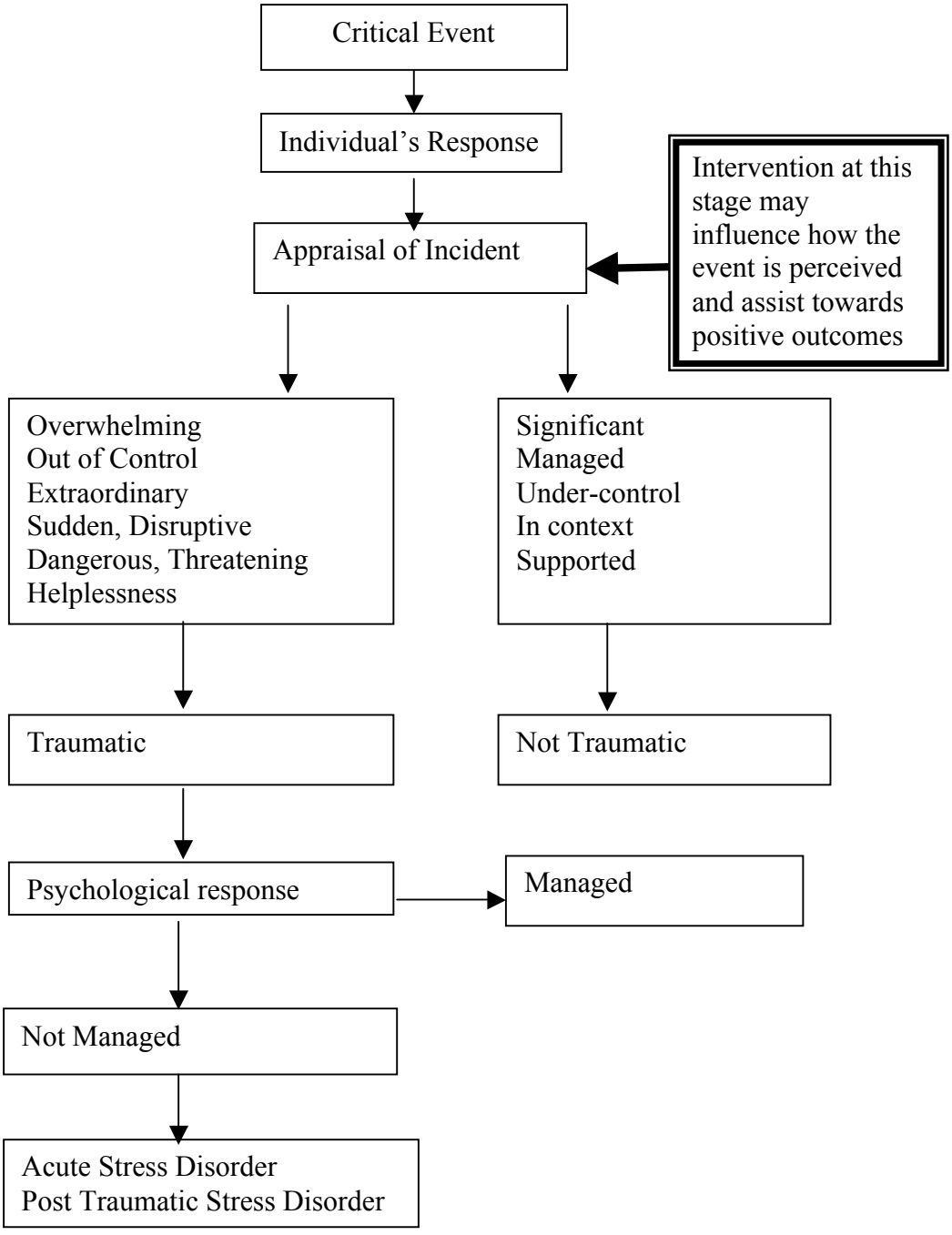
This involves the provision of appropriate support and counselling services to those individuals and groups at risk of emotional and psychological damage consequent to the event. It should be recognised that recovery is not an isolated phase and that it can commence while the crisis is still current. Trauma involves reappraisal of the event and, as such, early intervention while the event is still being evaluated may do much to influence the perception and assist towards positive outcomes.

While specialised psychological skills underpin many aspects of the Recovery phase, teachers and others can play a vital role. This is especially the case in the first minutes and hours of a crisis when teachers will be best placed to give

assistance to distressed students. It should be emphasised that the intention is not to make teachers into counsellors but rather to ensure that basic support skills are available in situations where they can be most useful. Optimal outcomes will be likely achieved when the roles of teacher and counsellor/psychologist do not overlap too far.

A mapping of individual response to trauma

Trauma involves the reappraisal of the incident. A traumatic event may be shared by many people but only be experienced as traumatic by some. Trauma response is a normal reaction to an abnormal event. Although these events are presented as a sequence, there is no inevitability to outcomes.



(Adapted from Department of Education, Employment and Training, State of Victoria, 1997.)

Children's Reactions to Traumatic Events

Individuals may react very differently to the same experience. The response may be determined by many factors. Some children and youth may be more vulnerable to trauma than others. It has been shown that the impact of a traumatic event is likely to be greatest in the child or adolescent who previously has been the victim of child abuse or some other form of trauma, or who already had a mental health problem (Duncan, Saunders, Kilpatrick, Hanson & Resnick, 1996; Boney-McCoy & Finkelhor, 1995). The young person who lacks family support is more at risk for a poor recovery (Doll & Lyon, 1998; Morrison, 2000). When children and adolescents are exposed to certain kinds of crisis situations, there is an increased likelihood of long-term psychological problems. Norris, Friedman and Watson (2002), in a meta-analysis of multiple disasters, found that events involving deliberate mass violence are extremely disturbing and lead to more severe impairment than natural disasters or large-scale accidents. Traumatic events have greater psychological effect when there is no warning, they occur at night, when the death and injury toll is high and when there is a great amount of physical damage (Gurwitch, Sullivan & Long, 1998; Flynn & Nelson, 1998).

The more direct a child or adolescent's exposure to a traumatic event, in terms of level of involvement and physical distance from an attack (physical proximity) and the higher the level of emotional involvement with those injured or killed (emotional proximity), the higher the risk for emotional harm. Witnessing destruction, physical injury, or death, if the individual's life was in serious danger, or if the individual suffered injuries, that child or adolescent is at a greater risk for long-term psychological harm. In some situations, emotional proximity may be a stronger predictor of posttraumatic response than physical proximity

(Pfefferbaum, 1997; Gurwitch, Sullivan & Long, 1998).

There does not appear to be any meta-analysis that systematically derives the typical responses of children and adolescents to either trauma in the broadest sense or to particular kinds of events. Although common responses are cited widely in the best practice literature, apparently with minimal if any empirical substantiation (eg, State of New York, 2000; Centre for Mental Health and NSW Institute of Psychiatry, 2000), there is little by way of guidance in predicting how an individual may react. Indeed a key question may be whether it is in fact possible to identify by research the common or likely reactions of, for example, a 12 year old to a broad range of critical events or to a specific event such as being involved in a bus crash with multiple fatalities. Simply being exposed to a crisis event does not lead to psychological trauma and the need for crisis intervention and assistance. Individual and situational factors are multiple, varied and unpredictable.

If the common response listings are accepted at face value, it would seem that some kinds of responses appear to be more frequent than others and some can be considered as typical to particular age groups. In considering responses, it is important to remember that these are viewed as normal reactions to abnormal events. When to seek help is an important consideration and unfortunately there does not seem to be any simple criteria for this suggested in the literature. Teachers, parents and other caregivers should be alert for behaviours that are uncharacteristic of the individual or where the individual's usual coping responses are clearly ineffective. Some studies (eg, Almqvist & Brandell-Forsberg, 1997) have found that parents and teachers may tend to minimise children's reactions to

trauma perhaps to reassure themselves that children have not been harmed or to reduce their own distress at the child's experience. Help should be sought when behaviours persist but care should be taken not to 'pathologise' these normal reactions. For example, just because a child has a disturbed pattern of sleeping for a week after a traumatic event does not mean the presence of Post Traumatic Stress Disorder. The research literature does not always make clear differentiation between Post Traumatic Stress Disorder and the symptoms of the disorder. Post traumatic stress disorder is not the normal response to the crisis experience. Most people recover from the event without any interventions. It has been noted that the responses of children and adolescents to disaster is a neglected area and that many of the studies that have been conducted are limited by a narrow focus on Post Traumatic Stress Disorder and its symptoms (Centre for Mental Health and NSW Institute of Psychiatry, 2000).

Unfortunately, there is but limited research that gives indication of how common particular reactions are. In a series of studies that did produce a frequency ranking, Yule (1994) identified a number of high probability symptoms experienced by adolescent survivors of the Jupiter cruise ship sinking.

Symptom	**% of victims**
Recurrent Intrusive thoughts	74%
Distress at exposure	74%
Avoids activities	71%
Avoids thoughts/feelings	65%
Poor concentration	63%
Irritability/anger	58%

Loss of interest	54%
Sleep difficulties	51%
Exaggerated startle	51%
Physiological reactivity	51%
Feelings of detachment	42%
Hyper vigilance	40%
Recurrent dreams	35%

In other studies, Yule, Udwin and Murdoch (1990) also found that 5 months after the disaster, those adolescents who had been on the cruise ship were significantly more depressed and anxious than those in the control groups with many fear items related to the event. The effects of the disaster on fears were specific to the nature of the event.

The lists of common reactions compiled below are drawn from a wide range of sources and reflects areas where there appears to be a consensus of opinion (eg, State of New York, 2000; Centre for Mental Health and NSW Institute of Psychiatry, 2000). It is interesting to note that a number of Yule's (1994) frequently found responses in adolescents involved in the Jupiter cruise ship sinking disaster do not appear in the best practice literature citations of common responses. For example, distress at re-exposure to the crisis event and avoiding thoughts, feelings and activities relating to the crisis event are not included in the summaries produced by the State of New York (2000), Centre for Mental Health and NSW Institute of Psychiatry (2000), Poland and McCormick (2000) or Whitla (2003). This raises the question of whether these commonly found list have become 'self-perpetuating' from one publication to the next.

Although Yule, Udwin and Murdoch (1990) were able to relate certain fears to a specific event, there is no research linking other kinds of reactions in children to specific trauma events nor the period of time after which a failure to show a reduction in distress behaviours should be considered a concern. These kinds of lists appear to be often used as handouts following a crisis. Reactions are often categorised into areas such as Behavioural, Emotional, Cognitive and Physical (eg, Whitla, 1994; Department of Education, Employment and Training, State of Victoria, 1997; Poland & McCormick, 2000). There appears to be no great consensus on which reactions go into specific categories or any justification for particular reactions being in one category rather than or as well as another. There is at present no evidence supporting the effectiveness of such lists in helping understand and support those affected by trauma but they are frequently seen and recommended in the best practice literature and resource manuals (eg Office of Mental Health, New York State, 2000; Poland & McCormick, 2000). The lists might be best considered as a 'grab bag' of possible reactions that may be useful in identifying distressed children.

Reactions considered as common to children of all ages

- Disturbed pattern of sleeping.
- Nightmares and vivid dreams often reliving the actual event.
- Fears around normal everyday occurrences.
- Fears about the future and about future events.
- Loss of interest in school and consequently lower academic achievement.
- Loss of sense of personal responsibility including simple things like hygiene and tidiness.

Reactions considered as common to children in pre-school and early primary

- Regressive behaviours such as crying, thumb sucking, bed-wetting, infantile language.
- Fears.
- Clinging, adult dependent.
- Irritable.
- Disobedient/oppositional.
- Aggressive behaviour, violent themes to play.
- Disturbed pattern of activity.
- Repeated talking about event.
- Upset at change to routines.
- Poor concentration, shortened attention span.
- Sleep disturbance in both pattern and duration.
- Change to eating patterns.
- Toileting problems:- change to bowel/bladder patterns.

Reactions considered as common to children in middle and upper primary school

- Regressive behaviours such as clinging, anxiety over separation.
- Competition with brothers or sisters particularly for parental attention.
- Crying, sadness, emotionally labile, mood swings.
- School refusal.
- Social withdrawal, refusing to go out of house, remaining in bedroom.
- Disturbed pattern of activity.
- Irritable.

- Disobedient, oppositional.
- Poor concentration and attention, lower achievement levels.
- Repetitive play concerning incident
- Overt competition with siblings and peers
- Fears
- Headaches, pains, nausea.
- Sleep disturbance in both pattern and duration
- Itching.
- Visual difficulties.

Reactions considered as common to young people of secondary school age

In a general sense, children of eleven and older share much of the adult understanding of death. As with many facets of adolescent behaviour, there is great variation between individuals. Level of understanding and acceptance may still be immature and incomplete. Adolescents want to have their feelings accepted by their peer group but may be self-conscious about the appropriateness of expressing these feelings.

- Depression.
- Discarding of responsible behaviours and attitudes.
- Sibling rivalry, intolerance and hostility.
- Withdrawal from age-appropriate activities.
- School refusal.
- Social withdrawal, refusing to go out of house, remaining in bedroom.
- Disturbed pattern of activity.
- Irritable, sadness, emotionally labile, mood swings.

- ❖ Disobedient, oppositional, defiant of authority, delinquent acts.
- ❖ Confusion over a range of sometimes-conflicting emotions or even no emotion.
- ❖ Poor concentration and attention, lower achievement levels.
- ❖ Increase in risk-taking behaviour, alcohol or drug use.
- ❖ Impulsive with an immediacy given to important decision-making.
- ❖ Strong identification with peer group, need for conformity with group.
- ❖ Fears, loss of sense of security, awareness of death as a personal threat.
- ❖ Disturbing flashbacks of the event or related occurrences.
- ❖ Avoids thoughts/feelings about the event.
- ❖ Distress at re-exposure to the event.
- ❖ Avoids activities related to the event.
- ❖ Preoccupation with the event.
- ❖ Premature assumption of adult roles and responsibilities.
- ❖ Headaches, pains, nausea.
- ❖ Appetite disturbance, eating disorder.
- ❖ Sleep disturbance in both pattern and duration.
- ❖ Itching, skin disorders.
- ❖ Visual difficulties

Reactions considered as common to adults

- ❖ Shock, anger, anxiety, fear, terror, panic, confusion, disbelief.
- ❖ Guilt, grief, sadness, despair, loneliness, numbness.
- ❖ Helplessness and loss of control.
- ❖ Fatigue, insomnia, sleep disturbance, hyper arousal, lack of energy, crying.

- Appetite disturbance.
- Social withdrawal, alienation.
- Conflict in relationships.
- Dreams about the incident.
- Impaired concentration and work performance.
- Decreased self-esteem and self-efficacy.
- Difficulty in making decisions.
- Intrusive thoughts and memories.
- Headaches, pains, feeling unwell.
- Dissociation- feeling like in a dreamlike state.

Providing support to children, young people and staff after a crisis

It is important to provide support to staff and students after a crisis but normal recovery should be assumed (National Institute of Mental Health (NIMH), 2002). After a crisis, it is essential not only to recognise how children and young people may react but also how to offer support and assistance. Schools should be aware that there might be potential legal liabilities if there is a failure to provide appropriate support following a crisis in school or on a school activity.

There is some evidence for the effectiveness of early, brief, and focused psychotherapeutic intervention (provided on an individual or a group basis) for reducing distress in bereaved spouses, parents, and children and that selected cognitive behavioural approaches may help reduce incidence, duration, and severity of Acute Stress Disorder, Post Traumatic Stress Disorder and depression in trauma survivors (National Institute of Mental Health (NIMH), 2002).

It is common in the best practice literature to suggest that when schools are required to respond to a crisis, a 'medical model' involving screening for potential pathology and referral for specialist intervention be employed (eg, Poland & McCormick, 1999). There is some support for an alternate, social service delivery model that employs outreach efforts to families and which assists with the more frequently found problems in daily living, as being more effective in assisting recovery (Baisden & Quarantelli, 1981). Social support may be a key factor in determining a child's recovery after exposure to a crisis event. The impact of trauma is decreased for children and adolescents when there is a strong relationship with a parent or another caring adult and when the child or adolescent has a place to go where they can feel safe (Osofsky, 1999). Parental psychopathology measured after a disaster event has been found to be the best predictor of child psychopathology after the event (Norris, Friedman & Watson, 2002). Children appear to be highly sensitive to the post-trauma state of the family. A family's positive reactions can reduce the impact on the child but negative reactions can accentuate problems in adjustment and coping. The most effective way to help children after a trauma may in fact be to provide support to the parents.

In looking at appropriate support after a crisis, the best practice literature particularly is a ready resource for suggestions (eg, Herbert, 1996; State of New York, 2000) but there appears to be a lack of empirical support for the effectiveness of such interventions in the broad range of crisis situations that might be encountered by schools. The most frequently studied reactions appear to be those associated with posttraumatic stress disorder and related symptoms

(Silverman & La Greca, 2002). Children and adolescents reactions to crises are likely to be variable and dependent on a large number of factors. Drawing generalised conclusions from a large range of crises on what might be helpful to all children or adolescents in a particular situation would appear to be fraught with problems Accordingly, the appropriateness of the suggestions detailed below should be reviewed before being implemented in any post-crisis situation. As with the listings for common reactions detailed earlier, the listings of support activities and strategies are drawn from a wide range of sources and reflect areas where there appears to be a consensus of opinion.

Children need security and stability. Fears may underlie much of the behaviour change seen after a trauma (Yule, Udwin & Murdoch, 1990). Familiar behaviours may substitute for those feelings and behaviours that are unfamiliar or uncomfortable eg. laughing when feeling sad or worried. Children may be helped in managing these intense feelings. Parents and teachers might also be struggling with their own emotional reaction.

Supporting younger children at school after a trauma

- ❖ Listen when the child wants to talk and answer only the question asked.
- ❖ Show the child you care so as to maintain their trust.
- ❖ Limit exposure to print or broadcast media coverage of the trauma.
- ❖ Give frequent reassurance. Be aware that children may be anxious on separating from parents.
- ❖ Allow children to be active and noisy as a way of expressing feelings.
- ❖ Look out for changed behaviour that may be aggressive or destructive.
- ❖ Use plain language when talking about death.

- If out of character behaviour persists for more than a month or so, or the child appears to be blaming himself/herself for the incident, then specialised intervention may be required and teachers are advised to discuss this with the parents.

Supporting children in middle and upper primary school after a trauma

Between the ages of 7 and 10, most children come to an understanding of the finality of death (Jimerson & Huff 2002; Rowling, 2003). The concept of death remains immature and it should be recognised that children will retain some unusual notions on what it means to be dead. At this age, death is generally seen as something that happens to other people, to older people.

- Provide a stable environment to assist adaptation to trauma. Re-establish routines
- Discuss what happened in the trauma to allow expression of feelings. Look for positive aspects. Don't feel that you have to hide your personal feelings or emotions. Children will feel less isolated if they see others sharing their emotions. If individual children have misconceptions/misinformation about the incident (particularly in relation to death) consult with the parents before correcting this.
- Limit exposure to print or broadcast media coverage of the trauma
- Use creative activities. Younger children will use play. Older children can benefit from using art, music or drama to express their feelings. This should be done cautiously and it may be wise to seek professional advice on these interventions

- ❖ Group activities can be especially useful in allowing children to regain a sense of control and security.
- ❖ Allow opportunity for creative play and encourage re-enactment of the incident. Expressing feelings through play make it less likely that the children will relive the trauma internally.

Supporting adolescents after a trauma

Most adolescents have an understanding of the finality of death and start to formulate their own views on what happens after death. The concept of death can remain immature and it should be recognised that children and adolescents may retain some unusual notions on what it means to be dead. At this age, death is still seen as something that happens to other people, to older people.

- ❖ Give information on the range of normal responses to trauma and reassure that the emotional disturbance will ease.
- ❖ Provide a stable environment to assist adaptation to trauma. Re-establish routines but retain flexibility.
- ❖ Limit exposure to print or broadcast media coverage of the trauma
- ❖ Allow opportunity to discuss what happened in the trauma to allow expression of feelings. Ensure that those who don't want to participate in a discussion can opt-out. Look for positive aspects but don't use these as a way to balance or justify the traumatic event.
- ❖ Don't feel that you have to hide your personal feelings or emotions.
- ❖ Encourage use of peer support and acceptance of a range of feelings and emotions.

- Acknowledge the impact and significance of the event and how it may effect attitude to other life matters.
- Provide a range of supports: individual counselling, group work, class discussion, articles or books on grief and loss.
- Encourage the postponement of major decision-making.
- If significant disturbance in individuals persists for more than a month, specialist intervention may be required and parents should be involved.

Supporting adults and taking care of yourself

Being involved in helping people after an event may be traumatising for teachers, principals and other school staff. Involvement does not need to be direct for a reaction to occur. Recognise that those in helping roles may experience some of the common reactions to trauma. Schools have a responsibility to staff as well as students and a range of supports should be put in place to assist recovery.

In their study of critical incident stress in Victorian State Emergency Services volunteers, Werner, Bates, Bell, Murdoch and Robinson (1992) identified six factors associated with a critical incident that increased the difficulty for workers of coping:

- The involvement of children or young people;
- The worker's first experience with death or multiple deaths;
- The goriness or enormity of the incident;
- Being unprepared for the incident;
- The presence of multiple deaths or injuries; and
- An existing association with the victim or their family.

Critical incidents in schools would generally involve at least one of these factors, the involvement of children or young people. Incidents involving death, serious illness and abduction within the school population are likely to be particularly stressful for the school and for the teachers and other professionals supporting individuals and groups.

To take care of the children in school, it is essential that staff take time for self-care. Hyper arousal (which can be described as feeling "switched on" or like "a coiled spring") is a common response. This can lead to over-reaction, anxiety, disorganised thinking and impaired memory, sleep disturbance and difficulty in managing everyday tasks. Sometimes the response is quite different with individual coping mechanisms complicating the picture. Remember that trauma response is a normal reaction to an abnormal event. These suggestions may be useful for helpers and other adults following a trauma.

Try to

- Rest a bit more, even if you don't sleep
- Have someone stay with you for at least a few hours
- Maintain as normal a routine as possible
- Eat regularly with a well-balanced diet. Complex carbohydrates, which are slow to metabolise, may slow down the arousal rate.
- Reduce stimulants such as tea, coffee, alcohol and chocolate (however painful!), again to slow down arousal rate.
- Regular physical exercise provides a good outlet for the physical effects of stress. After strenuous exercise, remember to cool-down and use relaxation activities.

- Increase time with friends.
- Talk to people you trust.
- Let those who are important to you, talk about their feelings.
- Share information on reactions to trauma, how to be supportive, with family and friends so they can help you.
- Use support networks at school and at home.
- Don't bottle things up.
- Be open to the option of counselling or other specialised support.

Following a trauma, those persons involved are more vulnerable to accidents and physical illness so take care and allow time for relaxation. If feelings persist for more than one month, or you feel you cannot deal with your emotions, or your reactions are seriously interfering with you everyday life, then it is important to seek assistance.

Suicide prevention

Crisis Planning should take particular account of responding to a death by suicide and suicide prevention. Prevention of suicide clusters or contagion should be a major concern even when the trauma event is not a suicide.

Be aware of organisational requirements on Youth Suicide Prevention. Comprehensive training in suicide prevention is available to all staff in schools in Western Australia and it is important that Principals ensure that training levels are maintained. Parents should always be advised when school has information that indicates that a student is at risk of suicide.

In this document, only those elements significant to crisis management are considered.

- Verify that the death was by suicide. In Western Australia, suicide is a verdict given by the Coroner and this can occur a considerable time after the event. Accordingly, the word ‘suicide’ should not be used. Rather a phrase such as ‘taken his/her own life’ would be appropriate.
- Contact to the family is essential. Ensure that the family knows of and understands the school’s plans.
- If a death was from suicide, this should be recognised and acknowledged by the school.
- Staff and students should be given appropriate support and counselling where needed. Students should be advised of the death in normal class groups. Close friends might be advised individually or as a small group.
- Any discussion should be kept to the facts. Do not provide unnecessary detail about the death.
- Send a letter home to all parents and distribute a fact sheet advising of the most common warning signs of suicide.
- There should be no memorialising if the death was by suicide (This should also apply if the death was consequent to a high-risk behaviour such as drink-driving or drug overdose). This can require some sensitivity particularly with the bereaved parents.
- Take care not to glorify or sensationalise the death which may put other young people at risk.

- ❖ Discourage changes to the school routine to accommodate attendance at the funeral.
- ❖ Be alert to the increased probability of suicide in 'at-risk' adolescents
- ❖ Provide information on how to seek help for self or others
- ❖ Be aware of emergency contact telephone numbers and make this information known to adolescents (eg, Samaritan Youthline 9388 2500 or 1800 198 313)
- ❖ The media are unlikely to give detailed coverage to a suicide unless there are other factors involved such as celebrity involvement or a murder-suicide. There are Media Guidelines issued by the Commonwealth Department of Health and Aged Care (2002) and by the Australian Press Council (2001) which schools should access.

Psychological First Aid

Early intervention after a crisis event may, as noted earlier, influence the perception of the incident and assist towards positive outcomes (Department of Education, Employment and Training, State of Victoria, 1997). The National Institute of Mental Health (NIMH) consensus workshop (National Institute of Mental Health (NIMH) 2002) agreed that there was acceptable evidence for the effectiveness of early interventions for reducing distress in bereaved spouses, parents and children and that there was some evidence to support cognitive behavioural approaches in reducing incidence, severity and duration of post traumatic stress disorder, acute stress disorder and depression following a trauma. The NIMH consensus workshop considered psychological first aid to be a key aspect of early intervention and detailed these steps:

- ❖ Protect survivors from further harm;
- ❖ Reduce physiological arousal;
- ❖ Mobilise support for those who are most distressed;
- ❖ Keep families together and facilitate reunions with loved ones;
- ❖ Provide information and foster communication and education; and
- ❖ Use effective risk communication techniques.

Yet there does not appear to be a single model for the provision of psychological first aid nor indeed to be any kind of agreement on what exactly it entails. There appear to be a range of models for this helping process. The Centre for Mental Health and NSW (New South Wales) Institute of Psychiatry (2000) in considering disaster mental health response describe psychological first aid as including the following components:

- ❖ The basic human responses of comforting and consoling a distressed person;
- ❖ Protecting the person from further threat or distress as far as possible;
- ❖ Furnishing immediate care for physical necessities including shelter;
- ❖ Providing goal orientation and support for specific reality-based tasks;
- ❖ Facilitating reunion with loved ones from whom the individual has been separated;
- ❖ Sharing the experience;
- ❖ Linking the person to systems of support and sources of help that will be ongoing;
- ❖ Facilitating the beginning of some sense of mastery; and
- ❖ Identifying needs for further counselling or intervention.

Although there are many common elements in the National Institute of Mental Health (2002) and the Centre for Mental Health and NSW Institute of Psychiatry (2000) descriptions of psychological first aid, there are also some significant differences. Additionally, psychological first aid as described by Pynoos and Nader (1988) appears to expand the critical incident stress debriefing model (Mitchell, 1983; Mitchell and Everly, 1995) into two or three sessions.

Psychological first aid has a high level of acceptance in the best practice literature and National Institute of Mental Health (2002) consensus workshop considered the process to be supported by research though there was no elucidation of the supportive evidence. Litz, Gray, Bryant and Adler (2002) propose that psychological first aid is an appropriate initial intervention but also conclude that it does not serve a therapeutic or preventive function and that further research is required.

Psychological first aid is an early intervention strategy that should be viewed as having a support function. It needs to be offered as soon as possible after a crisis event, much like physical first aid, by those who have first contact with the victim. The model described here is adapted from Slaikeu (1984). These procedures take only a short period of time and can be offered by a wide range of helpers.

Make Psychological Contact

By inviting the victim to talk, the helper attempts to make a close and meaningful contact. The helper should listen for facts and feelings, summarise and reflect these, and by showing an empathy and concern, help bring a sense of calm and

control to an intense situation. The intention is to make the victim feel heard, understood, accepted and supported

Explore The Problem

The helper should take on a more active role. Enquire about the immediate past, about events that precipitated the crisis. Try to gauge how well the victim managed before the crisis as a way of identifying strengths and weaknesses.

Look to the victim's basic functioning now and consider what strengths they can bring forward. The intention is to gather as much information as possible that might be relevant to the immediate situation.

Explore Options For Action And Short Term Solutions

Ask what the victim has tried to do so far to help cope with their experience. Explore what other options are available. It may be that this is the first chance the victim has had to do anything to help themselves. Try to offer some alternative ideas that might offer short-term relief. Consider whether additional professional help should be sought.

Assist In Taking Action

It is important in taking action that the victim feels some sense of control over what has been agreed should be done. The principle is that the helper should give as much support as necessary and as little help as possible.

Follow-Up

Whatever the skill level of the helper, it is important that there is an appropriate level of follow-up. While showing that interest and concern were genuine, follow-up will ensure that the agreed actions were taken and give some indication as to their effectiveness

In conducting psychological first aid, it is not the intention that the helper should function as a psychologist or counsellor. The process is likely to be more effective, and be perceived as genuine, if the helper relates in their usual way to any child or adult who is distressed. Given this, it is difficult to be specific in terms of what might be said, asked or done. The undernoted should be regarded as a listing of possible actions rather than as a set of directions

Some Specifics

- Listen. Often words are not needed.
- If appropriate, make some physical contact. Just holding a hand may convey concern and support.
- Reflect the words of the victim. Don't judge the things being said.
- Some areas may be difficult to ask about but be prepared to do this if appropriate. What happened? What did you see? What did you do? Be cautious in asking about feelings.
- Keep the discussion based on things that really happened. Don't discuss "What if" or "I should have" statements. If the victim takes this line, bring the talk back to real events.

- ❖ Keep the discussion centred on the victim. Don't discuss your own experiences (this assumes that the helper is not also a victim. If the helper is also a victim of this event, sharing experiences may be beneficial).
- ❖ In many instances actions will involve getting professional psychological help. Your intervention here may do much to reduce or even remove the need for counselling.
- ❖ Remember that the victim may be in pain from physical injuries. Ensure that attention is given by medical services.
- ❖ Follow-up should be at a level appropriate to the relationship between victim and helper. In some instances it may be as simple as asking "How are you now?"

Debriefing

Debriefing has gained some popularity as a therapeutic intervention after a traumatic event. Paton (1992) identified four types of debriefing: the on-scene debrief, post-incident defusing, educational debriefing and psychological debriefing. It is psychological debriefing that has gained most interest and which is most often meant when debriefing is cited.

A number of writers have recently considered the evidence on the effectiveness of psychological debriefing and a particular variant known as Critical Incident Stress Debriefing pioneered by Mitchell (1983) and further developed by Mitchell and Everly (1995) There is no current evidence supporting psychological debriefing as a useful treatment for prevention of post traumatic stress disorder and some interventions have in fact been found to have adverse effects (Rose, Bisson &

Wessely, 2003; Devilly & Cotton, 2003). Accordingly, psychological debriefing, Critical Incident Stress Debriefing or any variants of these processes cannot be recommended for use in schools.

Conclusion

Tronc (1992) has argued that schools have a 'duty of care' to have crisis management plans in place. It would seem a logical extension of this argument that school plans should be firmly founded in empirical research, and where this is absent, in 'industry standard' best practice. A major aim of this document has been to inform school crisis planning. Research and best practice have been linked to provide a framework for plan development. Additionally a number of resource checklists have been included within the body of the document and, for ease of use, repeated in the appendices.

Areas have been identified where schools can have an active role in creating a safer school community. Mental health promotion is now widely advocated as a school initiative that can develop the resilience and mental health of young people and thus limit the onset, severity and duration of at-risk behaviours (World Health Organisation, 1994; Commonwealth of Australia, 1996). New initiatives are being developed to make schools safer environments (eg, Curriculum Corporation, 2003; United States Department of Education, 1998) focusing particularly on the prevention of bullying, harassment and violence.

Until recently, studies in the field of crisis management have often been descriptive reports of survivors and those who have responded with little objective

data collection. Crisis management planning in schools continues to be based on assumptions established in the broader field of crisis intervention and, accordingly, whether these have an effective applicability to schools remains open to question. Pagliocca, Nickerson and Williams (2002) propose a set of guiding questions about school crisis plans, policies and practices.

- What are the assumptions - or the theoretical or empirical foundation - upon which the plan/strategy is based?
- What is the intended purpose or outcome?
- Are the components in place?
- How will we know that the intervention has been implemented as planned?
- How will we know if we have accomplished the purpose?

Consideration of these questions is not only important at the planning stages but also at review, regardless of whether the plan has been implemented in the interim. As research on crisis management in schools develops, there can be an expectation that broad-based assumptions can be replaced by empirical support for specific actions appropriate to schools, children, staff and the wider school community.

In this document and the associated training workshop, an attempt has been made to give school personnel critical skills and understandings of good crisis management planning. In every school, the planning process and the consequent Crisis Management Plan will be different, customised to the particular characteristics and needs of the school community. An effective plan will not be produced by copying another school's plan or by using a proforma approach. It has been emphasised that planning is a participative and collaborative process: school personnel should be actively involved in planning. Planning is also an

ongoing process. Not only should the plan be reviewed regularly and modified as necessary, it should be accompanied by a commitment to training and appropriate resourcing. Taking action can prevent injury, save lives, minimise damage to buildings and aid in recovery. Planning can keep schools as safe environments.

Appendix 1

The Scenario

Part 1

Thursday 2.30pm

The school secretary comes into your office to tell you that there's a telephone call from Ms Example. Mary Example, the assistant principal, has been away at camp all week with the year 6 classes. You smile to yourself as you expect to hear of some minor delay, a puncture or even someone left behind! As you reach for the phone it strikes you as odd that the secretary didn't just put the call straight through. In response to your quizzical look, the secretary says that Ms Example sounds upset.

You pick up the phone. The conversation is as follows.

"Hello Mary. Any problems?"

"It's awful. There's been an accident.

(Shouting) Wait there Julie, don't cross.

Chris, the children are hurt. Susan and Bill, I think they're dead. I don't know when we'll get back to school. The freeway's blocked. I've got to go. The ambulance is arriving. A policeman is clearing a way. I'm covered in blood. I'm going to help Mark. He can't get out of the bus. Did you remember to water my plants?"

The phone is hung up.

Two children from Year 1 knock on your open door and come in, hand-in-hand. They've brought some writing to show you.

List your tasks for the 10 minute period following the phone call. Then rank them by priority.

Part 2

Thursday 2.45pm

You've called the police but have very little extra information at this stage. There has been a traffic announcement on the radio saying that the freeway is blocked at Mount Henry Bridge. Parents are starting to arrive outside school anticipating the return of the children from camp.

Jack Evans who teaches a Year 3 puts his head round the door to ask if everything is all right. Jack was in the office to collect some photocopies when the secretary mentioned that Mary had called, sounding upset. Jack has twins who are both with the group returning from camp.

The phone rings. It's the police. The news is still limited. At least one of the two buses from the school has been involved in an accident at Mount Henry Bridge with a semi-trailer carrying bricks. There have been fatalities and there are many injured. No details are available at this time.

List your tasks for the 30 minute period until school closes at 3.15pm. Rank them by priority.

Part 3

Thursday 3.30pm

You have informed the waiting parents of the accident. Many have left to try and reach the accident scene or to go to Princess Margaret Hospital. Around forty parents remain at school awaiting news. Some are in the staff room, some in the Year 6 classrooms and some wait outside. Most of the staff have stayed behind. There are children in the playground growing restless as they wait for parents to take them home.

There has been no further news from the police.

What can you do to help the waiting parents?

What do you expect of staff?

What must be done to prepare for later that day?

What must be done to prepare for tomorrow?

Part 4

Thursday 4.30pm

Parents are growing frantic as there has been no further news

Two police cars arrive carrying several officers. The officer in charge asks to see you alone. He informs you that four students and two adults have been killed in the accident. A number of other children have very serious injuries and some may not survive. The officer gives the names of the deceased children and asks if you will arrange for him to see their parents individually. Only one of the dead adults has been identified so far. Mary Example had collapsed and died within minutes of calling the school. You remember that you hadn't watered her plants that day.

The police cars escort most of the parents to the hospital. Those parents whose children have died go separately.

John Example, Mary's husband, phones to ask why Mary hasn't arrived back from camp. You tell John what has happened then pass the phone to a police officer who has been helping with bereaved parents.

You go to the Year 6 classroom and water Mary's plants.

On returning to the office 10 minutes later a call comes from a television news program asking if you'll agree to a telephone interview for broadcast on the 6.00pm edition.

List the tasks for the remainder of the day.

What must be done before children arrive the next day

Part 5

Friday 8.00am

Staff have all come in early. You have extra staff on playground duty. There are several relief teachers in the school to assist during the day. The school psychologist is present and has offered to arrange for additional counsellors to attend. The playground is already full of parents and children. You have made plans to tell all of the children of the tragedy as soon as they go to class. You will then assemble all parents and talk to them. One of the staff notices that many of the Year 6 children who were in the accident are in the playground.

Several children in hospital remain in critical condition.

List the tasks for attention before school starts.

What are the concerns that will likely need ongoing attention during the day?

What should be done in relation to the bereaved families?

Appendix 2
Sample Policy

Rationale

While experiencing or witnessing highly traumatic events is still uncommon, it is clear that the frequency of such events is growing. Consequently, the risks faced by students, staff and the broader school community are also growing. Such events can impact considerably on the psychological well being of students, teachers and families having an adverse influence in areas such as learning, occupational performance and family interactions. This school is concerned to reduce the traumatic effects of crisis situations both in the short and longer terms and accordingly shall ensure that adequate and appropriate measures are in place to manage the response to traumatic events.

Procedures

1. The School shall establish a comprehensive and integrated Crisis Management Plan and ensure that this is communicated to the whole school community.
2. The School shall ensure that there are appropriate organisational systems to allow prompt and effective response to a crisis situation.
3. The School shall establish and maintain liaison with appropriate community organisations (eg police, fire, hospital, State Emergency Services, counselling services) that may be involved in a response to a crisis situation.
4. The School shall ensure that a comprehensive training program is in place for all staff particularly those in leadership roles.

5. The School shall ensure that all students, staff and families have appropriate support, counselling and intervention programs available to them should a crisis event occur in the context of school activities or where such event has significant impact upon the school community.

6. The School shall establish a Crisis Management Team under the leadership of the Principal.

7. The School shall ensure that the development of a Crisis Management Plan follows a participative and consultative approach and addresses the four primary aspects of Prevention (and Mitigation), Preparation, Response and Recovery.

8. The School shall ensure the appropriate evaluation of response to any incidents, regular review and maintenance of the Crisis Management Plan (at least annually), induction of new staff to procedures, and shall maintain an ongoing commitment to remaining cognisant of current research and developments in this area.

Appendix 3

Gathering Information On An Incident

This is intended to give some direction on the information that will facilitate effective crisis management. It may be photocopied or used as the basis for a checklist.

- date_____time_____recorded by_____
- what happened
- who was involved
- where
- when
- who is reporting
- who witnessed the event
- who knows about the incident
- have emergency services been contacted
- are there police officers on the scene? Name of attending officer

- what is known on extent of injuries or deaths

- have any other actions been taken

- have parents been contacted

- telephone contact numbers

  name _____number_____

  name _____number_____

  name _____number_____

  name _____number_____

- crisis response team called together

  date_____time_____

- crisis management plan enacted

  date_____time_____ signed_____

Appendix 4

Task Checklist- Immediate to within first 24 hours

- ❖ Gather and confirm information (see Appendix 3).
- ❖ Is there a need for immediate contact to the police or emergency services?
- ❖ Is the school or crisis site safe? Is an evacuation or a lock-down required?
- ❖ Endeavour to save life. Provide first aid to the injured without putting anyone at increased risk.
- ❖ Decide on the level of response required.
- ❖ Call together the school Crisis Management Team.
- ❖ Enact the school Crisis Management Plan.
- ❖ Will the school or an external agency (eg, police or fire service) be managing the crisis site?
- ❖ Liaise with police and other emergency service to confirm information and establish the 'what' and 'when' of information the school may release.
- ❖ Has contact been made with families of those involved? Arrange to visit or meet as soon as possible particularly with those bereaved. Remember this may involve families of both staff and students.
- ❖ Prepare or adapt information release for groups in the school community.
- ❖ Inform staff.
- ❖ Support distressed staff.
- ❖ Decide on means of information transfer to students.
- ❖ Give staff guidelines on the role they can play with students.
- ❖ Can a telephone line be kept free for essential calls? Are mobile telephones available?
- ❖ Do staff members at an off-site crisis have mobile telephones?
- ❖ How will the school handle enquiries?

- Do front desk staff have an accurate written statement to use for incoming calls?
- Who will deal with media enquiries?
- Start keeping a written record of events
- Provide support facilities for distressed students. Who will deal with most affected students?
- Do outside agencies and/or organisational administrators need to be contacted?
- Establish a support centre within the school and ensure it is staffed at all times.
- Prepare for any parents who may arrive at the school.
- Have an area available to parents- make a staff member available to provide support and information.
- Prepare checkout arrangements for parents who wish to take a child home.
- Are there siblings? In this school or other schools?
- Do other schools need to be informed?
- Is parental or next-of-kin permission required for some kinds of information release?
- Do the most critically involved school helping personnel have support?
- Have arrangements been made to sustain staff providing support off campus, eg those attending hospital with students
- Have arrangements been made for staff members who may want to stay after normal school hours?
- Are Crisis Management Team members maintaining regular contact/meetings?
- Who will attend to victims' desks and personal belongings?

- Who will attend the funeral?
- Will the school hold its own memorial service or create a memorial to victims?
- Remember that there may be deaths subsequent to the initial fatalities
- Has some follow-up been considered for the most critically involved school helping personnel?
- What follow-up is planned for the next day?
- Arrange relief teaching.
- Arrange that the Crisis Management Team meet at the end of the day.
- Clarify the expectations on and of staff who are still actively involved at the end of the day, eg at the hospital.
- Arrange how overnight developments will be monitored and managed.

Appendix 5

Task Checklist- Medium Term

- ❖ Who will attend to victims' desks and personal belongings?
- ❖ Who will attend the funeral?
- ❖ Will the school hold its own memorial service or create a memorial to victims?
- ❖ Remember that there may be deaths subsequent to the initial fatalities.
- ❖ What level of support has been considered for the most critically involved school helping personnel?
- ❖ What follow-up is planned for the next week?
- ❖ Continue to monitor reactions within the school community and provide support.
- ❖ Return school as far as possible to regular routine.
- ❖ Consider whether particular events have to be cancelled or postponed (eg, graduation ceremonies, school ball).
- ❖ Consider whether there is a need and expectation of other actions (eg, mass or other religious ceremony, flowers at the site of a fatality, condolence notice in the newspaper).
- ❖ Update staff and students with new information.
- ❖ Consider giving advice to staff, students and parents on media enquiries.
- ❖ Keep parents informed.
- ❖ Consider preparation of school community for funeral and burial arrangements.
- ❖ Maintain contact and support to families of victims.
- ❖ Monitor those in caregiver roles.

- ❖ Keep note of expressions of sympathy, condolences and offers of help for later response.
- ❖ Arrange for relief teachers.

Appendix 6

Task Checklist- Long Term

- ❖ Will the school hold a memorial service or create a memorial to the victims?
- ❖ Has support been considered/offered for the critically involved school helping personnel?
- ❖ What follow-up has been planned for the most affected or at-risk students once things quieten down?
- ❖ Will the school do anything to mark the anniversary date? Will there be a watch for troubled or distressed students?
- ❖ Be aware of unforeseen anniversaries eg, birthdays of victims.
- ❖ A coronial inquest may take place some considerable time after the event. Students and staff may need time spent to understand the process. The inquest may cause some re-living of the events with consequent renewed distress.
- ❖ Establish when Crisis Management Team will reconvene to review the response made and make any necessary amendments to the Crisis Management Plan.
- ❖ Continue liaison with outside agencies.
- ❖ If liability is an issue, be prepared for legal proceedings.
- ❖ Remember that those who have had special roles to play (eg, the Crisis Management Team, the secretary dealing with all telephone enquiries), also need attention given to their wellbeing. It may also be helpful to publicly acknowledge those who have taken on a task outside of their usual responsibilities.

Appendix 7

Pre-school and early primary

Reactions considered as common to children of all ages

- Disturbed pattern of sleeping.
- Nightmares and vivid dreams often reliving the actual event.
- Fears around normal everyday occurrences.
- Fears about the future and about future events.
- Loss of interest in school and consequently lower academic achievement.
- Loss of sense of personal responsibility including simple things like hygiene and tidiness.

Reactions considered as common to children in pre-school and early primary

- Regressive behaviours such as crying, thumb sucking, bed-wetting, infantile language.
- Fears.
- Clinging, adult dependent.
- Irritable.
- Disobedient/oppositional.
- Aggressive behaviour, violent themes to play.
- Disturbed pattern of activity.
- Repeated talking about event.
- Upset at change to routines.
- Poor concentration, shortened attention span.
- Sleep disturbance in both pattern and duration.
- Change to eating patterns.
- Toileting problems:- change to bowel/bladder patterns.

Supporting younger children at school after a trauma

Children need security and stability. Fears may underlie much of the behaviour change seen after a trauma (Yule, Udwin & Murdoch, 1990). Familiar behaviours may substitute for those feelings and behaviours that are unfamiliar or uncomfortable eg, laughing when feeling sad or worried. Children may be helped in managing these intense feelings. Parents and teachers might also be struggling with their own emotional reaction.

- Listen when the child wants to talk and answer only the question asked.
- Show the child you care so as to maintain their trust.
- Limit exposure to print or broadcast media coverage of the trauma.
- Give frequent reassurance. Be aware that children may be anxious on separating from parents.
- Allow children to be active and noisy as a way of expressing feelings.
- Look out for changed behaviour that may be aggressive or destructive.
- Use plain language when talking about death.
- If out of character behaviour persists for more than a month or so, or the child appears to be blaming himself/herself for the incident, then specialised intervention may be required and teachers are advised to discuss this with the parents.

Appendix 8

Children in middle and upper primary

Reactions considered as common to children of all ages

- ❖ Disturbed pattern of sleeping.
- ❖ Nightmares and vivid dreams often reliving the actual event.
- ❖ Fears around normal everyday occurrences.
- ❖ Fears about the future and about future events.
- ❖ Loss of interest in school and consequently lower academic achievement.
- ❖ Loss of sense of personal responsibility including simple things like hygiene and tidiness.

Reactions considered as common to children in middle and upper primary school

- ❖ Regressive behaviours such as clinging, anxiety over separation.
- ❖ Competition with brothers or sisters particularly for parental attention.
- ❖ Crying, sadness, emotionally labile, mood swings.
- ❖ School refusal.
- ❖ Social withdrawal, refusing to go out of house, remaining in bedroom.
- ❖ Disturbed pattern of activity.
- ❖ Irritable.
- ❖ Disobedient, oppositional.
- ❖ Poor concentration and attention, lower achievement levels.
- ❖ Repetitive play concerning incident
- ❖ Overt competition with siblings and peers
- ❖ Fears
- ❖ Headaches, pains, nausea.

- ❖ Sleep disturbance in both pattern and duration
- ❖ Itching.
- ❖ Visual difficulties.

Supporting children in middle and upper primary school after a trauma

Children need security and stability. Fears may underlie much of the behaviour change seen after a trauma. Familiar behaviours may substitute for those feelings and behaviours that are unfamiliar or uncomfortable eg. laughing when feeling sad or worried. Children may be helped in managing these intense feelings. Parents and teachers might also be struggling with their own emotional reaction.

Between the ages of 7 and 10, most children come to an understanding of the finality of death. The concept of death remains immature and it should be recognised that children will retain some unusual notions on what it means to be dead. At this age, death is generally seen as something that happens to other people, to older people.

- ❖ Provide a stable environment to assist adaptation to trauma. Re-establish routines
- ❖ Discuss what happened in the trauma to allow expression of feelings. Look for positive aspects. Don't feel that you have to hide your personal feelings or emotions. Children will feel less isolated if they see others sharing their emotions. If individual children have misconceptions/misinformation about the incident (particularly in relation to death) consult with the parents before correcting this.

- Limit exposure to print or broadcast media coverage of the trauma
- Use creative activities. Younger children will use play. Older children can benefit from using art, music or drama to express their feelings. This should be done cautiously and it may be wise to seek professional advice on these interventions
- Group activities can be especially useful in allowing children to regain a sense of control and security.
- Allow opportunity for creative play and encourage re-enactment of the incident. Expressing feelings through play make it less likely that the children will relive the trauma internally.

Appendix 9

Young people of secondary school age

Reactions considered as common to children of all ages

- Disturbed pattern of sleeping.
- Nightmares and vivid dreams often reliving the actual event.
- Fears around normal everyday occurrences.
- Fears about the future and about future events.
- Loss of interest in school and consequently lower academic achievement.
- Loss of sense of personal responsibility including simple things like hygiene and tidiness.

Reactions considered as common to young people of secondary school age

In a general sense, children of eleven and older share much of the adult understanding of death. As with many facets of adolescent behaviour, there is great variation between individuals. Level of understanding and acceptance may still be immature and incomplete. Adolescents want to have their feelings accepted by their peer group but may be self-conscious about the appropriateness of expressing these feelings.

- Depression.
- Discarding of responsible behaviours and attitudes.
- Sibling rivalry, intolerance and hostility.
- Withdrawal from age-appropriate activities.
- School refusal.
- Social withdrawal, refusing to go out of house, remaining in bedroom.
- Disturbed pattern of activity.

- ❖ Irritable, sadness, emotionally labile, mood swings.
- ❖ Disobedient, oppositional, defiant of authority, delinquent acts.
- ❖ Confusion over a range of sometimes-conflicting emotions or even no emotion.
- ❖ Poor concentration and attention, lower achievement levels.
- ❖ Increase in risk-taking behaviour, alcohol or drug use.
- ❖ Impulsive with an immediacy given to important decision-making.
- ❖ Strong identification with peer group, need for conformity with group.
- ❖ Fears, loss of sense of security, awareness of death as a personal threat.
- ❖ Disturbing flashbacks of the event or related occurrences.
- ❖ Avoids thoughts/feelings about the event.
- ❖ Distress at re-exposure to the event.
- ❖ Avoids activities related to the event.
- ❖ Preoccupation with the event.
- ❖ Premature assumption of adult roles and responsibilities.
- ❖ Headaches, pains, nausea.
- ❖ Appetite disturbance, eating disorder.
- ❖ Sleep disturbance in both pattern and duration.
- ❖ Itching, skin disorders.
- ❖ Visual difficulties

Supporting adolescents after a trauma

Children need security and stability. Fears may underlie much of the behaviour change seen after a trauma. Familiar behaviours may substitute for those feelings and behaviours that are unfamiliar or uncomfortable eg. laughing when feeling

sad or worried. Children may be helped in managing these intense feelings. Parents and teachers might also be struggling with their own emotional reaction.

Most adolescents have an understanding of the finality of death and start to formulate their own views on what happens after death. The concept of death can remain immature and it should be recognised that children and adolescents may retain some unusual notions on what it means to be dead. At this age, death is still seen as something that happens to other people, to older people.

- Give information on the range of normal responses to trauma and reassure that the emotional disturbance will ease.
- Provide a stable environment to assist adaptation to trauma. Re-establish routines but retain flexibility.
- Limit exposure to print or broadcast media coverage of the trauma
- Allow opportunity to discuss what happened in the trauma to allow expression of feelings. Ensure that those who don't want to participate in a discussion can opt-out. Look for positive aspects but don't use these as a way to balance or justify the traumatic event.
- Don't feel that you have to hide your personal feelings or emotions.
- Encourage use of peer support and acceptance of a range of feelings and emotions.
- Acknowledge the impact and significance of the event and how it may effect attitude to other life matters.
- Provide a range of supports: individual counselling, group work, class discussion, articles or books on grief and loss.
- Encourage the postponement of major decision-making.

If significant disturbance in individuals persists for more than a month, specialist intervention may be required and parents should be involved.

Appendix 10

Adults

Reactions considered as common to adults

- Shock, anger, anxiety, fear, terror, panic, confusion, disbelief.
- Guilt, grief, sadness, despair, loneliness, numbness.
- Helplessness and loss of control.
- Fatigue, insomnia, sleep disturbance, hyperarousal, lack of energy, crying.
- Appetite disturbance.
- Social withdrawal, alienation.
- Conflict in relationships.
- Dreams about the incident.
- Impaired concentration and work performance.
- Decreased self-esteem and self-efficacy.
- Difficulty in making decisions.
- Intrusive thoughts and memories.
- Headaches, pains, feeling unwell.
- Dissociation- feeling like in a dreamlike state.

Supporting adults and taking care of yourself

Being involved in helping people after an event may be traumatising for teachers, principals and other school staff. Involvement does not need to be direct for a reaction to occur. Recognise that those in helping roles may experience some of the common reactions to trauma. Schools have a responsibility to staff as well as students and a range of supports should be put in place to assist recovery.

To take care of the children in school, it is essential that staff take time for self-care. Hyperarousal (which can be described as feeling "switched on" or like "a coiled spring") is a common response. This can lead to over-reaction, anxiety, disorganised thinking and impaired memory, sleep disturbance and difficulty in managing everyday tasks. Sometimes the response is quite different with individual coping mechanisms complicating the picture. Remember that trauma response is a normal reaction to an abnormal event. These suggestions may be useful for helpers and other adults following a trauma.

Try to

- Rest a bit more, even if you don't sleep
- Have someone stay with you for at least a few hours
- Maintain as normal a routine as possible
- Eat regularly with a well-balanced diet. Complex carbohydrates, which are slow to metabolise, may slow down the arousal rate.
- Reduce stimulants such as tea, coffee, alcohol and chocolate (however painful!!), again to slow down arousal rate.
- Regular physical exercise provides a good outlet for the physical effects of stress. After strenuous exercise, remember to cool-down and use relaxation activities.
- Increase time with friends.
- Talk to people you trust.
- Let those who are important to you, talk about their feelings.
- Share information on reactions to trauma, how to be supportive, with family and friends so they can help you.
- Use support networks at school and at home.

- ❖ Don’t bottle things up.
- ❖ Be open to the option of counselling or other specialised support.

Following a trauma, those persons involved are more vulnerable to accidents and physical illness so take care and allow time for relaxation. If feelings persist for more than one month, or you feel you cannot deal with your emotions, or your reactions are seriously interfering with you everyday life, then it is important to seek assistance.

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Crisis Management for Schools

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Modules 5

Crisis Management Planning: A step-by-step planning process for schools

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Introduction

This module is intended to provide a step-by-step guide to formulating a school crisis management plan with reference, where possible, to evidence and best practice. By presenting a graduated process, it is envisaged that schools will be able to consider risks and how to respond to these within a framework that provides support and guidance. The progression will lead the school to devise a comprehensive package that sets out how the Crisis Management Team will operate, the tasks it will perform and the support that will be available. The process will enable the school to clearly articulate the expectations of, and tasks for, each staff member. The process may be time-consuming and therefore requires some commitment of resources from the outset. To date, it appears that there has been no fully comprehensive presentation of such a step-by-step guide although there have been some attempts to cover parts of the process in a structured way (eg, Poland & McCormick, 1999; Dwyer & Jimerson, 2002; McManus, 2003). The process suggested herein is referenced where possible to evidence and best practice but, in essence, should be considered as another best practice model that extends and details previously published processes.

The school Crisis Management Plan is unlikely to be a single document- not everyone in the school or its community needs the same information. The plan may end up as a series of documents and resources. The United States Department of Education (2003), for example, suggest that these documents and resources might include detailed response guides for planners, flipcharts for teachers and a 'toolbox' of information and other necessary supplies for administrators. There may be a single reference Crisis Management Plan where all components are brought together. This might be modularised so that each staff member need only

access the relevant parts. Key to the effectiveness of this is ensuring that individuals are familiar with their part of the plan before a crisis occurs so that the components are not being read and implemented for the first time in the midst of a crisis but rather that the components serve as a prompt or reminder on the actions required.

Conducting a school safety audit is part of this process and is to be covered more comprehensively in a separate Module. (Note. It is not intended that such a safety audit cover in detail those aspects of the school's management of issues that are generally covered by legislation, guidelines and other diverse procedures relating to workplace or occupational safety and health such as, for example, the safe storage, handling, management and record-keeping relating to chemicals used in science laboratories. These areas would likely show such a range of demands across systems and jurisdictions as to make it unmanageable to produce or use a singe document covering all possible requirements.) The safety audit will have highlighted the relevant risk factors applicable to a school situation including a small subset of events that have potential to lead to a crisis. The school safety audit is included as part of the process considered in this Module but, as a major task in its own right, is given only passing attention as part of the Planning phase of the described process.

A school Crisis Management Plan, although intended to specifically address a limited number of unusual events that might have significant impact on the school, should also have broad ranging usefulness and applicability to 'lesser' events. Crises may range in scale and intensity from incidents that directly or indirectly affect a single student or staff member to those that impact on the whole

school community and beyond. Crises can happen before, during or after school and on or off the school site. The working definition of a crisis will vary with the specific needs, resources, and assets of a school and community. What constitutes a crisis for one school may not be so for another. More 'routine' kinds of emergency may have existing procedures that will need to be reviewed in relation to the circumstances where these events might constitute a crisis. Throughout this series of Modules on Crisis Management, the same definitions and characteristics of crises have been retained (MacNeil, 2003, 2004).

Establishing an overall school plan requires a considered process for identifying risks and security needs, developing prevention and intervention techniques, evaluating physical facilities, providing communication facility, and the provision of appropriate learning and development for staff, students and other members of the school community. Standard emergency procedures and a Crisis Management Plan are both essential components.

Following the terrorist attacks of 11 September 2001 on the Twin Towers in New York, research by Bartlett and Patarca (2002) indicated that some school crisis plans were unworkable having been written simply to meet the mandates of the Safe Schools Against Violence in Education Act (SAVE) (New York State Center for Safe Schools, [NYSCSS], 2001), the SAVE act having been introduced in response to a number of high-profile violent incidents in American schools. The best practice literature recommends against 'cutting and pasting' plans from other schools - each school plan should be unique, customised to the school and community needs and resources (United States Department of Education, 2003; National Strategy Forum, 2004). Plans, policies and procedures borrowed from

other schools may serve as useful models and information sources but what is effective for one school might be ineffective, counter-productive and even damaging in another. Every school has its own values, ethos, history, culture, structure and way of operating. Schools are at risk for different types of crises and will have their own criteria for what might constitute a crisis. To meet these unique needs, Crisis Management Plans need to be customised to the school and its community.

Parents and families trust schools to keep their children safe during the day and this is normally a realistic expectation. Research by the Bureau of Crime Statistics (2004) in New South Wales showed that schools were generally ten times safer than the broader community. An increasing focus of crisis planning has become the prevention of violence and the promotion of a safe school environment (Dwyer, Osher & Warger, 1998; Curriculum Corporation, 2003). Teachers and other school personnel must know how to help their students through a crisis and return them home safely. School staff also need to know how to take care of themselves during a developing crisis and afterwards. School safety is not simply a responsibility of the Principal; it is a shared responsibility of staff, students, parents, systems, government and the broader community.

There are proforma school safety audit documents available but these often cover areas relating to local legislative requirements (for example, DeMary, Owens, & Ramnarain, 2000) or in relation to occupational health and safety (for example, Department of Education, Employment and Training, 2000). There appear to be few such documents for schools that address the identification of issues relating to crisis and Crisis Management Planning yet such a tool, if used effectively, could

provide a picture of the school's safety state and help in identifying areas that need improvement.

The process for establishing a school Crisis Management Plan

The process used in this document will follow the Prevention/Mitigation, Preparation, Response and Recovery (PPRR) framework identified by Crondstedt (2002) as originating from work by the United States' State Governors' Association in 1978. This method, sometimes called the comprehensive approach to crisis or emergency management, has become widespread in the best practice literature (eg, Tierney, 1989; Paton, 1992; Whitla, 2003) and been adopted by many organisations and governments (eg, Emergency Management Australia, 1998; United States Department of Education, 2003). The PPRR model allows for the anticipation of potential crises and outlines a sequential planning and implementation of actions before, during and after an event. The first two levels, Prevention and Preparation, are enacted prior to any crisis. The latter two levels, Response and Recovery, are concerned with post trauma events and the effective implementation of previously established contingency plans. Although the planning process might be thought of as a Preparation phase task, in putting together a Crisis Management Plan it is essential that all four stages of the framework be worked through. The plan can then document and clearly communicate not only what the school has done to prevent and prepare for crisis but also what will be done to respond to a crisis situation and aid recovery.

In presenting this process, the PPRR model is used with each of these four phases broken down into a number of steps or tasks. The tasks are numbered from the

start to the finish of the process. (Note that not all schools will need to complete every step. For example, many schools will already have undertaken programs to promote resilience, positive mental health and personal safety.) At both the beginning and end of the process, there are tasks that do not fit comfortably into the PPRR model, notably numbers 1 and 26, and this may be indicative that the PPRR model has failings when used as a planning tool. The tasks are based on an analysis of the requirements at each stage of the planning process. Where other writers have identified tasks as presented here, these are referenced in the document. Some tasks have associated information giving background or other relevant detail presented as introduction before the task is detailed and this should be helpful to those unfamiliar with the planning process.

Preliminary Phase

The Planning Group

It might be assumed that putting together the planning group is part of the Preparation phase but this team has to be in place from the beginning of the process. The planning group is not necessarily the same group who will ultimately be on the school's Crisis Management Team. Not all tasks will be completed in the order seemingly prescribed by PPRR. This highlights one of the weaknesses of the PPRR model in that it has an apparently linear nature (Crondstedt, 2002) and the planning group should be mindful not to be constrained by this or confused in the planning process. Certainly the process described here is kept simple and is linear in that one task follows another but adherence to the PPRR model is not rigid. Some tasks might usefully be completed in parallel. Ideally, after each task there should be review of all that has gone before with

consideration of potential impact on future tasks and actions, and implications for other policies and practices in the school. Yet such a detailed, multi-dimensional model would likely make the process difficult and impractical. An effective compromise might be review, revision and consideration of past and future tasks at the end of each phase of PPRR with other policies and practices being subject to review at the completion of the Crisis Management Planning process.

Task 1. Decide who will be part of the planning group involved in the process of developing the Crisis Management Plan (eg, McManus, 2003)

This is an essential preliminary undertaking before beginning work on the Crisis Management Plan using the Prevention/Mitigation, Preparation, Response and Recovery (PPRR) framework.

Identify, and involve in the planning group, those concerned for the safety of the school. Dwyer and Jimerson (2002) recommend that, at a minimum, the team should include an administrator, a teacher and a mental health professional. This may include school staff, external personnel and anyone who may be called to provide assistance when a crisis situation occurs. If external support is likely to be used during a crisis event, it is particularly important that there is representation from these support providers on the planning group. This allows for common understanding and agreement on any role to be played and avoids a mismatch of expectations at a critical time (United States Department of Education, 2003).

The planning team may choose to set out goals in terms of how the plan will be put together and what the school might aim to offer in response and recovery but

these initial goals will likely evolve as the process unfolds. The planning team will aim to elicit a range of information from varied sources in order to formulate a coherent plan that will meet the school's needs and the expectations of the school community.

Prevention/mitigation Phase

The Prevention element

Because no two schools are the same, no manual or checklist will provide all of the necessary information to prevent or reduce the impact of every potential crisis situation. Nor are any two crises the same so it cannot be assumed that, having managed one circumstance, a school will be equipped to successfully manage another.

A school and facilities safety audit

A school and facilities safety audit will be given detailed attention in another module. The information below is intended only as a brief overview of the process and outcomes.

Many if not all schools will fulfil statutory or organisational requirements to undertake safety audits in relation to legislative and occupational safety and health. The range of requirements and the level of detail for these audits may be varied. It is not the intention to cover areas that are mandated by legislation, educational systems/organisations or where risks are readily identified. Rather, the intention is to consider areas where risk may be less apparent or where there is an underlying assumption of safety as may often be the case with schools. A school

and facilities safety audit would generally focus on risk assessment but there is a second element, the promotion of safety, and this is covered at a later stage.

Risks can be identified in a range of formal and informal ways. Information from the Australian Bureau of Statistics (ABS) may provide information on death rates and help in identifying changes to risk levels. For example, age specific death rates increase 6 fold from age ranges 5-14 (5-9 and 10-14) to 15-19. These rates are comparatively low as death rates generally increase with age but the size of the increase is substantially greater than that seen between any other contiguous age ranges. (Australian Bureau of Statistics, 2003). Other ABS data may prove useful in identifying likely causes of death or injury. Less formal methods might involve reviewing incident data and previous crises within the school or other schools. Further guidance is provided in Task 3 which identifies a range of possible risk situations which might be relevant to most schools.

A safety audit may identify a wide range of risk areas but it is probable that only a limited number of these will be relevant to Crisis Management Planning. Many 'routine' kinds of emergency situation will likely already be catered for within existing processes, for example, fire and evacuation procedures, accident or medical emergency generally have established response mechanisms within schools and other organisations. Although there will be clear links between the two, it is important to retain the differentiation between standard emergency plans and the Crisis Management Plan. When the emergency is over, the crisis may just be starting and not every emergency situation will match the defining characteristics of a crisis.

Risk assessment is a process of measuring the potential loss of life, personal

injury (both physical and psychological), economic impact and property damage resulting from a range of potential hazards by assessing the vulnerability of people, processes, buildings and other infrastructure (Federal Emergency Management Agency, 2001). Risk assessment provides a basis for the rest of the prevention and mitigation phase of the planning procedure. The risk assessment process focuses attention on areas of need by evaluating which groups, processes and facilities are most vulnerable and to what extent injuries and damages may occur. It gives information on:

- the hazards to which the school and its community are susceptible;
- what impact there may be to individuals and groups, to physical, social and economic assets if the dangers associated with the risk factor come to fruition;
- which individuals, groups, buildings facilities and areas are most vulnerable to these hazards; and,
- the resulting cost of injury and damage or costs avoided through present and future prevention and mitigation undertakings.

In addition to benefiting mitigation planning to both reduce the risk and reduce the impact, risk assessment information also allows the school's Crisis Management Team to establish early response priorities from the identification of potential hazards and vulnerabilities. A safety assessment of school and facilities can be a strategic evaluation used to identify emerging and potential school safety problems. These activities identify the policies, processes, practices and places within the school environment that may be overlooked due a lack of understanding or an assumption that these are safe and trouble-free. During an assessment, these factors are examined to ascertain their impact on the school's

educational mission, student and staff safety, school climate, school attendance, and overall school security.

Principles

- ❖ Know the school buildings and grounds.
- ❖ Know the staff and students.
- ❖ Know the local community.
- ❖ Work with others from the community.
- ❖ Establish and maintain internal and external lines of communication.
- ❖ Promote safety throughout the school.

Task 2. Conduct a school safety audit (McManus, 2003; United States Department of Education, 2003)

The physical condition of the school building and grounds can have an impact on the attitude of students, their behaviour and motivation to achieve. Dwyer, Osher and Warger (1998) report that there are frequently more incidents of fighting and violence in school buildings that are dirty, covered in graffiti, too hot or too cold, or in need of repair or maintenance. Although not all inclusive, schools should address the following areas:

- ❖ The surrounding environment;
- ❖ Play and sports areas;
- ❖ Canteen and kitchens;
- ❖ Entries and exits;
- ❖ Monitoring/surveillance, staff, student and visitor identification, security and alarm systems, key control;

- Building and grounds: exterior walls, windows, paths, walkways, stairways, boundary walls and fences, public access, vehicle access, parking, bicycle racks, bins and waste disposal etc.;
- Main entrance and Administration;
- Corridors;
- Toilets and shower areas;
- Classrooms, library, gymnasia and other teaching areas;
- Student lockers, bag and book storage areas;
- Common areas including staff rooms, student common rooms, kitchen and dining areas, assembly areas including those for building evacuations.

Consider the contribution that students, staff and community members may make in identifying potential hazards or trouble spots. For example, students may identify 'hot spots' in the school where bullying or violence may be more likely (see for example, Cross & Erceg, 2004). Parents may be aware of changing factors within the community such as new gathering areas for young people, gang activity or group conflict.

Task 3. Assess vulnerabilities that might precipitate a crisis

While it is not possible to prepare for every crisis situation, schools should have an awareness of the kind of situations where there may be some vulnerability. There should be a focus on realistic events relevant to the local context rather than improbable events. Brock (2002) classifies crisis events as follows.

- Severe illness and injury (eg, life-threatening illness, road traffic accidents, suicide attempts, assaults).

- ❖ Violent and/or unexpected deaths (eg, fatal illness or accident, murder, suicide).
- ❖ Threatened death and/or injury (eg, robbery, mugging, rape, child and spouse abuse, kidnap).
- ❖ Acts of war (eg, invasion, terrorism, bomb, hijacking, hostage-taking, chemical/biological substance).
- ❖ Natural disasters (eg, Flood, fire, hurricane, cyclone, avalanche, earthquake).
- ❖ Man-made/industrial disasters (eg, aeroplane crash, nuclear accident, exposure to toxic agents, industrial accident).

The following table covers some of the more common kind of risks that may precipitate a crisis and these are likely to be applicable to many schools. One task may be to decide if and when a 'routine' emergency will continue or escalate into a crisis and this will vary by individual circumstance. Although this list is neither exhaustive nor in rank order, it may help in identifying risks. Rating of risk should be considered as an interaction between likelihood of an event occurring and the severity of the consequence. The table is repeated as a stand-alone document in the Appendices.

Type of Risk	Risk level			
	High	**Medium**	**Low**	**None**
Sudden death of student, staff or community member				
Fire				
Arson				
Assault				
Motor vehicle accident				
Suicide				
Abduction or kidnapping				
Hostage taking				
Murder				
Shooting				
Explosion				
Sexual assault				
Chemical spill				
Bushfire				
Flood				
Cyclone				
Fight				
Drug overdose				
Major infectious disease				
School camp/excursion incident				
Medical emergency				
Adverse media coverage				
Industrial accident				
Armed robbery				

Having identified realistic risks to the school community, safety strategies can be developed to prevent events occurring and to minimise the risk when these hazards cannot be removed entirely. Some strategies will be intended to minimise the impact should an event occur. A critical part of this process may involve a costs and benefits analysis in order to help to prioritise actions. Mitigating crisis

events is also important from a legal standpoint. If a school does not take all necessary and reasonable actions to create and maintain a safe school environment, it could be vulnerable to a lawsuit claiming negligence.

Task 4. Define and identify the kind of crises the plan will address (United States Department of Education, 2003)

This task may be delayed until the Preparation phase but it does follow-on logically from the preceding task. (Crondstedt [2002] has noted another weakness of the PPRR model in that it places excess importance on the phase of the PPRR in which activities occur rather than the value of the activities within the process.) It is important to bear in mind the defining characteristics of a crisis (see MacNeil, 2003). Crises events are sudden, threatening, overwhelming and traumatic and this sets them apart from many 'lesser' emergency situations.

Before establishing a membership to the Crisis Management Team, before assigning roles, responsibilities and tasks or looking at resourcing, define what a crisis might be for the school. Describe the types of crises that the school aims to address in the plan including those elements identified from the safety audit, incidents that may occur during off-site excursions, community factors and environmental events.

Since the attacks of 11 September 2001, terrorism has featured heavily in Crisis Management Planning in the United States and elsewhere with extensive materials being made available not only for the community but also directed at schools (eg, National Association of School Psychologists, 2002; United States Department of

Education, 2003). In September 2004, there was a terrorist attack on a school in the town of Beslan in Chechnya. Of the reported 332 dead, 176 were children (National Counterterrorism Centre, 2005). In spite of this tragic event, there appears to be no evidence that schools are at high risk of direct terrorist attack. There have been reports of threats to International schools (for example, BBC, 2002; 2003). Schools should be aware of community vulnerabilities, for example, of proximity to other potential targets for acts of terror, or the responsibilities and expectations of the school in an attack on the broader community. Any potential vulnerability related to terrorism should be given careful consideration, be subject to a costs/benefits analysis and involve community emergency responders in clarifying roles and responsibilities.

The Mitigation element (of the Prevention/Mitigation phase)

While Prevention considers what can be done to stop certain kinds of event from happening, Mitigation takes a further step, focusing on how to reduce the risk when it is not possible to entirely eliminate the hazard and on how to reduce any subsequent impact on the school and the community.

Some risks may be removed entirely through effective prevention strategies. In instances where the risk cannot be entirely removed, it may be possible to take actions to reduce the likelihood of an event occurring. Fire risk, for example, cannot be removed entirely but may be reduced by ensuring that petrol, solvents and other highly flammable materials are kept in appropriately secured locations. In some instances it may be possible to remove the hazard by substituting a safe alternative. Administrative controls such as policies, procedures and practices can serve to reduce risk, for example, good security practices in the school may reduce the chance of theft, vandalism or other malicious attacks.

Although schools may have little or no control over some of the hazards that may impact on them, steps can be taken to minimise the effects that these might have on the school and its community. Staff training in areas such as Youth Suicide Prevention may assist in providing timely intervention to distressed young people. Curricula can be an important way to reduce the impact of crisis events on students and this is addressed in the following tasks.

Task 5. Promote Positive Mental Health and Resilience

Schools are being encouraged to promote positive mental health (World Health Organisation, 1986, 1994; Commonwealth of Australia, 1996). As part of the preparation for making the school safe, it is important to ensure that policies, procedures and practices foster a positive school climate (Feinberg & Jacob, 2002). Consider the range of health education curricula already implemented within the school or available locally and nationally. Make contact with other schools to elicit information on the success of any programs they might be using. A number of programs are available that can be used within the curriculum (see MacNeil, 2003 for examples).

"Resilience is the ability of rebounding or springing back after adversity or hard times. It is the ability to bungy-jump through life. It is as if the person has an elasticised rope around their middle so that when they meet pitfalls in their lives they are able to bounce back out of them" (Fuller, 1999). Fuller, McGraw and Goodyear (1998) found that the factors that promote resilience in young people include family connectedness, peer connectedness and fitting-in at school and that young people with these links are less likely to develop mental health problems.

In promoting resilience via the school curriculum, the benefits should be twofold. First young people should be less likely to develop the kind of mental health problems that can lead to crisis situations such as risk-taking behaviour, violence or suicide. Secondly, when facing a crisis, the young person should be able to cope with the challenge more successfully. Schools can access resilience-building support materials from packages such as MindMatters (Curriculum Corporation 2000).

Task 6. Review the social climate of the school

Social disruption can be a defining characteristic of a disaster (Barton, 1989). In order to determine the degree of social disruption brought on by any such crisis, it is necessary to know something about the pre-crisis state of the community. According to this assertion, the severity of the effect of a crisis on a school will be significantly affected by its pre-crisis state as well as the nature of the presenting crisis situation. Preparation for crisis management in schools should, for that reason, include a review of the pre-crisis social climate of the school and a consideration of the current level of social stability.

Personal safety issues can be important determinants of the school climate. Bullying, harassment and violence have received growing attention within the school environment (eg, O'Toole, 2000; Rigby, 2001; Curriculum Corporation, 2003). The United States Department of Education (1998) in presenting a summary of research on school violence prevention, intervention and crisis response emphasised that:

- ❖ everyone has a responsibility for reducing the risk of violence,
- ❖ everyone should have an understanding of the early warning signs that may indicate trouble, and
- ❖ everyone should be prepared to respond appropriately in a crisis.

The United States Department of Education(1998) describes effective schools as fostering learning, safety and appropriate behaviour. Safety was felt to be enhanced when students were given suitable support to achieve strong academic standards, the school fostered positive relationships between staff and students and promoted significant parental and community involvement (The United States Department of Education 1998).

Fein, Vossekuil, Pollack, Borum, Modzeleski and Reddy, (2002) identify the major components and tasks for creating a safe school climate. These include:

- ❖ assessment of the school's socio-emotional climate;
- ❖ emphasis on the importance of school personnel and students being prepared to listen;
- ❖ adoption of a strong, but caring stance against the 'code of silence';
- ❖ prevention of, and intervention in, bullying and harassment;
- ❖ involvement of all members of the school community in planning, creating, and sustaining a school culture of safety and respect;
- ❖ development of trusting relationships between each student and at least one adult at school; and,
- ❖ creation of mechanisms for developing and sustaining safe school climates.

O'Toole (2000) offered a classification of threats of violence and suggested ways to assess and respond to these incidents. Findings from The Safe School Initiative study (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002) indicated that incidents of targeted violence in school were rarely impulsive. The students who carried out these attacks usually planned in advance, making preparations that were often observable. Prior to most attacks, there were other children who knew that an attack was to occur but those who knew of pending attacks rarely told adults. In a climate of safety, Vossekuil, Fein, Reddy, Borum, and Modzeleski (2002) contend that students are more willing to break this code of silence, are more likely to turn to trusted adults for help in resolving problems and are more willing to share their concerns about the problem behavior of peers with their teachers and other adults in positions of authority within the school without feeling that they are betraying a friend. A number of government programs have occurred as a consequence of student-initiated violence in schools. In "Early Warning, Timely Response: a guide to safe schools" (United States Department of Education (1998), warning signs of possible violence are identified and linked to principles aimed at ensuring these signs are not misinterpreted and are used responsibly as an aid in identifying and referring students who may need help. Further research into indicators and predictors of potentially violent behaviour is presented in "The School Shooter: A Threat Assessment Perspective" (2000) wherein a model is offered, together with indicative warning signs, to allow evaluation of threat. Such programs have had an influence on Crisis Management Planning in as much as schools appear more aware and equipped for early detection and prevention. In is difficult however to gauge their effectiveness as events such as those that occurred in Jonesboro, Columbine and Dunblane are rare.

Phase 2: Preparation

Preparation involves planning, training, education and practice. Being well prepared involves an investment of time and resources beyond that already made in pursuing the planning process.

Checklist for Preparedness

To aid in establishing the Crisis Management Plan and enhancing the school's state of effective preparedness, consider the items on the following checklist. Some elements of this are adapted from that of the United States Department of Education (2003).

- Determine what crisis or other emergency plans already exist in the school, district and community and review how the school's crisis planning fits in with these.
- Identify all stakeholders involved in crisis planning and response.
- Involve those who may be part of your school response in order to ensure a common understanding of responsibilities.
- Develop a process for documenting actions and information flow during a crisis.
- Develop procedures for communicating with staff, students, families, organisational administrators, emergency services and the media both during and outside of the school's normal hours.
- Develop communication procedures for when normal communication capability is disrupted.

- Develop draft documentation appropriate to some of the identified risks for the school.
- Establish procedures to account for students, staff and any visitors to the school during a crisis.
- Gather information about the school facility such as maps and the location of fire hydrants and electricity and gas shut-off points.
- Identify the necessary equipment that needs to be assembled to assist staff in a crisis.
- Identify the human resources that can be called upon to fulfill roles in the crisis management team or who may be called on to support the school.
- Ensure all staff and students know which staff members are qualified in first aid and where to go for help. Remember that students may also hold first aid qualifications and be prepared to assist in a crisis. (Students should not be asked to assist if there is any element of risk, danger or if distressed by the event.)
- Ensure all staff and students know where to access safety and first aid equipment.
- Identify areas or rooms within the school for Crisis actions, eg, for the Crisis Management Team to meet, for counselling, for parents to gather etc.
- Identify alternate facilities should the crisis mean that school is not available or where existing facilities are insufficient.

In the event of a crisis, a school Principal would be unlikely to successfully manage the many tasks associated with responding to a critical event without assistance (National Strategy Forum, 2004). Principals must delegate authority

and rely on other key school personnel to perform tasks that will ensure the ongoing safety and wellbeing of students, school personnel and families during a crisis. The use of a Crisis Management Team is accepted in the best practice literature as the most effective way of dealing with a critical incident (eg, Poland & McCormick, 1999; Brock, 2002).

Define and identify the kind of crises the plan will address

This task has been addressed earlier as part of the Prevention/Mitigation phase but could alternatively be addressed at this stage. (Refer to Task Number 3 where vulnerabilities were considered.)

Task 7. Consider existing plans (United States Department of Education, 2003)

Before committing time and resources to putting together a Crisis Management Plan, investigate whether any other plans exist within the organisation, at local government level or with emergency services. Look at plans for more 'routine' kinds of emergency such as evacuation in the event of a fire. There may be an existing Crisis Management Plan within the school that could be revised and updated. Consider how any such plans might interact with the school's response and how to coordinate a response to a crisis that has effects outside of the school. Is there information or processes from other plans that can be adapted for use in the school's Crisis Management Plan? (As noted earlier, copying and pasting of plans is not recommended.)

Task 8. Consider any recent changes in the school

Review any completed or planned changes to the school environment including renovations or new buildings and facilities. Check that the list of staff is current and that emergency contact details are up to date. Review when student and parent information was last updated and, if necessary, take steps to make this current. Examine whether there are likely to be any changes to the environment surrounding the school such as road changes, new factories or other building and whether these might be of future risk.

Instruction, training and practice

These might be considered as the final elements of the Preparation phase of the PPRR model. In putting together a plan, the instruction, training and practice can only usefully occur when the plan is completed. These tasks are therefore addressed later in the process (See Task 26).

Phase 3: Response

It is worthwhile re-iterating here that putting together a Crisis Management Plan is a Preparation phase task from the PPRR model. Addressing Response and Recovery as part of the planning process means that the plan can document and communicate not only what the school has done to prevent and prepare for any crisis but also what will be done to respond to crisis and aid recovery.

It is at this Response phase of the PPRR model that the planning group starts to consider what the school will actually do when responding to a crisis. In these tasks, it is critical that the planning group have realistic aims and expectations on

what the school can do and what might be achieved. It may be that the goals are very general (for example, to provide support to children, staff and families; to aid recovery; to facilitate return to normal school functioning) or very specific (to provide counselling to students and staff; to help parents manage children's distress; to implement depression prevention programs for students; to help staff cope with grief). There may well be overlap of the Response and Recovery phases reflected in the goals but these should remain firmly anchored in the context of the available school and organisational resources.

Task 9. Identify the human resources available to form the Crisis Management Team

The membership of each school's Crisis Management Team should consist of an immediately available group of school personnel who have the knowledge and skills to handle a critical event. In addition to the school principal, members should be selected based on specific skills required to meet those needs that will likely be encountered during an emergency. Selecting a wide range of members for the Crisis Management Team is recommended in the best practice literature (eg, National Disasters Organisation, 1992; Said, 2001; Dwyer & Jimerson, 2002) and should help ensure the various aspects of crisis planning can be accomplished. There is no evidence at this point to suggest that having particular members or skills in the team leads to better outcomes for the school.

Having a range of available personnel is relatively easy for most schools but smaller establishments may have very few school personnel to assist. In these circumstances, schools may have to consider inviting members of the school

community to be part of the Crisis Management Team. Parents, priests, ministers and others from the community may have skills that can be brought to bear at short notice. Be aware of any legislative of organisational requirements relating to who may provide services in schools, for example, a police clearance may be needed by some organisations or jurisdictions.

There is no consensus in the best practice literature on whether external individuals or agencies should be involved in either the school's Crisis Management Team or in any response role. Regardless of whether external agencies are to be involved or whether the overarching organisation takes on management responsibility, the school will have to manage using only its own resources at least in the initial stages of the crisis. Accordingly, first response measures should be solely school-based and not dependent on external support. Each member of the Crisis Management Team should be identified, linked to a role, able to respond rapidly, and be practiced and comfortable with his or her role (or roles) before a crisis occurs.

Task 10. Identify the Roles that may have to be filled in the Crisis Management Team (Poland & McCormick, 1999; United States Department of Education, 2003)

Some of these roles and the associated tasks will be relevant to every crisis and some will only apply in particular situations. It may be that one individual will fill multiple roles. Roles should be filled and tasks allocated only when necessary to effectively manage the presenting crisis. Some of these roles and tasks have been adapted from Poland and McCormick (1999). When putting together the Crisis

Management Team, ensure that there is a individual and a back-up person allocated to each role to ensure the team can continue to function if members are unavailable. There is an obvious need here for the Principal to delegate authority should he or she be unable to fulfil a leadership role in the team during the crisis.

- Team Leader -usually, the Principal.
- Communication- A Deputy or Assistant Principal, a public relations or media officer.
- Security - A Deputy or Assistant Principal with caretaker or grounds person.
- Parent/Family/Community Liaison- Pastoral care staff, a teacher.
- Medical - A Deputy or Assistant Principal, school nurse or a teacher qualified in first aid.
- Counselling - School Psychologist, counsellor or social worker
- Staff Welfare- Deputy or Assistant Principal, School Psychologist

Smaller schools may have to consolidate some of these roles with, for example, the Principal filling roles of Team Leader, Communication and Staff Welfare. When multiple roles have to be filled, it may be that important tasks are neglected or forgotten unless each team member has adequate documentation to aid in working through responsibilities and prioritising functions.

When a crisis becomes public, there may be a range of individuals or groups who offer assistance to the school. Some of these may be genuinely helpful, others may not. A degree of caution is needed before accepting any outside help so that there can be some assurance of real benefit to the school. It may be useful to decide in advance whether and in what circumstance any such offers would be accepted.

Task 11. Identify the duties associated with each role within the Crisis Management Team (Poland & McCormick, 1999;)

An example of a role and duties is given below. See MacNeil (2004) for a full listing of other possible roles and tasks. The duties associated here with Team Leader are extensive and it may be that some of these can be delegated to others.

Team Leader

In this consideration of the Team Leader's duties, there is an assumption that this role will generally be filled by the Principal. If this is not the case, it is important that there is recognition of the delegated authority that goes with the role.

- Initial verification of the facts.
- Enactment of the Crisis Management Plan and summoning of the Crisis Management Team.
- Delegation of any incident-specific tasks to team members.
- Emergency services liaison.
- Approval and authorisation of information dissemination.
- Advising staff, students and parents of the incident or delegating some of these elements to other Crisis Management Team members
- Organisational communication.
- Record keeping.
- Requests to external agencies for assistance.
- Visiting any bereaved families.
- Meeting with parents and families of those involved.
- Visiting those in hospital.
- Being available and visible to the school community.

Task 12. Identify the tasks that the Crisis Management Team will have to undertake from the immediate through to the long term

Extended task checklists are provided elsewhere (see MacNeil, 2004). Although comprehensive, these are not all-inclusive and are not a chronology of what to do and when. Checklists should be adapted to take account of the school's particular situation and resources. Published checklists tend to be limited but can be found in many resource manuals (eg, Western Australian Youth Suicide Advisory Committee, 1998; Department of Education, Employment and Training, State of Victoria, 1997). The checklist should be revisited regularly during a crisis. Some actions may occur multiple times and at different stages.

Initial decision-making involves:

- Verifying the facts.
- Taking any actions required immediately, eg, evacuation, call to emergency services.
- Deciding if this is, or may, constitute a crisis for the school.
- Enacting the Crisis Management Plan and calling together the Crisis Management Team.
- Deciding on the level of response required initially.
- Delegate and action tasks.
- Review actions and processes on an ongoing basis.

Task 13. Identify and plan for event-specific tasks

Some kinds of events may require actions that are specific to the event. Consider the list of potential crises already identified to find those that may require a specific kind of response or action. For example, a fire in the Administration area would not only require an evacuation but would likely have immediate consequences for the functioning of the Crisis Management Team. A bomb threat might require an alternative evacuation route. Any kind of lock-down or protect-in-place strategy might disrupt communication.

Some situations such as a suicide require responses that are unlike those that might be expected for other kinds of crises- death by suicide is fundamentally different to death from a road traffic accident All schools should ensure that they have key staff who have undergone extended training in Youth Suicide Prevention and are able to inform actions appropriately after a suicide. When death is by suicide, a number of event-specific responses are required, for example, striving to prevent contagion effects by not normalising suicide or presenting it as a viable response to difficulties, not glorifying or memorialising the deceased (Western Australian Youth Suicide Advisory Committee, 1998; Poland & McCormick, 1999).

Task 14. Identify the resources needed for the Crisis Management Team to function and for the Crisis Management Plan to be effective (United States Department of Education, 2003)

Identify the resources that all members of the Crisis Management Team might need such as access to telephones and computers. Provide task and duty lists for all team members. Identify the resources specific to roles within the team such as keys for the Security role or emergency contact information for the Parent/Family/Community liaison role.

Provide task and duty lists for all staff. Make it clear what is expected of each staff member during a crisis. There will likely be a need for a number of different lists. Provide for all staff to have ready access to the equipment needed to respond to a crisis situation. Have mobile phones available where necessary. Ensure that first aid kits are well stocked and that staff and students know where these are located. If rooms or areas are likely to be required for specific activities such as counselling or for parents to gather, then ensure that these are identified and can be made quickly available in a crisis situation. It is generally a good idea not to allocate the staff room to another purpose unless there is no alternative- staff need to be able to gather as usual during an unfolding crisis.

Task 15. Establish a record keeping process

Record keeping is an essential part of crisis management. Schools need to have accurate and detailed record keeping for all aspect of the Crisis Management process. Each member of the Crisis Management Team should keep records of the what, how and when of decisions and actions taken. Not only might these records be important if there are liability issues associated with the crisis but they will also be a valuable resource in reviewing the implementation and effectiveness of the plan at a later date.

Task 16. Plan a communication process that allows information to flow to and from those who need to know what is occurring (United States Department of Education, 2003)

Communication is a key component of the Crisis Management Plan. The communication process should be wide-ranging allowing for contact with all relevant groups through a variety of medium in a spectrum of circumstances. Develop communication procedures for when normal communication capability is disrupted. It is important to decide on a process for passing information to staff, students, families and others. It can be helpful to again consider the list of potential crises already identified and look at communication needs in these circumstances. A crisis occurring outside of normal school hours might use a simple 'telephone tree' to pass information upwards or downwards to and from staff members and this would be relatively simple. If there is an emergency evacuation of the school premises because of a fire, communication of vital information could be more difficult. For such a situation, consider how information on a missing student or teacher would be conveyed to those who need to know and how this would be passed to emergency responders. Consider how parents might be contacted to advise of injuries, to collect individual students or if school is to be suspended. There would likely be special considerations needed when staff and students are off-campus. Consider how any special needs students will be given appropriate information about the crisis situation.

In some situations, staff and students may need to be alerted to an imminent risk. Fire alarms are an obvious instance of this kind of alert. Other situations can pose

threat that may need to be advised to staff and students, for example, an intruder with a weapon on the school premises. In this kind of situation, an evacuation would not be safe and other actions are needed. Australian standard 3745-2002 (Standards Australia, 2002) sets out a colour-coding system for different kinds of emergency situations that schools may choose to use. Other kinds of code may also be used, for example, a public address announcement advising of a visitor in the buildings might serve as warning of an intruder and have staff and students go into a protect-in-place or shelter-in-place mode. As codes can be difficult to remember and may be meaningless to visitors, contractors and others legitimately in the school, there is support for using plain language warnings from, for example, Poland and McCormick (1999) and the United States Federal Emergency Management Agency (2003).

Task 17. Prepare draft documentation suitable for a range of realistic crises that may impact on the school

Draft documentation is widely endorsed in the best practice literature (eg, Department of Education, Employment and Training, State of Victoria 1997; Poland & McCormick, 2000; McManus, 2003) and should be prepared to cover a range of likely events. It is easier to make small changes to draft documents than to start from scratch in the midst of a crisis. The associated task at this stage is to decide who needs to know what. It is generally not a good idea to hold back information particularly if it is likely to become public. Confidential or private information should be protected unless permission has been given for its release.

It can be useful to follow a standard format, modifying information for each audience. The sample documents included in the Appendices follow a seven-stage process.

- ❖ Introduction.
- ❖ The facts.
- ❖ What the school has done so far.
- ❖ What the school is going to do.
- ❖ Who to contact and how.
- ❖ Close statement.
- ❖ Authority statement.

Task 18. Prepare for immediate response (United States Department of Education, 2003)

Some situations will require an immediate response, often in adverse conditions. Having the whole school evacuate for a fire drill may mean everyone exposed to the weather for a few minutes. A real fire might mean a lengthy time in the open before students can be safely returned to class or released to parents. Plans should address how these and other similar circumstances might be managed. Emergency responders may have to be called before the Crisis Management Plan is brought into play. Develop procedures to address basic needs such as safety, shelter, water, sun protection and reassurance for distressed individuals. Consider how student and staff medical needs might be met during a crisis. How will the school meet the need for any medications (for example, medications for diabetes, asthma, epilepsy, anaphylactic shock) if an evacuation is for an extended period and personal belongings have been left behind?

If the school has students with Special Needs, identify any other steps that may be needed to ensure their safety and comfort. The California Department of Education (2005) recommends that these resources be available.

- Name cards posted by the door.
- Current significant medical information.
- Agreements to include medical treatment.
- Medications as necessary.
- A strobe light for deaf students.
- Picture cue cards for neurologically involved or significantly delayed students.
- Sign language or cue cards.

For the whole school, plan for these circumstances.

- Evacuation- rapid exit of all staff, students and visitors from the buildings. Review facilities that might be used as emergency shelter if the evacuation is extended;
- Reverse evacuation- quickly getting all staff students and visitors into the buildings when there is an external threat;
- Lock-down and/or Protect-in-place - when it is necessary to secure classrooms and other buildings when movement may be dangerous.

Identify the steps and actions that individual staff members must take when evacuation, reverse evacuation or lock-down/protect-in-place is needed. This might include actions such as collect the student register, class first aid or emergency kit, and student medications when evacuation is needed. The

emergency response box advocated for Administrators (Lockyer & Eastin, 2000) might prove to be a suitable means for managing emergency resources for all teaching staff.

Identify any event-specific actions expected of students. For example, students may be expected to act as messengers when a school has evacuated or if there is a medical emergency. In such circumstances, it should be clear to whom the students are to report, where, and if they should return to their class groups thereafter. Students should not be involved in any activity that may put them at heightened risk.

Task 19. Account for students, staff and any visitors to the school

Develop procedures to account for all students, staff and visitors during a crisis situation. Schools routinely keep track of where each student is at a given time but may not always do so for staff or visitors. If anyone is missing, this has to be quickly established, confirmed and advised to the Coordinator of the Crisis Management Team so, if necessary, the information can be passed to emergency services.

As part of the continued accounting, plan student-release processes and ensure that students can only be handed over to those authorised.

Task 20. Put together Action Cards or Flipcharts describing what each person must do for a limited number of situations

A Crisis Management Plan is an extended document that will likely be too unwieldy for most staff in a crisis situation. Most school staff will benefit from a much simpler set of instructions that detail the 'nuts and bolts' of the plan at the individual level. An example for a class teacher implementing an evacuation procedure in the event of a fire might be as follows.

1. Collect register or class roll.
2. Identify any students from class presently in other parts of the school.
3. Collect any medications, first-aid box or crisis response box.
4. Evacuate via designated route.
5. Leave the classroom after all children have exited using designated evacuation route.
6. Leave classroom door closed (and windows if time permits).
7. Assemble students at designated point.
8. Account for students and report this as required.

For a bomb or substance threat, the steps may be supplemented or modified as follows.

1. Collect register or class roll.
2. Identify any students from class presently in other parts of the school.
3. Have students gather their schoolbags and other personal belongings.
4. Identify but leave untouched any unclaimed bags or unfamiliar packages.
5. Collect any medications, first-aid box or crisis response box.
6. Leave the classroom after all children have exited using alternative evacuation route.

7. Leave classroom door open (and windows if time permits).
8. Assemble students at designated point, clear of any buildings or vehicles
9. Account for students and report this as required.
10. Caution students against the use of mobile phones.

Phase 4: Recovery

Recovery can be considered as beginning from the very first steps taken in crisis planning. When an event occurs, again recovery should be viewed as starting from the earliest moments of the crisis, not simply from that time when the Response phase might be considered complete.

Task 21. Strive to maintain the school's functioning (United States Department of Education, 2003)

If possible, keep the school open during the crisis. Where circumstances are such that alternate accommodation is needed, try to have students and staff resume as soon as possible. Routine can be supportive to those who have been involved in a crisis. Encourage parents to send students to school. Any support provided by the school to students and staff will likely be in the school.

Task 22. Provide support to students and staff

There are a number of subheadings associated with his task.

Who will need support?

It is important not to pathologise normal reactions, to increase the expectancy of developing psychological symptoms in those who would otherwise not have done so. The National Institute of Mental Health (NIMH) consensus workshop (2002) agreed on the working principle of expecting normal recovery in the immediate post-incident phase.

Children's reactions to traumatic events have been found to be closely aligned to parental reactions (Norris, Friedman & Watson, 2002). A family's positive reactions can reduce the impact on the child but negative reactions can accentuate problems in adjustment and coping. Providing support to parents in managing the impact of an event may be the most effective way to support children's adjustment and coping.

An event that may appear localised can reach out to affect others in the community. The severity of the impact on an individual may not reflect the person's 'closeness' to the event. Be prepared to offer appropriate support to more than just those who appear to be immediately involved.

Key considerations are therefore to:

- expect normal recovery;
- support parents in helping their children; and,
- be prepared to offer support to a range of individuals in the school community.

What kind of support can be provided?

Provide support to students, staff and, where appropriate, families. The responses of children and adolescents to crises events remain a relatively neglected area of research. This of course raises the question of what can be done to support students and staff. There is a growing evidence base that indicates the efficacy of various interventions following a crisis.

Counselling and debriefing services are often the first plans for the emotional needs of those involved in a crisis (eg, Mitchell, 1983; Paton, 1992). The supportive evidence for these kind of interventions is lacking (National Institute of Mental Health, 2002; Rose, Bisson &Wessely 2003; Devilly & Cotton, 2003) and, accordingly any kind of psychological debriefing or Critical Incident Stress Debriefing should not form part of the school's Crisis Management Plan.

In considering best practice, the NIMH consensus workshop (2002) agreed that:

- Early, brief and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents, and children;
- Selected cognitive behavioural approaches may help reduce incidence, duration, and severity of acute stress disorder, post-traumatic stress disorder, and depression in survivors.

Devilly and Cotton (2003) suggest that early intervention should be differentiated from psychological debriefing. Early intervention is described as providing 'restorative treatment' to individuals who request psychological help following a trauma and who have a clinically significant presentation. Treatment for Acute Stress Disorder would be an examples of early intervention and this can be

viewed as an active attempt to treat a present pathology as opposed to the supposedly preventative role of psychological debriefing.

Daily-living tasks can be an area where support has benefits to individuals and families. Baisden and Quarantelli (1981) found that long-lasting emotional problems rarely occurred after disasters but that problems in daily living were common. Baisden and Quarantelli (1981) concluded that a social service delivery model that employs outreach efforts to homes and schools and which assists with problems in daily living was more effective in helping people cope than a medical model of treating pathology.

Specialised psychological support provided by appropriately qualified and trained professionals

Have counselling services available for those showing ongoing distress. The NIMH consensus workshop (2002) agreed that there was acceptable evidence for the effectiveness of early interventions for reducing distress in bereaved spouses, parents and children and that there was some evidence to support cognitive behavioural approaches in reducing incidence, severity and duration of post traumatic stress disorder, acute stress disorder and depression following a trauma.

Support that can be provided by most people given a minimum of training

The NIMH consensus workshop (2002) endorsed Psychological First Aid as one appropriate early intervention strategy although there are a number of different models of this process. Litz, Gray, Bryant and Adler (2002) propose that psychological first aid is an appropriate initial intervention but also conclude that it does not serve a therapeutic or preventive function which suggests that it is

supportive in some unspecified way. In contrast, recent research on a most similar process, Mental Health First Aid (Kitchener & Jorm, 2004), showed unexpected benefits to the mental health of the participants. The authors speculate that the evidence-based information given in training allowed participants to take action to benefit their own mental health. See MacNeil (2004) for more information on psychological first aid.

Particular interventions for Depression

Devilly and Cotton (2003) suggest that Depression is of much higher likelihood than post traumatic stress disorder for those who have been through a traumatic event. Although untested in such circumstances, it may be that anxiety and depression prevention programs could be usefully initiated as an aid to student recovery following a crisis event (see MacNeil, 2003 for examples of school-based programs). Another possible resource for combating depression in both adolescents and adults is Moodgym. The Centre for Mental Health Research at the Australian National University developed an Internet based cognitive behavioral therapy called 'Moodgym', and have made it available free of charge to the general public. Although still undergoing evaluation and untested as a post-trauma intervention, initial results indicate reduction in anxiety and depression in those working through the internet-based interactive learning modules (Christensen, Griffiths & Korten 2002; Christensen, Griffiths & Jorm, 2004).

Task 23. Monitor the emotional and psychological impact of the crisis

Consider how staff are dealing with the impact of the crisis. Teaching staff may have to deal with the impact at a number of levels, for example:

- ❖ personal- how the crisis is affecting them as individuals in daily living and relationships
- ❖ students- how the crisis is affecting their interactions with students and performance of duties, and
- ❖ colleagues- how the crisis is affecting interactions with colleagues in school and out.

The psychological impact of the crisis may manifest effects in one area but not in others. It is important not to assume that because one area of functioning in unaffected that others will be similarly unaffected. Ensure that support is available to staff who are experiencing difficulty or distress.

Consider how staff are evaluating student needs. Staff should have some guidelines on both how to support students after a crisis and how to identify those who may need additional support. Guideline documents based on best practice standards have been included in a previous module (see MacNeil, 2004).

Monitor student needs and ensure that there are a variety of avenues through which help can be accessed, for example: self, parent or teacher referral to individual counselling; opportunities to talk in class; group discussion; and, telephone counselling or support services such as Kids Help Line or Samaritan Youthline.

Attend to the needs of the caregivers and those in the Crisis Management Team. Continue to monitor until it is clear that normal functioning has resumed for most individuals in the school and its community.

Task 24. Closure

Some crises events may be over very quickly; others may linger on for months or even years as coronial enquiry and verdict are awaited or where there is protracted litigation. A closure event such as a funeral or memorial service, although difficult and painful, may help the community move towards more normal functioning. Memorial events are not recommended in the case of death by suicide as care must be taken not to glorify the individual or sensationalise the event as these might lead others to copy the act (for further information, see Poland & McCormick, 1999; Ministerial Council for Suicide Prevention & Telethon Institute for Child Health Research, 2004). Closure will likely come at different time for different people. It is important to remain alert for any lingering effects brought on by coronial enquiries, anniversaries, birthdays and the like.

Task 25. Review

The final task after an incident is to review the effectiveness of the plan, policies and the processes involved in responding to the crisis. It is important to conduct such a review in a climate of no-blame even when the management of the incident may have been less than optimal. Accordingly, 'review' is preferred to 'evaluation' as a title for this activity. Of course, this does not mean that there will not be liability issues if an incident has been mishandled but it does allow for moving constructively to look at what could have been done more effectively.

Consider general elements such as

- what was successful and why;

- ❖ what was ineffective and why;
- ❖ what was superfluous;
- ❖ were community expectations met;
- ❖ were resources sufficient;
- ❖ was communication effective;
- ❖ were previously established goals met

as well as specific elements such as

- ❖ were roles allocated appropriately;
- ❖ were roles fulfilled as expected;
- ❖ were students supported effectively;
- ❖ was there an effective communication flow;
- ❖ did staff feel supported;
- ❖ was the normal functioning of the school resumed within an appropriate timeframe;
- ❖ are there any indicators that suggest serious problems remain, for example, high absency rates, falls in academic achievement, changes to social climate.
- ❖ are there other planning actions in any of the four phases of Prevention/mitigation, Preparation, Response and Recovery required to support future planning and management.

This task might be best accomplished by using a range of questionnaires directed at particular groups within the school community which would allow for event and group-specific targeting of questions.

Task 26. Training and practice (eg, McManus, 2003)

The final task in this Crisis Management Planning process is to address training and practice.

"Schools and communities often mistakenly believe that funding alone will solve their school emergency response, planning and exercise needs.... However, school safety planners often find themselves in competition for the time needed for planning, making time as scarce a resource as money" (National Strategy Forum, 2004, page 12).

Being prepared includes providing training for staff in managing crises situations. Regardless of the size of the school, all staff should have instruction in the operation of school's Crisis Management Plan. It is particularly important that staff know not only what will occur at the school's administrative level but also what is expected at the individual level.

Practice involves drills and exercises for staff and, to a lesser extent, students. "Desktop" simulations may be particularly useful for the Crisis Management Team allowing the particular demands of a range of scenarios to be considered in relation to the school's plan. There have been concerns raised that drills and simulations can create anxieties or cause children to be more fearful of a possible crisis so these should be used with caution (Kramen, Kelley & Howard, 1999; State of Missouri, Department of Elementary and Secondary Education and Department of Public Health, 1999).

Conclusion

Crisis planning is cyclical. The 26 tasks described should take the planning team back to the beginning of the process. Poland and McCormick (2000) have an apposite title for their book: “Coping with crisis: Lessons learned.” The lessons learned from the planning process and from any implementation of a Crisis Management Plan must be applied to the Crisis Management Plan, to update, enhance and strengthen the school’s ability to respond in the future.

Appendix 11

The table covers some of the more common kind of risks that may precipitate a crisis and these are likely to be applicable to many schools. One task may be to decide when a 'routine' emergency will continue or escalate into a crisis and this will vary by individual circumstance. Although this list is neither exhaustive nor in rank order, it may help in identifying risks. Rating of risk should be considered as an interaction between likelihood of an event occurring and the severity of the consequence.

Type of Crisis	**Risk level**			
	High	**Medium**	**Low**	**None**
Sudden death of student, staff, or community member				
Fire including arson				
Assault				
Motor vehicle accident				
Suicide				
Abduction or kidnapping				
Hostage taking				
Murder				
Shooting				
Explosion				
Sexual assault				
Chemical spill				
Bushfire				
Flood				
Cyclone				
Fight				
Drug overdose				
Major infectious disease				
School camp/excursion incident				
Medical emergency				
Adverse media coverage				
Industrial accident				
Armed robbery				

Appendix 12

Sample documents

Front desk statement following a camp drowning

Introduction:
This is an authorised statement.
The school principal was informed early this morning of some tragic news.

Facts:
Insert Student Name, a Year 7 student at our school, drowned yesterday afternoon while attending the Year 7 school camp. Supervising teachers were present and although resuscitation was attempted, Joe could not be revived.
At this time the school has no further information available regarding his death.

What we've done so far:
Year 7 students and the supervising staff are traveling back to school today. All parents of children at the camp were contacted by telephone so that they can meet their children on arrival of the bus.

All staff and students at school today have been informed of this situation. Some parents have been contacted by telephone where students have been particularly affected by this news.

The school has a number of supports in place including School psychologists who will be available to staff, students and parents for counselling, information and advice following this sad event.

What we're going to do:
School personnel have arranged to have this counselling support available for the next few days.

Who you can contact:
If parents are worried about their son or daughter or would like to talk to a psychologist, they can contact the Deputy Principal on (Insert Telephone Number) to arrange for this to take place.

Close Sentence:
We ask that the school community keep Insert Student Name family in our thoughts and prayers.

Authority Statement:
The Principal has authorised this statement after consultation with the Insert Family Name family.

Sample documents – Letter home following a suicide

Introduction:
With sadness, I write to advise you of some tragic news for our school.

Facts:
This morning Insert Family Name have informed the school that their son Joe, a Year 11 student, was found dead at home yesterday afternoon. The family have agreed that we inform the school community that Joe appears to have taken his own life. We are sharing this information in the hope that we may be able to help other distressed young people.

At this time the school has no further information available regarding the death.

What we've done so far:
All staff and students at school today have been informed of this situation. Some parents have been contacted by telephone where students have been particularly affected by this news.

The school has a number of supports in place including School Psychologists who will be available to staff, students and parents for counselling, information and advice following the tragedy. Some information sheets are attached on children's responses to traumatic events.

What we're going to do:
School personnel have arranged to have this counselling support available to the whole school community for the next few days.

Who you can contact:
If you are worried about your son or daughter or would like to talk to a psychologist yourself, please contact the Deputy Principal on Insert Telephone Number to arrange for this to take place. Students may also ask to see the psychologist. Young people who are in distress can access support at school or by telephoning Insert Agency name and Telephone Number.

Close Sentence:
I ask that the school community keep the Insert Family Name family in our thoughts and prayers.

Authority Statement:
The Principal has authorised this statement after consultation with the Insert Family Name family.

Sample documents – Information for students following a fatal road accident

Introduction:
The school principal received some very bad news that I have to tell you about.

Facts:
Early this afternoon, the bus that was transporting the Year 6 students home from camp was involved in an accident on the freeway. Many children and adults were hurt and have been taken to hospital. We've been told that some of those from our school have died but we don't know whom at this stage.

At this time the school has no more information about what happened.

What we've done so far
All of the staff have been told this news. Teachers are currently telling students. All parents of children on the bus have been contacted by telephone as have family members of teachers and accompanying adults. All other parents will be told in a letter that you'll be given to take home.

What we are going to do
We're going to have some extra help and support in the school over the next few days. This kind of news can affect people in different ways. Some people, both adults and children, may feel upset or sad, others may feel angry, some may feel sorry for the families, and some may not feel any different. It's quite usual for different people to have different kinds of reaction. The school staff is here to help you manage these different kinds of reaction. There will also be other support people in the school if more help is needed than teachers can provide.

Who you can contact
You can ask any staff member to arrange for you to talk with someone. If you're worried about a friend, tell a teacher. Your parents will be given information on what help is available if they're worried.

Close statement:
We ask that you keep the Year 6's and the families in your thoughts and prayers. Try to look after one another during this time. Some of the unhurt children may be back in school tomorrow and later we'll talk about that.

Does anyone have any questions?

Sample documents – Media statement following a school fire

Introduction
This is an authorised statement. The Principal was called out last night by the police when a fire broke out in the school.

The facts
The fire, believed to be arson, resulted in the school library and two classrooms being destroyed. Fortunately, no one was injured in the fire. At this time the school has no further information available regarding the fire or the possible suspects.

What we've done so far
The school has informed staff and students of the news. Parents have also been informed in a letter or via phone, in the case of students particularly affected.

The school will remain open as normal. Students of the classes involved will be taught in alternative classrooms.

The school has a number of supports in place including Psychologists, who will be available for support, information and advice to staff, parents and students.

What we're going to do
School personnel have arranged to have this support available to the whole school community for the next few days. The buildings involved will be re-built as soon as possible. In the meantime, temporary accommodations will be used.

Who you can contact
If parents are worried about their son or daughter, or would like to talk to a Psychologist themselves, they can contact the Deputy Principal on Insert Phone Number to arrange for this to take place.

Close sentence
The school will keep parents informed of any further developments.

Authority statement
This statement has been authorised by the Principal.

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Modules 6

A School Safety Audit Process

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Introduction

This module will consider school safety as an integral element of the Preparation and Prevention phases of Crisis Management Planning. Crisis Management Planning and the Prevention, Preparation, Response, Recovery (PPRR) model have been comprehensively covered in earlier modules (MacNeil, 2003, 2004). While there can be no guarantee that a school will ever be completely safe, school safety should always be a priority item. Creating safe schools is a continuing process that focuses on the development and implementation of strategies to support the safety and security of children at school and in the community. When school leaders make a conscious decision that a safe school is a high priority, that commitment provides the basis for the development of plans and strategies to achieve this goal.

School safety seems a relatively simple concept but it is surprisingly difficult to find any kind of consensus on what this might involve. The Australian Government's National Safe Schools Framework (Curriculum Corporation, 2003; Education Services Australia, 2010), whose implementation has been mandatory for all Australian schools, acknowledges that students have a fundamental right to learn in a safe and supportive environment and to be treated with respect. The aim of this Framework is to assist school communities in building such environments where bullying, harassment, aggression and violence are minimized, and, where students receive support on issues related to child abuse and neglect. For the Australian Government, and accordingly, Australian schools, safety revolves around the issues of bullying, harassment, aggression, violence and child protection. Other groups, agencies and Governments have quite different views.

The United States Department of Education's Office of Safe and Drug-free Schools administers, coordinates, and recommends policy for improving quality and excellence of programs and activities that are designed to provide financial assistance for drug and violence prevention activities, and, actions that promote the health and well being of students in elementary and secondary schools, and institutions of higher education. (United States Department of Education, 2010) The emphasis is on prevention of drug-use and violence together with the promotion of health and wellbeing yet it is not clear whether the prevention of drug-use is part of, or separate to, safety. When the United States Department of Education's policy and program is implemented at the State level, there are some apparent deviations from the focus and aims of the federal policy. In California, for example, the implementation of the United States Safe and Drug-Free Schools and Communities Act 2002, part of the No Child Left Behind legislation (United States Government, 2002), aims to support programs that prevent violence in and around schools; that prevent the illegal use of alcohol, tobacco, and drugs; that involve parents and communities; and that are coordinated with related federal, state, school, and community efforts and resources to foster a safe and drug-free learning environment that supports student academic achievement. Programs to promote youth development, resiliency, buffers, protective factors, and assets are also part of this effort. The stated purpose of these prevention and development efforts is to foster a positive learning environment that supports academic achievement (Department of Education, California. 2007). In this context, 'safe' seems to be about the prevention of violence and the illegal use of drugs while promoting positive mental health.

The Safe Schools Coalition, a group based in Seattle in the USA identifies their

role as to reduce bias-based bullying and violence in schools and to help schools better meet the needs of sexual minority youth and children with sexual minority parents/guardians locally, nationally and internationally (Safe Schools Coalition, 2007). Another view is expressed in the National Strategy Forum: Exploring School Safety in the 21st Century (2004) where the articulated focus is on the threat of terrorism but which also acknowledged vulnerability to a range of potential threats including campus shootings, natural disasters and accidents. Within this range of views, there are some similarities but not all education authorities have such specific direction. School safety in Scotland appears to address a broad range of concerns. The Scottish Executive website provides an array of information in areas such as safe routes to school and child protection procedures in the *Safe and Well Pocketbook* (Scottish Executive, 2005 [A]) and the more comprehensive *Safe and Well Handbook: Schools and Education Authorities Good Practice in Schools and Education Authorities for Keeping Children Safe and Well* (Scottish Executive, 2005 [B]) addressing good practice for staff, schools and education authorities which states that children and young people who need help may be experiencing physical harm or injury; emotional hurt; fear; living conditions that are unacceptable; risk of long-term harm or immediate danger to health and mental and emotional wellbeing. Interestingly, the Safe and Well Handbook does not address either violence in schools or keeping schools drug-free, although these are addressed elsewhere in Scottish Executive publications, but does venture into areas such as living conditions and danger to health, which might not be considered the traditional role of the school.

These diverse authorities, perhaps unsurprisingly, have diverse views on what constitutes school safety. Having a safe school seems to include addressing areas

such as bullying; harassment; aggression; violence; child protection; the prevention of drug use; promotion of health and wellbeing, youth development, resiliency, buffers, protective factors, and assets; supporting sexual minority youth and parents; the threat of terrorism and other potential threats such as school shootings, natural disasters and accidents; physical harm or injury, emotional hurt, fear, unacceptable living conditions. Although there are obvious areas of overlap, the small sample of views produces a surprisingly long list of the factors to be addressed in making a school safe. It seems unlikely that each of these groups has not considered at least some of the elements raised by the others so it may be a reasonable assumption that choice reflects the group priority. This kind of prioritisation may also be needed at the individual school level.

With this apparent lack of accord on what exactly is involved in school safety, it is difficult to characterise what might constitute a meaningful safety audit. One way to address this would be to have a comprehensive procedure that deals with anything that might reasonably be considered as relating to school safety and to have a format that allows freedom to use or ignore particular elements not applicable to the local context. Unfortunately, ‘comprehensive’ can too easily translate to ‘cumbersome’ and as such can ultimately be unmanageable. Yet ignoring potential dangers carries its own risk and such ‘inaction’ may be viewed as negligence should an incident occur in an area that has not been given attention. Any kind of Safety Audit would have to ensure relevance and that the threats considered are all of those which pose genuine risk. Consequently, identifying realistic risks should be seen as a key process when considering school safety.

In the context of crisis events, it may be logical to place limits on the scope of a safety audit, to be able to say that these are not all of the risks but rather that subset that might lead to a crisis situation, ie, for all practical purposes, prioritising events. In this circumstance, an effective school safety audit should identify hazards, highlight all of the risk factors and identify that group of events that have the potential to lead to a crisis for a school and its community. Based on an assumption that school staff and students are in the best position to know their own community and their environment, this safety audit might be undertaken by using a process that allows schools to carry out their own investigations and self-evaluation. Although there will almost certainly be a number of commonalities across schools, the picture that is formed should be specific having been established through the gathering of information that is particular to each school and that reflects its circumstances and environment.

Establishing an overall plan for school safety requires a process to:

- identify safety issues and needs;
- evaluate physical facilities and the school environment;
- develop prevention and intervention techniques; and,
- provide communication, learning and development for staff members, students and others in the school community.

Although schools may have a designated safety officer or a safety committee, school safety is not the responsibility of just one person or group. It is rather a shared responsibility of staff, students, parents, the system or organisation, the community and government. Failure in school safety may mean both individual and group liabilities and it is these potential liabilities that may prove the main

driver behind organisational requirements for safety audits. Given a shared responsibility, there is an implication that employees in every school should have to be mindful-of and incorporate safety into their planning and other work-related activities; that there is an obligation on students to be attentive to the safety of themselves and others; and, that parents and other school community members should be expected to advise the school or other appropriate authority of concerns.

There are proforma school safety audit documents freely available (for example, Department of Education, Employment and Training, State of Victoria, 2000) and although these are often limited to specific areas relating to occupational safety and health or other local legislative requirements, comprehensive variants can be easily accessed. However, there appear to be few safety audit documents for schools that take an additional step and link directly to Crisis Management Planning. A safety audit tool might provide a picture of the school's safety state, help in identifying areas that need improvement and give a broad measure of the likelihood of specific hazards and their associated risks developing into critical events. This kind of approach could be a platform for the school's task of creating a Crisis Management Plan and may help ensure that students and staff have a safe and secure teaching and learning environment whether this is on-site or on excursions.

Given the nature of crises events, particularly the unpredictability and rarity, a number of key questions have to be asked in relation to this process. Will a safety audit have any meaningful value to crisis management planning or will the main value be at a lower level of incident? Can available data on how and where children are most likely to come to harm be used to guide a safety audit and,

consequently, Crisis Management Planning? Is there evidence that implementing a safety audit and taking actions derived from this makes for a safer school?

Key Definitions

The terms used in this field can easily be employed inaccurately. Examples are that the term "hazard" is often confused with "risk" and that “safety” and “security” may or may not mean the same thing depending on the context. To clarify one of these examples, a high voltage power supply, powered machinery or a toxic chemical may present a hazard, meaning that these present the potential for harm. The likelihood of that potential harm occurring is described as the risk. Those who are not familiar with these words as “technical language” may use these terms incorrectly or interchangeably. An illustration of such common usage is that the word processing software used to prepare this paper gives ‘risk’ as a synonym for ‘hazard’. Nonetheless, there are clear differences when the words are used as technical language and schools should be aware of, and use, these and other related terms appropriately in auditing and planning.

Definitions are offered for some key terms used. It is interesting to note some of the differences in definitions for particular terms and how these can relate to the environment in which the terms have currency but it does highlight a difficulty in that there are no widely accepted definitions. Although definitions can vary, those presented appear to embrace some concepts common. Definitions are given in italics. Where multiple definitions are offered for comparison, these are dot pointed. Comments are offered for several of the definitions.

Audit

A formal and structured process for assessing certain operations of an organization to determine the level of compliance or conformity with specific recognized requirement. (International Air Transport Association. 2004.)

Hazard

- *A condition or situation that has the capacity to harm people, plant or buildings.* (Department of Education, Western Australia, 2004.)
- *Something with the potential to cause harm. This may include ill health or injury, damage to property, products, production losses or increased liabilities.* (International Association for Oil and Gas Producers, 2005.)

Both of the explanations of hazard given above are more precise than the common usage meaning of a danger or threat. An interesting comparison between definitions is the use of 'capacity' as opposed to 'potential'. Although these have similar meanings, 'potential' does appear to provide more emphasis on the likelihood of an event occurring. The notion that a hazard has the potential for something undesirable to happen rather than the actual event itself is significant. (For example, something that might cause a building fire and what may be done about that is different to having a building fire and what might be done then.) This difference is important in guiding an approach towards hazard identification and risk assessment. Another central aspect of this latter definition, which reflects its origin in industry, is the extension of the harm beyond people and property to products, production losses and increased liabilities all of which would have counterparts in the school or other educational institution but which are interestingly not included in the 'Education' definition.

Hazardous event

A hazardous event occurs when the hazard's potential to cause harm is realized. This might be the release of hydrocarbons under pressure, the dropping of an object, the electrocution of a person or the collision of a ship with the installation. For chronic hazards, this might include the exceedance of limits set to prevent chronic effects on health. (International Association for Oil and Gas Producers, 2005)

Risk –

- *The likelihood of a hazard resulting in harm such as injury or disease. (Department of Education, Western Australia, 2004).*
- *A term in general usage to express the combination of the likelihood a specified hazardous event will occur and the severity of the consequences of that event. Using this definition, the level of risk may be judged by estimating the likelihood of the hazardous event occurring and the severity of the consequences that might be expected to follow from it.* (International Association for Oil and Gas Producers, 2005.)

Both definitions of Risk consider 'likelihood' as a critical element but again the industry-based definition goes further, this time including a rating of the severity of the outcome. Even when severity of risk is included, there can be differences in the way risk is expressed. When identifying hazards and assessing their effect, the term risk appears to be used in slightly different ways depending upon the approach adopted. When using experience-based, qualitative approaches, risk is commonly given as 'the direct product of the probability of occurrence and the

severity' (International Association for Oil and Gas Producers, 2005) which, given the use of the word 'product', oddly sounds more quantitative than qualitative. The risk associated with a specific activity is judged by estimating both the probability and the consequence often in the aforementioned qualitative terms such as "low", "medium" or "high", and combining the two using some previously agreed formula. Examples of this are presented later. This approach to the expression of risk appears sufficient for many types of evaluation, allowing a structured methodology to be adopted in situations where more exact mathematical methods would be unsuitable or overly complex.

In some situations, it is necessary to be more exact and in these instances one type of process is to express risk as 'the probability that a specified hazardous event will occur in a specified time period or as a result of a specified situation.' (International Association for Oil and Gas Producers, 2005.) This method uses the probability of a number of different consequences to give the overall risk picture. Using this approach, three parameters are needed to define risk:

- the undesired consequence of the event;
- the probability of the event occurring;
- the time frame for the probability of occurrence.

Foreseeable risk

A quantified observation that could reasonably be made by a mature and prudent person in relation to a hazard and its likelihood to occur. (Department of Education Western Australia, 2004.)

Acceptable or Tolerable Risk –

- *A measure of the risk of harm, injury or disease arising from a process that will be tolerated by a person or group. Whether a risk is "acceptable" will depend upon the advantages that the person or group perceives to be obtainable in return for taking the risk, whether they accept whatever scientific and other advice is offered about the magnitude of the risk, and numerous other factors, both political and social.* (Oxford University, 2005.)
- *Risk which is accepted in a given context based on the current values of society***.** (International Association for Oil and Gas Producers, 2005.)

Risk Evaluation

The establishment of a relationship between the risks and benefits of potential hazards to which organisms or people may be exposed. The relationships may be quantitative or qualitative (Oxford University, 2005)

Risk Management

- *Brings together risk evaluation, exposure control and risk monitoring. It attempts to develop a suitable response to a hazard, taking into account all relevant regulatory, political, environmental, engineering and social factors which might be relevant. Risk assessments form a fundamental part of risk management. (Oxford University, 2005)*

- *The systematic application of management policies, procedures and practices to the task of identifying, analysing, evaluating, treating and monitoring risk.* (AS/NZS Standard 4360: 2004.)

The risk is the probability or chance that the hazard posed will lead to injury or damage. Thus, concentrated sulphuric acid is a dangerous chemical because it is very corrosive and reactive. Provided it is handled in an appropriate way, the risk it poses may be small.

It is therefore evident that hazards are often things about which little can be done. The hazards posed by a carcinogen, a concentrated acid or explosive substances are inherent properties of the material. The risks they pose, however, can be and should be minimised by initially preparing a suitable risk assessment, and then following the procedures laid down in that assessment to achieve appropriate management and risk reduction.

Safety

A condition in which the risk of harm or damage is limited to an acceptable level. (International Air Transport Association. 2004)

School safety audit

A written assessment of the safety conditions in each public school to (i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses may include recommendations for structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct (State of Virginia, 2002).

Undertaking Safety Audits in Schools

Parents send their children to school each day assuming the school to be safe. Research by the Bureau of Crime Statistics in New South Wales (2004) found that schools are ten times safer than the broader community but this is obviously a context-dependent figure. In contrast, in the United States, the Bureau of Justice Statistics and National Center for Education Statistics (2005) cited by National School Safety Center, (2006) found that students are twice as likely to be victims of serious violence away from school yet an unsubstantiated claim that "Students are 99 times more likely to be victimized in the community - on the streets, at the mall, at movie theaters, in fast food restaurants and other public places - rather than at school" is made by the same National School Safety Center (2005). Part of the causation in these apparently contradictory statements lies with the language used whereby, for example, 'victimized' refers to particular kinds of crime and not simply being a 'victim' in the broader sense. More recent data from the United States Departments of Education and of Justice (2010) show that in 2008, students of ages 12 to 18 were victims of about 1.2 million non-fatal crimes (theft plus violent crime) at school, compared to about 1 million non-fatal crimes away from school. The total at-school violent crime and theft victimization rates of students of ages from 12 to 18 declined between 2007 and 2008. Figures from the Australian Bureau of Statistics (2005) indicate that 32% of children's accidents occur at school, which of course means that the remainder happen in locations other than school. Drawing a meaningful conclusion from this assortment of figures is difficult: schools may or may not be dangerous places!

It might be sufficient reason in some instances to simply accept that the value of a school safety audit lies in reducing potential liability but the aims and outcomes

should be much broader. Conducting a school safety assessment can be an effective strategy that promotes student and staff safety, and, creates or raises expectations that school community members will act in safe ways. It can help in the identification and management of safety and security risks. Knowing what the risks are can help prioritise school safety and security needs and the effective use of limited resources. The assessment can heighten awareness about best practice in school safety and further the confidence and support of parents and the community. The assessment may also help the school review existing Crisis Management and other Emergency plans to address any overlooked, evolving or new, threats and risks.

According to the National School Safety Center (2004) "*Safe school planning- of which crisis response is one element- is not a new process for most school communities*" and "*it is imperative for schools without a crisis response plan to create one.*" Many schools will fulfil statutory or organisational requirements to undertake safety audits or risk assessments in relation to issues of occupational safety and health. The parameters for these audits may be varied. Within this document, it is not the intention to cover areas that are already mandated or where hazards and risks are readily identified. Rather, the intention is to consider areas where risk may not be so apparent or where there is an underlying assumption of safety, as may often be the case with schools, and to consider how these relate to the kind of events that can lead to a Crisis. Risk assessment is the process of measuring the potential loss of life, injury (both physical and psychological), economic impact and property damage resulting from a range of potential hazards by assessing the vulnerability of people, processes, buildings and other infrastructure. From this, it can be seen that safety or risk assessment provides the

foundation for the Prevention and Mitigation (see MacNeil, 2003) process in Crisis Management Planning.

"*Schools should consider conducting annual safety assessments that can result in the evaluation of vulnerability and readiness*" (National Strategy Forum 2004). Assessments should extend beyond what might be considered the obvious physical security steps to include reviews of policies and procedures, training opportunities for staff, emergency planning, crime prevention awareness, safety and security personnel, prevention and intervention programs, and the associated safety mechanisms. Internal, self-assessments should be viewed as a continuing process aimed at not only maintaining but also developing processes. Resources from external agencies (police, fire, emergency medical, emergency management agencies, etc.) should be accessed to participate with school officials in these self-assessments. Outside, expert consultants may provide specialised expertise and an independent viewpoint for identifying strengths and weaknesses that can otherwise go undetected in self-assessments.

Key Principles

There are a number of fundamental principles that can be applied when identifying hazards and the associated risks.

Know the school buildings. Conditions can change quickly particularly when areas are of high-use and subject to the attention of children and young people. Assess potential hazards on the school site on a regular basis. Include the grounds, play areas, parking, boundary fencing and any access controls. Include in this any buildings or grounds used for regular camps or excursions undertaken by staff and

students. Ensure that there is a clear mechanism for evaluating and approving any off-campus activity that may be planned under the auspices of the school.

Know the local community. Look to the local community to provide relevant information to the school. Be cautious in assuming that things will remain the same, rather, assume that there will be change and look to those who are in the best position to identify both major and less obvious differences that may have an impact. Assess local hazards including those associated with individuals, groups and the surrounding environment. This might include, for example, consideration of drug use patterns in the community, gang-related violence, natural events such as flood or bushfire and proximity to major roads or industrial complex.

Work with others from the community. Some aspects of the school's safety needs may be reliant on resources available from Government or community such as Police and Emergency Services, school crossing patrols or safe houses. Other schools may have similar needs, and coordination can make for a mutually supportive planning process, but be cautious and avoid simply adopting another school's processes as these are unlikely to reflect local needs.

Establish and maintain lines of communication. Schools need to work with their Educational organisation and key external agencies to share information and meet common goals. Additionally, communication within the school's planning team, with staff, students, families, and the broader community are critical to maintaining cooperation and support for the school's efforts to maintain a safe environment.

Assessing the school environment

"Threats and risks to students, staff, and faculty are both tangible and intangible. Schools mitigate those risks in a variety of ways every day." (National Strategy Forum 2004). An assessment of the school environment is a necessary step in preparing for emergencies. While some planning may be mandated, other initiatives may be warranted due to a school's unique location or student population. This builds on the key principles discussed already. The following is adapted from School Safety in the 21st Century (National Strategy Forum 2004).

i. Are there emergency or crisis planning mandates that apply to the school and is the school in compliance?

- Are there legislative or organisational directives that require particular plans and actions?
- Are there requirements from licensing agencies or accrediting organisations?
- Are there mandates related to insurance coverage or risk management policies?
- Are there penalties for non-compliance with legislative directives or other mandates?

ii. Are there barriers that have prevented or limited emergency and crisis planning?

- Does the administration or do other staff minimise or even dismiss the possibility that an emergency or a crisis could happen?
- Does the school administration cite lack of resources or organisational support?
- Is security absent because it is not seen as a priority?

- Does the size of the task at hand seem too big to undertake?

iii. Does the school leadership practice safety in its operations?

- Do school administrators conduct and document regular safety audits?
- Does the school have a basic emergency plan and practice it annually?
- Does the school attempt to prevent bullying, harassment, aggression, violence and discrimination based on race, gender, sexuality, ethnic or other factors via policy, procedures, practices and programs?
- Does the school have and use a consistent visitor policy to limit access and track the people in the building(s)?
- Within the school and its buildings, are maintenance and laboratory chemicals, and cleaning agents stored according to legislative or organisational requirements.
- Are propane or other gas tanks, diesel, petrol or other flammable agents stored and secured at a safe distance from the main school buildings according to legislative or organisational requirements?
- Are vehicles permitted to park within a preset 'safe radius' of the school? If not, what physically prevents a vehicle from doing so? Can the school increase the distance between vehicles and the building(s)?
- Are industrial rubbish bins or skips positioned within the 'safe radius' of the school? Are they secured or open? Can they be moved further away than their current location?

iv. Does the school rate highly in terms of physical safety?

- Are all required exits from the building maintained, clearly accessible and well signposted?

- Do windows have appropriate hardware for their intended usage with working locks that allow safe, emergency exit?
- Are there vehicle entry prevention obstacles (such as steel gates or poles, concrete posts, fences, barrier rails etc.) to protect vulnerable areas, even from accidental collision? Is car parking monitored?
- Does the school administration take account of the possible impact from incidents in high-risks areas within the immediate vicinity of the school. This would include: high-crime areas, especially in terms of personal safety and a drug-free environment; railways, roads, or factories that process, store, or transport potentially dangerous substances; power stations, substations and transformers; and, airports and flight paths to them.

v. Is the school technologically astute?

- Are fire protection devices regularly maintained with appropriate personnel trained in their operation.
- Does the school have an effective system through which it can notify staff and students of an emergency and of any required actions
- Is the school equipped with any uninterruptible (emergency) power supply? If so, what items and systems are connected to it?
- Does the school have working television and radios to hear and monitor public emergency notifications? Are they on the emergency power supply and/or equipped with good batteries?
- Does the school control access to key systems including computers, communication and management.

What to Consider in the Risk Assessment Process

The risk assessment process focuses attention on areas of need by evaluating which groups, processes and facilities are most prone and to what extent injuries and damage may occur. The assessment should give information on:

- the hazards to which the school and its community may be exposed;
- the effects on individuals and groups, to physical, social and economic assets should there be an incident associated with these hazards;
- which areas are most vulnerable to damage from these hazards; and
- where a cost can be calculated, the resulting potential cost of damage and potential costs avoided through planned mitigation projects.

A safety audit may identify a wide range of hazards and risks but it is likely that only a limited number of these will be relevant to Crisis Management Planning. Some 'routine' kinds of emergency situation will likely already be catered for within existing processes; for example, fire drills and evacuation procedures are generally mandated for all schools. In the United States, the National School Safety and Security Services organisation recommends the following components to be included as part of a school safety and security assessment (2007).

- School emergency and crisis preparedness planning
- Security, crime and violence prevention policies and procedures
- Physical security measures including access controls, communications capabilities, intrusion detection systems, perimeter security, after hours security, physical design, and many related areas
- Professional development training needs related to school safety and emergency planning
- Examination of support service roles in school safety, security, and

emergency planning including facilities operations, food services, transportation services, pupil services, physical and mental health services, technology services, and associated school departments

- School security and school police staffing, operational practices, and related services
- Linking of security with prevention and intervention services
- Personnel and internal (buildings) security
- School and community collaboration, school and public safety agency partnerships, and school community relations issues on school safety

The factors that might make the school more safe or less safe

In addition to benefiting prevention and mitigation planning to both reduce the risk and reduce the impact of a potentially critical event, risk assessment information can also allow the school's Crisis Management Team to establish response priorities by identifying and addressing potential hazards and vulnerabilities. A school safety assessment can be strategic in that the evaluation can be used to identify existing, emerging and potential school safety problems. These activities can point to practices and places that may be overlooked due to a lack-of, or poor consideration, or an assumption that they are safe and trouble-free. During an assessment, key factors can be examined to ascertain their direct impact on teaching and learning, student and staff safety, school climate, school attendance, and overall campus security. These factors may include the following (Adapted from Virginia Department of Education, 2000).

- ❖ Existing school safety plans (including existing Crisis Management Plans), policies procedures and practices and ongoing review measures

- Legislative requirements and other standards for safety
- Enforcement and development of existing policies, procedures and practices (including behaviour management and discipline practices) together with identification of where new approaches may be required
- The present condition, safety and security of the school buildings and other facilities
- The use of environmental management to reduce or prevent behavioural problems, disruption and possible criminal behaviour
- Existing and planned procedures for data collection
- Employee recruiting, screening, selection, supervision, training and development practices
- The prevalence of bullying, harassment, racism, homophobia or other negative behaviours directed at individuals, minorities or other groups in the school or the community
- The presence of gangs, weapons, drug and alcohol use in the school and the school community
- The social climate of the school (including staff, student and parent perspectives)
- School and police partnerships
- Standards for any security services used including use of, access to and data retention of closed circuit television monitoring
- Safety-promoting initiatives including those that are curriculum based.
- Emerging school safety trends, issues and concerns

The Specific Areas To Consider In A School Safety Audit

Although it may seem a simple task to look around the school and find areas that are safe or not so safe, it can be easy to overlook things because they are obvious or because they are familiar. These are among the reasons why checklists can be so helpful and why there can be benefits from having an external consultant undertake the review or provide advice on hazard and risk identification. The following, which builds upon the areas previously highlighted, is intended as a starting point for a school-specific safety checklist but should not be viewed as either comprehensive or detailed.

- The surrounding environment: where the school is located and the hazards and risks associated with this
- Play and sports areas
- Canteen and kitchens
- Entries and exits including emergency exits, fire or smoke-stop doors, and critical access ways for Emergency Services
- Monitoring and surveillance, staff, student and visitor identification and tracking, security and alarm systems
- Building and grounds: exterior walls, windows, paths, walkways, steps and stairways, lifts, parking, bicycle racks, pick-up and drop-off areas, assembly points
- Main entrance and Administration.
- Staff areas including staff lockers and personal storage areas.
- Corridors, passageways
- Toilets and shower areas, medical room, changing areas, laundry

- ❖ Classrooms, library, gymnasia, swimming pool, performance art centre and other teaching areas
- ❖ Industrial or technical areas
- ❖ Chemical or hazardous material storage
- ❖ Fire control points including location of extinguishers, hoses, other fire suppression devices and points for Fire Service access to water supplies
- ❖ Heating and cooling, hot water storage
- ❖ Power, water and gas supplies including shut-off points
- ❖ Ground and building maintenance equipment (ladders, lawnmowers etc)
- ❖ Student lockers and other storage areas used by students
- ❖ Areas where valuable items may be kept, eg, computer lab, cash storage in a safe
- ❖ Common areas including staff rooms, student common rooms, kitchen and dining areas
- ❖ Any facility shared with, or used by, another agency
- ❖ Any other areas

Assess vulnerabilities that might precipitate a crisis

While it is not possible to prepare for every crisis situation, schools should have an awareness of the kind of situations where there may be some vulnerability. There should be a focus on realistic events relevant to the local context rather than improbable events. Brock (2002) has classified crisis events and this can be of valuable assistance in making the evaluation of whether any hazard and the associated risk fall into the realm of events that have potential to lead to a crisis.

- ❖ Severe illness and injury (eg, life-threatening illness, serious infectious disease, road traffic accidents, suicide attempts, assaults)

- Violent and/or unexpected deaths (eg, fatal illness or accident, murder, suicide)
- Threatened death and/or injury (eg, robbery, mugging, rape, child and spouse abuse, kidnap)
- Acts of war (eg, invasion, terrorism, hijacking, hostage-taking)
- Natural disasters (eg, flood, fire, hurricane, cyclone, avalanche, earthquake, volcano, tsunami)
- Man-made/industrial disasters (eg, aeroplane crash, nuclear accident, exposure to toxic agents, industrial accident). (Brock, 2002)

Within these types of incidents, there are many variations that highlight a primary difference between natural and manmade or technological hazards. The types, frequencies, and locations of many natural hazards are identifiable and can, in some cases, be predictable. Malice, incompetence, forgetfulness, indolence, negligence, stupidity and other behaviours are functions of being human. While they are known and understood to a large extent, they cannot be predicted with any accuracy. This means that there is the potential for many types of manmade, hazardous events to occur anywhere and anytime and to range from minimal to catastrophic impact.

As can be seen from the multiple lists presented, disasters are often a focus of safety audits and crisis management. Norris (2005) reports that on average, a disaster occurs somewhere in the world each day. It may be a flood, hurricane, tsunami, or earthquake, a nuclear, industrial, or transport accident, a multiple shootings incident or peacetime terrorist attack. What these various events share in common is their potential to affect many people simultaneously and to cause an

assortment of stressors, including threat to an individual's life and physical wellbeing, exposure to the dead and dying over short or extended periods, bereavement and loss, personal, family, social and community disruption, and ongoing hardship.

Moving from the above classification, allows identified hazards and risks to be viewed in relation to the specific focus herein of whether these can lead to a critical incident and a consequent crisis for the school. Although it is obviously helpful to have a checklist that provides indicators that particular areas should be reviewed in a safety audit, this doesn't give any indication or evidence as to whether these have risks that might lead to a crisis situation for the school. To take this next step, it's important to identify what might lead to a crisis and make that link to the school environment.

The following table covers some of the more common kind of events that may precipitate a crisis and these are likely to be applicable to many schools. Although it is neither exhaustive nor in rank order, it may help in identifying risks in terms of priority.

Type of Crisis	**Risk level**			
	High	**Medium**	**Low**	**None**
Sudden death of student, staff or community member (As there may be different risk levels for each of these and the linked items below, linked items might have to be separated into 2 or more items)				

Fire or Arson				
Assault				
Motor vehicle accident				
Other kind of serious accident (eg, fall, trip)				
Suicide				
Abduction or kidnapping				
Hostage taking				
Murder				
Shooting				
Explosion				
Sexual assault or child abuse				
Chemical spill				
Bushfire				
Flood				
Cyclone				
Fight				
Drug overdose				
Major infectious disease				
School camp/excursion incident				
Medical emergency				
Adverse media coverage				

Having identified realistic risks to the school community, safety strategies can be developed to address those events where prevention may be possible and to minimise or reduce the risk when this cannot be removed entirely. Some strategies

will be intended to minimise the impact should an event occur. A critical part of this process may involve a costs and benefits analysis in order to help to prioritise actions. Mitigating crisis events is also important from a legal standpoint. If a school does not take all necessary and reasonable actions to create a safe school environment, there could be a vulnerability to a lawsuit claiming negligence.

From Knowing the Risks to Analysing the Risks

So far, the process has gone from establishing a context to identifying risks. The next step is to analyse the risk, that is, to look at the likelihood of particular events and the consequences of these arising. A risk analysis matrix is a common way to undertake this step and an example of such is shown below.

Risk Analysis Matrix: Likelihood/Impact to Consequence (Adapted from AS/NZS 4360)

Likelihood/Impact	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
A (almost certain)	High	High	Extreme	Extreme	Extreme
B (Likely)	Moderate	High	High	Extreme	Extreme
C (Possible)	Low	Moderate	High	Extreme	Extreme
D (Unlikely)	Low	Low	Moderate	High	Extreme
E (Rare)	Low	Low	Moderate	High	High

Without going into the definitions of the terms used in the table (which would be a task for those undertaking the risk analysis), this process leads to a ranking of possible events. The ranking then leads into setting of priorities for action. Typically, anything rated as of extreme risk would be given immediate attention, to be addressed as soon and as far as possible whereas items of low risk might be delayed, given little attention or be deemed as of tolerable risk.

Developing Safety Strategies

Injury risks from hazards can be identified using a Haddon Matrix (Haddon, 1972), a framework for analysing injury based on the host (ie, the person injured), the agent (ie, the cause of the injury) and the environment (ie, the physical and social context in which the injury occurred). These aspects are looked at over the time or phases leading up to the injury event, the injury event itself, and, directly after the event. Analysing injury in this way helps to develop a three-tiered approach to preventing injury that includes social, environmental and policy changes. The matrix can be used to assess injury and identify methods of prevention.

A Haddon's Matrix consists of four columns and three rows.

Columns

The **Host** refers to the person at risk of injury (eg. child).

The **Agent** of injury is energy (e.g. mechanical, thermal, electrical) that is transmitted to the host through a vehicle (inanimate object) or vector (person or other animal).

The **Physical Environment** includes all the characteristics of the setting in which the injury event takes place (eg, roadway, building, playground, or sports arena).

The **Social Environment** refers to the social and legal norms and practices in the culture and society at the time (eg, norms about child discipline, usage of child restraints, alcohol consumption, policies about licensing drivers, sales of firearms).

Rows

Pre-injury event phase/Primary prevention. This is about stopping the injury event from occurring by acting on its causes (eg, pool fences, divided highways, and good road or house design).

Injury event phase/Secondary prevention. This is when there is an attempt to prevent an injury or reduce the seriousness of an injury when an event actually occurs by designing and implementing protective mechanisms (eg, wearing mouth guard, a seatbelt or helmet, having safety barriers).

Post injury event phase/Tertiary prevention (Treatment and Rehabilitation). This is where there is an attempt to reduce the seriousness of an injury or disability immediately after an event has occurred by providing adequate care (eg, the application of immediate medical treatment such as cardio pulmonary resuscitation or first aid with a prompt response time), as well as in the longer term working to stabilise, repair and restore the highest level of physical and mental function possible for the injured person.

An example of a Haddon Matrix is given below and this is in reference to having children properly restrained when traveling in a motor vehicle. (Edmonston and Sheehan, 2001).

Phase	Host	Agent/equipment	Physical Environment	Social Environment
Pre-event	Driver ability, driver training	Maintenance of brakes, vehicle inspection programs, installation of child restraint, child restraint checking programs	Adequate roadway markings, correct installation of child restraint, right child restraint for child's height and weight	Attitudes to drink driving/speed/use of child restraints for every car trip

Event	Human tolerances to crash forces, wearing of seatbelt, having child in a correctly fitting child restraint	Crash worthiness of the vehicle (eg. crush space and other vehicle protective factors), crash worthiness of child restraint (eg, head extrusion, strength of seat shell)	Presence of fixed object near roadway, presence of unsecured object within the vehicle	Enforcement of mandatory seatbelt and child restraint use
Post-event	Crash victims general health status	Petrol tanks designed to minimise likelihood of post crash fire	Availability of effective and timely emergency response	Public support for trauma care and rehabilitation

Prevention, which is addressed more fully in the next section, can be focused in any cell of a Haddon matrix. For example, interventions can address the host/pre-event cell (eg, teaching people to avoid injury by changing behaviour such as holding banisters when on stairs) or the pre-event/equipment cell (eg, improvements in vehicle safety such as airbags, antilock brakes or stability control). Interventions can also be implemented to change the physical environment that would reduce the risk of injury pre-event, during the event or post-event (e.g. impact reduction materials to reduce head injury during a playground fall, lowering speed limits, removing trees from the edge of the road to minimise impact damage to vehicles and occupants, improving the response time and skill levels of emergency responders to provide earlier victim treatment). Changes can also be made in the social environment (e.g. reducing bystander behavior that condones bullying, changing social norms around domestic or sexual violence, promoting organ donation programs).

In addition to the matrix, Haddon identified ten strategies that, when combined with the matrix can be used to determine the most effective interventions for a given injury event:

1. Prevent the creation of the hazard in the first place
2. Reduce the amount of the hazard that exists
3. Prevent the release of the hazard
4. Modify the rate of spatial distribution of release of a hazard from its source
5. Separate people in time or space from the hazard and its release
6. Separate people from the hazard by interposing a material barrier
7. Modify the relevant basic qualities of the hazard
8. Make the person more resistant to damage
9. Counter the damage already done
10. Stabilise, repair and rehabilitate the injured person

Preventive actions

The first step towards effective risk management is to take preventative action to stop incidents occurring or to reduce the chance of recurrence of previous incidents. This approach reflects the Prevention element in Crisis Management Planning. Effective preventive action is only possible if information about incidents or potential issues is accurate and accessible. Information about accidents in schools or workplaces may be obtained from various documents including Incident Notification records, First Aid and/or Accident registers, copies of Workers Compensation claims and from Hazard Alert notices. Absence records for students and staff may provide further information. Some countries gather National or State statistics.

When considering the already cited principles and multiple checklist-type of information that comes to hand in the area of school safe, it would be easy to overlook the typically minor accidents that happen in schools and the potential for these to have a more serious side. Accidents are major source of disruption in educational settings (Australian Bureau of Statistics, 2006). Accidents can result in personal injury and suffering; interruption to teaching and learning in both the short and long-term; a significant disruption to workplaces; costs associated with compensation claims and legal liability; and, staff replacement and material damage costs.

Information on accidents is usually easily accessed whether it is from the school's own records or from collated data sources provided by governmental organisations. "The immediate aim of information gathering is to obtain the most accurate and detailed information about the circumstances and the causes of the accident, as promptly as possible, that is, what happened and how. If this occurs it is more likely that it will be possible to prevent or reduce the likelihood of the occurrence of similar accidents in the future." (Department of Education, Employment and Training, State of Victoria, 1992.)

In Australia, children are much less likely to have long-term health conditions than adults, and infant and child death rates are generally declining and are at their lowest in a century. In 2003, 20% of the Australian population was aged 0-14 years (around four million children), while child deaths accounted for 1.3% of all deaths registered in that year. Most child deaths are of infants aged less than one year (68% of deaths of 0-14 year olds in 2003), and are related to perinatal and congenital factors. Once the infancy period has passed, injury deaths emerge as

the leading cause of death for children. The next most common cause of death of children aged 1-14 years is malignant neoplasms, which caused less than half the number of child deaths over the same period (Australian Bureau of Statistics, 2006).

Over the five-year period 1999 to 2003, Australian Bureau of Statistics (2005) findings indicate that 41% of deaths of children aged 1 to 14 years (ie, excluding infants) were injury deaths (1,260 children in total, around 250 children per year). By comparison, injuries caused around 6% of deaths of people aged 15 years and over. Boys were more likely than girls to experience and die as a result of an injury. While half of all children are boys (at 30 June 2001, 51% of 1 to 14 year olds were boys), nearly two-thirds of injury deaths (62%) for this age group between 1999 and 2003 were boys (Australian Bureau of Statistics, 2005). This difference between girls and boys in relation to injury and deaths exists regardless of the child's age, and across all Organisation for Economic Cooperation and Development (OECD) countries (United Nations Children's Fund, 2001). The reasons for these disparities may include differences in behaviour, in the type of activities boys and girls engage in, and in the ways in which boys and girls are socialised from a young age.

Total Children Injury Deaths In The Five Years 1999 To 2003 (ABS, 2006)

	Age (years)					
	under 1	1-4	5-9	10-14	Total deaths 0-14 years	
	no.	no.	no.	no.	no.	%
Transport accidents	17	182	161	227	587	39.9
Accidental drowning	29	200	35	22	286	19.4
Other accidental threats to breathing(b)	88	45	12	18	163	11.1
Assault	39	44	30	15	128	8.7
Exposure to mechanical forces(c)	10	25	13	16	64	4.3
Intentional self-harm	. .	. .	n.p.*	n.p.	56	3.8
Smoke, fire, flames	7	21	14	8	50	3.4
Falls	3	12	11	7	33	2.2
Accidental poisoning	3	10	n.p.	n.p.	25	1.7
Other injury deaths	17	22	19	23	81	5.5
All injury deaths	**213**	**561**	**299**	**400**	**1,473**	**100.0**

(*Note n.p. means not published)

In most deaths that were the result of a transport accident, the child was either the occupant of a motor vehicle (44% of deaths) or a pedestrian (35%). The remaining deaths were in accidents where the child was a cyclist (5%) or motorcycle rider (4%), or were other transport accidents (12%)

Accidental drowning accounted for 19% of all child injury deaths between 1999 and 2003 (286 children). Accidental drowning accounts for a relatively high number of child deaths in Australia and this can be linked to the high incidence of homes with backyard swimming pools and the clustering of the population centres

close to the ocean. Other accidental threats to breathing, such as suffocation or choking, accounted for 11% of deaths (163 children).

Assault accounted for 9% of child deaths (128 children) between 1999 and 2003. Young children were more likely to have died from assault than older children. Two thirds (65%) of child deaths from assault were of children aged less than 5 years (83 children).

In 2001, 498,000 children aged 5–14 years reported being injured recently. The most common activities these children had been undertaking at the time of injury were leisure activities (eg, playing non-organised sport or games, reading, watching videos), and organised sports. In 2001, half of all recent injuries for children this age (51%) occurred during leisure activities, and around a third (27%) while children were playing sports (Australian Bureau of Statistics, 2005). Data published in 2003 indicate that a further 17% occurred while attending school (Clapperton, Cassell and Wallace, 2003). The most common locations at which 5 to 14 year olds received injuries were outside their own or someone else's home (32%), at school (30%), at a sports facility (20%), or inside their own or someone else's home (16%) (Australian Bureau of Statistics, 2005).

In 2001, 11% of all children aged 0 to 14 years were injured in a fall, 3% in a collision (hitting something or being hit by something), 2% by a bite or sting, and 0.6% in an attack by another person. Note that bite and sting injury can be particularly serious in Australia. Falls caused the greatest proportion of recent injuries for children (61%). Of children injured in falls, most were injured in a low fall of one meter or less (93%), rather than a high fall from more than one meter

(7%), and most were engaged in sporting or leisure activities at the time (75%). Collisions were the next most common cause of recent injury for children (17%). Boys were more likely to be injured this way than girls (20% of recently injured boys, and 13% of girls in 2001). As with falls, sports and leisure activities were the most common activities being undertaken at the time of the collision. Of children injured in collisions, 41% were participating in leisure activities (38% of boys and 46% of girls), and 34% were involved in sports (37% of boys and 29% of girls) (Australian Bureau of Statistics, 2006)

Of children recently injured, 12% were injured by a bite or sting (including bites from animals such as dogs and snakes, and some insect and spider bites). Children were more likely than any other age group to have been injured this way. Half (51%) of children who were bitten or stung were outside their own or someone else's home at the time (Australian Bureau of Statistics, 2006).

In 2001, around 25,000 children had been injured in an attack by another person in the four weeks prior to interview - accounting for 4% of recent child injuries. Children were more likely than adults to have experienced injury from attack in the previous four weeks (0.8% of children aged 5 to 14 years compared with 0.2% of people aged 15 years and over). Most 5 to 14 year olds recently injured in an attack, had been at school at the time (72%) (AIHW 2003). Boys in this age group had been injured in an attack by another person at three times the rate of girls (1.2% and 0.4% respectively) (Australian Bureau of Statistics, 2006).

Children living in regional and remote areas of Australia are more likely to die from injury than those living in major cities. This could be because children in

different areas have different socioeconomic characteristics, are exposed to different and more dangerous hazards, or have more restricted access to various health services (Australian Bureau of Statistics, 2005).

Aboriginal and Torres Strait Islander young people had considerably higher rates of death and hospitalisation due to injury than other young Australians. In particular, the assault hospitalisation rate was 6 times as high. Injury death and hospitalisation rates increase substantially with remoteness and socioeconomic disadvantage. The injury death-rate in 'Very Remote' areas was almost 5 times those in Major Cities, and the hospitalisation rate was 3 times as high. Those in the most socioeconomically disadvantaged fifth of the population had an injury death rate almost twice as high as those from the least socio-economically disadvantaged fifth, and were almost 30% more likely to be hospitalised for injury. (Australian Institute of Health and Welfare, 2003)

The RSA (The Royal Society for the encouragement of Arts, Manufactures and Commerce) 'Risk and Childhood' report (Madge and Barker, 2007) is particularly relevant to assessing the balance of perception and reality. After considering the statistical evidence its report concluded:

"Parental concern is not necessarily in line with statistical risk. Parents show most concern about traffic accidents and abduction, but accidents at home, unhealthy living and becoming the victim of crime are much more common."

The 'Risk and Childhood' report said: **"**Not all children are equally at risk, and age, sex, culture, social background and geography are among the characteristics that can make a difference ... There are some types of risk, such as falling downstairs, that almost anyone may face, but there are others which ... reflect the

inequalities in our society. In many ways, risk stands as a present-day proxy for inequality." A similar conclusion might be drawn from the previously stated information from the Australian Institute of Health and Welfare (2003) on socio-economic disadvantage.

It is clear from these comprehensive data sets from Australian Bureau of Statistics and other sources that there is much relevant information for schools that can be readily accessed and that many factors have considerable relevance to schools in terms of Crisis Management Planning. It provides an affirmative answer to one of the critical questions posed in the introduction: *Can data on how and where children are most likely to come to harm be used to guide a safety audit and, consequently, Crisis Management Planning?* Injury has a major, but largely preventable, impact on the health of young Australians. It is the leading cause of death among young people aged 12 to 24 years (Australian Institute of Health and Welfare, 2008). 30% of accidents were found to have happened at school (Australian Bureau of Statistics, 2005, 2006). In 2001, around 25,000 children had been injured in an attack by another person in the four weeks prior to interview - accounting for 4% of recent child injuries. Most 5 to 14 year olds recently injured in an attack, had been at school at the time (72%) (Australian Institute of Health and Welfare, 2008).

While school Administrators don't need to be over zealous, prudent risk reduction and preparedness measures can be taken in a reasonable and balanced way. "In choosing among potentially useful preventive measures, priority should be given to the ones most likely to effectively reduce injuries. In general, these will be measures that provide built-in, automatic protection, minimizing the amount and

frequency of effort required of the individuals involved" (Haddon, 1974). Simple measures can be effective such as ensuring that staff members greet and challenge strangers on the school premises, that attention is given to access and perimeter security, and by providing staff supervision in a highly visible manner. Adult visibility is considered to be the single, most effective, and least costly strategy to prevent inappropriate student behavior (Cross and Erceg, 2004). Basic school security measures need not be expensive and include cost-free and lower cost measures such as reducing the number of doors that can open from the outside, having effective communications systems, keeping trees and shrubs trimmed to promote natural visibility, and, planning measures to be built into the design of new and upgraded schools.

The Public Enquiry into the shootings at Dunblane Primary School highlighted many of the difficulties in making a school safe and how challenging it can be to retain a warm and welcoming environment for children while in essence also being able to keep people out (Cullen, 1997). Security is often equated with metal detectors, surveillance cameras, fences, police and security officers, and other physical measures. While these measures may be needed in some situations and can play important role in many school systems, there remains a human element behind it. When security equipment is used in schools, it should be viewed as a supplement to a more comprehensive school safety program.

The UNICEF report (United Nations Children's Fund, 2001) "A League Table of Child Deaths by Injury in Rich Nations" notes that "children's judgment of potential dangers and of their own physical ability is developed through pushing the boundaries of their experience, developing their own sense of risk and danger,

and taking progressive responsibility for their own lives." This report also notes that children's activities may be becoming increasingly limited in response to parental concern about accidents and other threats. For example, concern about transport accidents may lead to fewer children cycling, walking, participating in sports or otherwise being active. Alexander (2008) has commented: “We have also reported a perceived loss of children’s personal freedom due to increased traffic and parental fears about their children’s safety; and that although parents understand the importance of play in early childhood, many children lack outdoor play provision and many parents are unwilling to allow them to play away from home. This means that children are losing the opportunity to learn to cope with risk”. It is clear that risk aversion is becoming a growing factor in how parents raise their children and that accordingly there is a growing expectation that school activities should not involve any element of risk, not simply a minimised risk.

Risk Management Strategies

Having established information on where risks lie from information such as accident statistics, the school should be in a position to look at ways to manage risk and this involves more than just prevention. The Australian and New Zealand standard AS/NZS 4360 (2004) uses five categories.

- **Risk avoidance** might involve stopping or not proceeding with an activity that might involve an unacceptable risk.
- **Reduction of the likelihood** of an occurrence of an unacceptable risk by for example training programs, preventive maintenance and inspection programs.
- **Reduction of the consequences** that may result from an unacceptable risk by for example having Crisis or Emergency Management Plans, providing

protective equipment or structures, and by reducing vulnerability and increasing resilience.

- **Risk retention** involves accepting the risk and managing the consequences in the event of an occurrence.
- **Risk transference** involves shifting the risk to other parties or to another place by using for example insurance, out-sourcing or contracting, or working in partnership in order to share the risk.

Discussion

Earlier in this module, three questions were posed in relation to whether a safety audit has value in terms of Crisis Management planning given the rarity and unpredictability of Crisis events

Will a safety audit have any meaningful value to crisis management planning or will the main value be at a lower level of incident?

This is perhaps the most difficult question to answer since there is much about the question that is subjective yet some answers can be derived. Since lower level incidents are more common, it is reasonable to extrapolate that most value from a safety audit will come at this level. This does not detract however from the likelihood that there will be value in relation to Crisis events. The points raised in the question do not have mutually exclusive answers nor can the answers be applied as a broad sweep to every school.

Can statistics on how and where children are most likely to come to harm be used to guide a safety audit and, consequently, Crisis Management Planning?

The answer to this question has already been given in the affirmative. The Australian statistical data presented indicated that the majority of deaths of school-aged children are from accidents. Further, almost one third of accidents to children happen at school. Although child fatalities are uncommon, the consequences for a school could be catastrophic and would certainly fall within the realms of the kind of event addressed within a Crisis Management Plan.

The proportion of accidents to children happening at school might be a surprise to many schools and to parents. Given the Parental concern is not necessarily in line with statistical risk (Madge and Barker, 2007), it would be interesting to know if the same is true of schools. There is a danger though that risk aversion might become an over-riding factor in school activities. Alexander (2008) commented on the loss of children's personal freedom because of increasing parental concern over safety. Much is made in the popular media of activity levels in children falling with once-common activities such as walking or cycling to school becoming much less common. The example of a Haddon Matrix used earlier in this module was centred on child safety when travelling on a school bus and was intended to provide assurances that this form of transport was safe, safer even than travelling in the family car (Edmonston and Sheehan, 2001). Risk aversion is already established in schools and it seems likely that it will become a growing factor in respect to a broad range of activities.

Is there evidence that implementing a safety audit and taking actions derived from this makes for a safer school?

On face value, this seems the easiest question to answer. There would seem to be an irrefutable, prima facie case that a school would be safer if actions were taken

to address concerns raised in a safety audit. Indeed, this would seem to be the case for almost any situation. Maintaining handrails makes stairs safer. Fitting seat belts and airbags limits injury in car crashes. Having anti-scald devices on hot water taps prevents burns. These examples not only seem obvious but would all be supported by evidence. Making a school safer though seems to be a more difficult task. The Education Department of the State of Virginia has been one of the leaders in the area of addressing school safety having had mandatory requirements for audits from 1997. The school safety audit legislation required each school to conduct a safety audit, created a safety audit process, developed a checklist of relevant safety issues to be considered, and implemented an information reporting and dissemination strategy. Yet a review of the process after 6 years concluded that: “Despite these efforts, the status of school safety in Virginia’s schools is still unclear ” (Virginia Department of Criminal Justice Services, 2003).

Finding further evidence is problematic. There appears to be little substantive research in the area perhaps because the case seems overwhelmingly obvious. The lack of sound research is pervasive in the area of Crisis Management Planning. Perhaps it is unsurprising that it also appears to be true in terms of safety audits and the implementation of appropriate strategies to address concerns.

Some additional discussion areas

The lack of research evidence on whether using safety audits assists in making school safer has been noted. The famine in this area though is balanced by abundance in another area. There are a plethora of checklists available for schools

to use when looking at safety. The mindset almost seems to be that if schools are to be safer, then a checklist is essential, more than one is even better. The checklists may even present lists of which checklists to have! It would be easy to fall into the trap of viewing these checklists as providing all the answers. Some such checklists have been used as starting points in this module but the weakness in these is readily apparent in that they are written for use by many different schools in many different situations. The usefulness of the abundant checklist may be great for some, may be little value to others and may lead to quite negative results for others. Checklists carry their own risk in that they can provide a false view that all risks have been identified.

Risk transference is an interesting concept. In an 'opinion' article published in the Sydney Morning Herald, Gittens (2007) comments on how risk and risk management have become ubiquitous terms in present day society and, that when business looks at this, the solution becomes one of shifting the risk to their employees, ie, risk transference. Gittens relates this mainly to financial risk such as a pension or superannuation funds but it has become increasingly apparent in other areas to see organisations offering 'all care but no responsibility' or similar assertions that people will be looked after as well as possible but should there be an accident, the responsibility lies with the individual. Schools have fewer options when it comes to transferring risk since an obligation to care for children is typically the norm but out-sourcing and contracting may become options of choice when it comes to activity such as camps or excursions which may be viewed as too risky for the school to undertake. As evidenced by the RSA Risk and Childhood report (Madge and Barker, 2007), parents see risk where it may not exist. Some activities may become simply too difficult for schools to

undertake due to the effort required to satisfy parent concerns. It may became an option of choice for parents and schools to look to organisations that specialize in particular activities perceived, rightly or wrongly, to be risky

Gittens (2007) also refers to the High Court of Australia being involved in risk transference, deciding that employees who give misleading advice may be sued separately from their company. Formerly, the employer was solely responsible for the conduct of employees. There may be profound implications for teaching staff who have advisory roles.

Conclusion

School safety isn't easy to define. It has been shown that school safety means different things to different organisations but this should not serve as a deterrent to those seeking to make schools safer and to make the management of crisis events more effective. It would be important for any school undertaking a safety audit process to make decisions at the outset on what safety means for the school, what the parameters of the audit are to be, and, whether there are any limits to actions that can be taken.

A safety audit may be a valuable tool for a school when looking to identify areas that may be of importance to Crisis Management Planning. When looking at the process however, it does have a degree of complexity which may act against uptake. There might be a case for an ecological model that supports a comprehensive approach that not only addresses an individual school's risk factors, but also the norms, beliefs, environment, and social and economic systems that create these conditions. Such complexity though can be counter-

productive and many schools would not have the time or inclination to be involved in such a process. Nevertheless, it appears that it is possible to have a process that covers the main issues relevant to schools and that much relevant information, such as accident statistics, is readily available to inform decision-making. Checklists are an altogether simpler solution but have a more limited usefulness. The true value in terms of Crisis Management Planning comes from being able to identify real risks and from this, evaluating the impact by way of either a qualitative or quantitative value should an event come to fruition. This allows potentially catastrophic events to be considered and appropriate strategies to put in place.

Finally, there seems little doubt that the main value of a safety audit will come at a lesser level of significance than that addressed in a Crisis Management Plan but this not the same as saying that there is no value. A school's ability to manage a crisis is founded on a number of factors, not the least of which is having a knowledge of the natural or man-made events that can lead to catastrophic consequences. Knowing the hazards and understanding the associated risks are fundamental to school safety and to Crisis Management.

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Modules 7 and 8

How the school can support recovery after a crisis event

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Introduction

In previous modules, the Prevention, Preparation, Response, Recovery model (PPRR) has been noted as a comprehensive framework from which to approach crisis management. PPRR may have originated in the work of Caplan who in 1964 proposed a three-stage model. PPRR is now widespread in usage (eg, Paton, 1992; United States, Department of Education, 2003)). Some authors refer to Mitigation rather than Prevention (e.g. Tierney, 1989) but in spite of having clearly different meanings, these elements appear to involve essentially the same actions. Crisis Management has become a widely accepted term suggesting the notion of preparedness and being able to address the situation before during and after an event. A proactive approach has become the norm replacing any notion that crisis response is purely reactive. Previous modules have addressed a number of specific areas in the PPRR process such as establishing a plan and auditing the safety state of the school. Nader and Pynoos (1993) described how mental health professionals can support teachers in returning classes to normal functioning by sharing knowledge, giving information on common behaviour and school performance changes that may occur, by helping to problem solve, and, by providing guidance on how to recognise when it is appropriate to seek further assistance. Johnson (2000) identified a more active role for schools suggesting a number of strategies that schools can use to restore normal functioning and manage the effects of a crisis situation including administrative consultation, staff consultation, information sharing, parent meetings, identification of community and school resources and class activities.

The intention in modules 7 and 8 is to consider the Recovery element of PPRR, particularly the practical actions that schools can take after a crisis. “The recovery

phase is the prolonged period of return to community and individual adjustment or equilibrium. It commences as individuals and communities face the task of bringing their lives and activities back to normal. Much depends on the extent of devastation and destruction that has occurred as well as injuries and lives lost" (Raphael, 1993). What exactly is meant by Recovery is often left undefined (eg, National Institute for Mental Health [NIMH], 2002, McManus, 2003) and to some extent this is understandable. Recovery will have different meaning for individuals, groups, organisations and governments. McManus (2003), in offering a model for school emergency management, identified the Response phase as dealing with immediate issues and the Recovery phase as dealing with long-term issues. These long-term issues included reorganisation, resumption of routine, ongoing support for individuals, counselling and reconstruction. The United Stated Department of Education (2003) gave the following synopsis.

> The goal of recovery is to return to learning and restore the infrastructure of the school as quickly as possible. Focus on students and the physical plant, and to take as much time as needed for recovery. School staff can be trained to deal with the emotional impact of the crisis, as well as to initially assess the emotional needs of students, staff, and responders. One of the major goals of recovery is to provide a caring and supportive school environment.
>
> **Return to the "business of learning" as quickly as possible.** This may involve helping students and families cope with separations from one another with the reopening of school after a crisis.
>
> **Schools and districts need to keep students, families, and the media**

informed. Be clear about what steps have been taken to attend to student safety. Let families and other community members know what support services the school and district are providing or what other community resources are available. Messages to students should be age appropriate.

Focus on the building, as well as people, during recovery. Following a crisis, buildings and their grounds may need repairing. Conduct safety audits and determine the parts of the building that can be used and plan for repairing those that are damaged.

Provide assessment of emotional needs of staff, students, families, and responders. Assess the emotional needs of all students and staff, and determine those who can be supported from the school's resources and those need intervention by an external mental health professional. Available services need to be identified for families, who may want to seek assistance for their children or for themselves.

Provide stress management during class time. Create a caring, warm, and trusting environment for students following a crisis. Allow students to talk about what they felt and experienced during the traumatic event. Address any issues of guilt

Take as much time as needed for recovery. An individual recovers from a crisis at his or her own pace. After a crisis, recovery is a process filled with ups and downs for both individuals and organisations. Depending on the traumatic event and individual and group factors, recovery may take months

or even years.

Remember anniversaries of crises. Many occasions will remind staff, students, and families about crises. The anniversary of crises will stimulate memories and feelings about the incident. Other occasions may remind the school community about the crises, including holidays, returning to school after vacations and other breaks, as well as events or occasions that seemingly do not have a connection with the incident.

This provides some helpful guidance on the direction that a school might take but does not provide a great deal of detail. There is no evidence cited to support the suggestions made. There is no differentiation of the interventions that can be undertaken by teachers and those that might require specialised skills.

What kind of crises are being considered?

Slaikeu (1990) drew a distinction between different kinds of crisis situations. The events which lead to a Developmental Crisis are part of the normal process of maturation while Situational Crises are unexpected and beyond the everyday and may bring about feelings in the individual of helplessness and loss of control over life. When considering Crisis Management, the focus is on situational crises which can have the potential for a large-scale impact on school communities (Brock, 2002). These situational crises can include sudden death, suicide, violence and assaults (Poland and McCormick, 1999) and can significantly impact on a whole school community. Hereafter, crisis will mean a situational crisis.

What is Recovery?

Following any kind of crisis situation, it would seem reasonable to expect that at some point there will be a return to normal and this might be seen as getting back to how things were before. In such a context, Recovery seems a straightforward proposition where the intent is to facilitate people and things getting back to the previous normality. Yet there are many circumstances in which a return to how things were before would clearly not be possible. In such conditions, recovery therefore would have a different meaning, where there might be a return to normal functioning in a situation that is fundamentally changed. Recovery becomes a more complex proposition when it is recognised and accepted that pre and post-crisis have differing normalities. Accordingly, it may in fact be an advantage to not have a definition of Recovery beyond the simple view of people and groups being able to resume functioning and coping at adequate levels in whatever the changed environment might be.

A Focus on Disasters

Much of the literature in this area focuses on large-scale disasters associated with natural disasters such as hurricanes and floods or human-made events such as war or terrorist attacks (eg, Norris, 2005). In common usage, the term ‘disaster’ refers to a great misfortune causing widespread damage and suffering. Common to most definitions is that they stress that a disaster is a severe destruction which greatly exceeds the coping capacity of the affected community. Thus, the coping capacity and the psychosocial resources of a community are essential in defining when a destructive event is to be seen as a disaster (Weisæth, 1995). ‘Personal disaster‘ is a term sometimes used to describe an individual’s experience of horror, traumatic death and the like, (Raphael, 1981). ‘Community disaster’ is used to refer to an

event that may impact a wider group, or community. For example, in a community disaster with a high death toll, grief affects many: close family members, extended family, friends, and co-workers. Others may suffer the loss of businesses, jobs and property. There is however, no consensus on a scientific definition of the term.

Disasters and Schools

At one time, a school crisis would have been seen in relation to events such as suicide, a sudden death of a student, staff member or a parent, or, a serious assault. More recently, schools across the world have been affected by large-scale events which have threatened the whole community and have consequent multiple fatalities. The terrorist attack on the World Trade Center in 2001, which forced the evacuation of four nearby schools, and another 36 schools within a 4 mile radius of the World Trade Center; the Dunblane shootings of 1999 with 15 children and one teacher killed; the terrorist attack on a school in Beslan in 2004 resulted in the deaths of almost 400; the London bombings of 2005; and, the tsunamis in Indonesia in 2004 and Japan in 2011 have directly and indirectly affected schools in ways that require a different level of crisis management. Such large-scale events can have a profound effect on people all around the world. Large-scale incidents involving public safety are managed predominantly by agencies including police, fire and other emergency services. Nevertheless, in these circumstances, schools must retain some responsibility for their students and staff and must plan and act accordingly. Barenbaum et al (2004) state: “Recent literature also suggests that childhood trauma can have a lasting impact on child cognitive, moral, and personality development, and coping abilities” and these elements are clearly relevant to schools.

Disaster-based findings

A substantial amount of research relevant to understanding the effects of disasters has been published. Norris (2005) in an update report to previous reviews (Norris et al, 2002a, 2002b) considers results for 225 distinct samples composed of over 85,000 individuals covering 132 different events. On average, a disaster occurs somewhere in the world each day. It may be a flood, hurricane, or earthquake, a nuclear, industrial, or transportation accident, a shooting spree or peacetime terrorist attack (Norris, 2005). Norris notes that most disaster studies examine the effects of a particular event that occurred at a particular time to a particular population in a particular place. Accordingly, the ability to generalise from any one study is limited.

Norris (2005) reported that studies of children and young people often assessed and observed problems specific to their age groups. For young children, these problems included clinginess, dependence, refusing to sleep alone, temper tantrums, aggressive behaviour, incontinence, hyperactivity, and separation anxiety. Adolescents have shown elevations in deviance and delinquency (Auerbach and Spirito, 1986; Pitcher and Poland, 1992). Analysis of objective school records have suggested that there may actually be a decrease in disruptive behaviours, or a decrease in teachers' reporting of them, after disasters (Shaw et al., 1995, Shaw, Applegate and Schorr, 1996). Reactions to traumatic events do seem to have a degree of unpredictability.

Disaster effects can be transitory or minimal

Norris (2005) observed that the most transitory effects in the entire disaster

database were found in a study by Nolen-Hoeksema and Morrow (1991) at intervals of 10 days and then 7 weeks after the Loma Prieta earthquake that struck the San Francisco Bay area in 1989. The sample of 137 Stanford University students showed no overall change in depression from 14 days before to measures taken shortly after the earthquake. As the impact was minimal, the participants' actual experiences in this earthquake were examined. Half of this sample experienced none of 4 stressors assessed and, among those who did experience a stressor, the most frequent was that of inconvenience! Two other studies of adult survivors after the Loma Prieta earthquake also reported minimal effects. Siegel et al (2000) conducted a randomised telephone survey of adults in the area and found exposure variables to be virtually unrelated to Post Traumatic Stress Disorder assessment scores. Marmar et al. (1996) compared rescue workers who responded to the double-deck freeway collapse to a control group of other rescue workers and found minimal differences between them.

Six months after an earthquake, Bradburn (1991) classified 22 children on the basis of their scores on the Child Post Traumatic Stress Disorder Reaction Index (Pynoos et al 1987a): 37% showed no symptoms, 36% mild, 27% moderate, and 0% severe. Moreover, the symptoms exhibited were largely ones of intrusion and the children did not show diminished enjoyment or loss of interest in activities.

Norris (2005) noted that another natural disaster that appeared to have minimal effects on mental health was the 1994 Northridge earthquake, which caused its greatest damage in a suburban area of Los Angeles. Of the 6 studies of this event, only 1 found even moderate levels of impairment. Siegel at al. (2000) found almost no effects of exposure to this disaster in a large sample of residents of the

area who were assessed 6 to 10 months after the earthquake.

More severe effects of disasters

When natural disasters cause extreme degrees of destruction and disruption, as was the case with Hurricane Andrew which struck Southern Florida in 1986, psychological effects may become quite severe. Ironson et al. (1997) assessed adults at 1 and 4 months after the hurricane and found that 33% met criteria for Post Traumatic Stress Disorder, and that several physiological measures were affected in a direction indicating a lowering of immune functioning. In the study by Perilla, Norris, and Lavizzo (2002), 25% of the sample of highly exposed residents of the area met study criteria for Post Traumatic Stress Disorder, and symptom levels varied strongly with severity of exposure. In an analysis of this same sample's data, Norris and Kaniasty (1996) replicated the finding from Hurricane Hugo (which struck Caribbean islands and South Carolina in the mainland USA also during 1989) that disaster-related declines in perceived support explained much of the Hurricane Andrew sample's symptom level. High levels of received support (actual post-disaster help) reduced the tendency for disaster victims to experience declines in their perceived support. Norris (2005) notes that relative to Hurricane Hugo, the "deterioration path" was greater and the "mobilization path" was weaker, producing more adverse mental health consequences.

Norris (2005) reported that children and young people were under significant scrutiny in the aftermath of Hurricane Andrew. Garrison et al. (1995) surveyed 400 adolescents who were representative of a wide geographic range. In this sample, 7% met criteria for Post Traumatic Stress Disorder. At 6 months after the

disaster, Warheit et al (1996) assessed a group of approximately 5,000 adolescents who had been surveyed one year before the hurricane and found that hurricane-related stress predicted post-disaster depressive symptoms and suicidality even with pre-hurricane depression and suicidality controlled. La Greca et al. (1996) assessed 442 children at 3 months post-disaster and found that 27% of the sample showed moderate Post Traumatic Stress Disorder and 29% showed severe or very severe Post Traumatic Stress Disorder symptoms. Shaw et al. (1995) assessed 144 children at 2 months and found that 56% of the children from a 'high impact' school and 39% of the children from a 'low impact' school scored in the severe symptom range. Despite some variability, most of the studies of Hurricane Andrew pointed to a high prevalence of psychological disturbance, especially in the areas where the losses, damage and danger were most severe.

In relation to the 11 September 2001 terrorist attacks on the USA, Norris (2005) reported that the aggregated severity rating of the ten sample studies was 2.1, compared to 2.8 for other mass violence events in the United States and that these terrorist attacks classified as only a "moderate impact" event although Norris notes that this could change as new studies emerge. Of the studies conducted in New York City, Norris (2005) reported that one of particular note was conducted by Galea et al (2002). In this study, 1008 adults living in lower Manhattan were selected randomly and interviewed by telephone 5 to 8 weeks after the attack. At that time, approximately 8% reported symptoms consistent with a diagnosis of current Post Traumatic Stress Disorder, 10% reported current depression, and 14% reported one or the other. Compared to their counterparts, persons who lived south of Canal Street, ie, near the World Trade Center, (5%), lost possessions (4%), lost their jobs (6%) or experienced panic (13%) during the event were more

strongly affected, but these groups composed relatively small proportions of the sample. Four months after the event, the same team of researchers reviewed a second sample of 1,570 adults representative of New York City (Galea et al, 2003). In this sample, the prevalence of Post Traumatic Stress Disorder since the attacks was 15% among directly exposed persons and 4% among those indirectly exposed. By six months post-event, the prevalence of Post Traumatic Stress Disorder had declined to less than 1%. The 7.5% rate obtained within weeks of the attacks may have reflected temporary distress rather than Post Traumatic Stress Disorder.

Gleser et al (1981) studied the Buffalo Creek dam collapse of 1972 in West Virginia. Two years after the dam collapse, two thirds of 380 adults and one third of 273 children were evaluated as moderately or severely impaired, with Generalised Anxiety Disorder (60% among adults, 20% among children) and Major Depressive Disorder (70% among adults, 25% among children) the most prevalent disorders. Some years later, these data were reanalysed for probable Post Traumatic Stress Disorder, which had not been a recognised disorder in the Diagnostic and Statistical Manual of Mental Disorders at the time of the original study (Green at al., 1990a, 1990b). The estimated rate of Post Traumatic Stress Disorder at 2 years was 44% among adults and 32% among children. Rates of Post Traumatic Stress Disorder remained high 14 years after this event.

Some conclusions from disasters

Norris (2005) notes that taken together, the data on magnitude and duration clearly show that disasters do have implications for mental health for a significant proportion of the communities that experience them. Most published studies

identified specific psychological problems, such as anxiety, depression and most notably Post Traumatic Stress Disorder, non-specific psychological distress, or varying health problems and concerns. Children and young people exhibited additional problems unique to their age groups, such as behavioural problems, hyperactivity, and delinquency, but like adults, they were also vulnerable to Post Traumatic Stress Disorder, depression, somatic complaints, and ongoing stress. In interpreting these results, Norris notes that the relative frequencies of these outcomes are a function of how often they were assessed as well as how often they were observed if assessed. The breadth of the outcomes observed clearly indicates that there should not be too narrow a focus on any one condition in either research or practice.

In relation to the influence of disaster type, Norris (2005) reports that the findings regarding the consequences of experiencing disasters caused by malicious human intent were unequivocal. Samples that experienced mass violence were more likely than other samples to be severely or very severely impaired. Disasters of mass violence may be especially difficult for victims to comprehend or assimilate, making intrusion and avoidance symptoms more likely.

Crises in schools

The best practice literature on school crisis management tends to address smaller events, with recommendations for planning stressing the need to focus on realistic events (eg, Paton 1992). In looking at realistic events, it is generally also recommended to plan for multiple casualties (Poland and McCormick, 1999), perhaps with the view that it is easier to scale-down than to scale-up the actions required in responding to any given situation. In following this path, there is a

generally unaddressed assumption that individual and group responses and needs are seen to be very much the same regardless of whether ten or ten thousand people are involved. Barenbaum, Ruchkin and Schwab-Stone (2004) in looking at children exposed to war wrote *"Immediate relief operations can start with non-specific interventions to help groups of affected individuals organize around issues of feeling safe and promote perspectives for the future that involve mastery and engagement in rebuilding."* This statement could be applicable to virtually any size of group, in a multitude of situations and, although there is clearly value in the actions suggested, it would seem wise that those involved in crisis management constantly review the appropriateness of any actions to the given circumstance. As described by Jimerson, Brock, and Pletcher (2005), crisis intervention must be site-specific, sensitive to the context of the tragedy.

A number of authors, including this writer in previous modules, have noted that there is a lack of evidence for the effectiveness of many of the suggested actions for responding to school crisis events (MacNeil, 2002; Pitcher and Poland, 1992). Pagliocca, Nickerson and Williams (2002, p. 771) state that "for more than two decades, researchers and practitioners have called for evaluation of crisis intervention programs and strategies". Schools are often required to develop a school crisis management plan, establish a crisis management team and identify the nature of the supports to be available should a crisis occur. Yet the evidence for the effectiveness and value of any of these actions is still largely lacking and it remains the case that practices appear to be simply handed-down from one author to another with little attempt to justify the origins or evaluate the effectiveness of the treatments. An interesting example of such a hand-down effect was encountered when researching this module. The School Mental Health project

document “Responding to a crisis in school” (Center for Mental Health in Schools at UCLA, 2008) contains a contentious assertion: *“Children who experience an initial traumatic event before they are 11 years old are three times more likely to develop psychological symptoms than those who experience their first trauma as a teenager or later.”* This is referenced as being excerpted from *FEMA* (Federal Emergency Management Agency) *For Kids : Resources for Parents & Teachers* with a web-address attached. However the web page no longer exists. Trying to track the document using Google search for the exact sentence provided over 200 results but no original document. The quoted statement may be based on strong evidence but this can’t be verified, rather it serves as an illustration of how readily assertions are accepted and repeated.

Observations and case studies of school crisis situation outcomes in the 1990’s have mostly guided the intervention practices that are currently recommended for use with school populations (Brock, 2002; Pitcher and Poland, 1992). Most of these recommended actions have been used in actual school crisis situations and would have accordingly gained a ‘best-practice’ status, perhaps undeservedly.

Providing support to aid recovery

Ronan and Johnson (2005) identified two main sources of support for the majority of people: tangible supports; and, communication, information and support systems. They are of the view that schools need to provide effective crisis intervention that aligns with the process of problem solving and includes students, school staff and the wider school community following crises. Help from naturally occurring support systems is seen as important in increasing coping and resolution of distress and related difficulties. According to Brock and Poland

(2002), school level crisis response is primarily seen as responding to those who are experiencing acute distress and require assistance to re-establish adaptive coping mechanisms. This kind of response is often referred to as "Selective" in that those who are known to be at risk are targeted. Ronan and Johnston (2005) suggest that having people appropriately prepared can be vital to ensuring a move towards recovery. Much of this kind of crisis preparedness, which is designed to minimise the traumatising effects and to identify and respond to those in distress, has little or no evidence as to effectiveness in fulfilling this aim.

Mental health promotion

Children and young people typically show normal reactions to crises events, particularly if supported by caring adults (Raphael, 1986). Goldman (2005) refers to resilience as the resources that individuals use to cope with difficult situations and their ability to "bounce back". Goldman argued that children can increase their resilience and their ability to understand traumatic events with the help of caring adults able to provide safety, protection, hope and optimism, key elements as identified by Hobfoll et al (2007). Goldman (2005) noted that parents and teachers too readily attempt to fix the problem for the child rather than taking on the larger task of enhancing child and adolescent resilience which engenders an ability to cope and overcome difficult situations. Parents and teachers can contribute by facilitating child and young person's positive adaptation to challenging situations. Being resilient means that children and adolescents can develop coping strategies and problem solving that might assist them with adapting to traumatic events.

Meagher (2002) described a process for reducing the onset of acute emotional upset by increasing student resilience through teaching appropriate programs that strengthen and enhance the decision making options that are available to the individual. Accordingly, although there is little supportive evidence, there has been some endorsement of steps to mitigate the impact of crises events should they occur. Creating safe and supportive school environments, programs aimed at preventing anxiety or depression, identification of those students at risk of being violent or the subject of violence, the promotion of social and emotional skills, and addressing bullying issues are some examples of 'Universal' approaches which may serve to enable school students to manage crises events more effectively. Schools are being encouraged to promote positive mental health. (World Health Organisation, 1984, 1994; Commonwealth of Australia, 1996). Australian programs such as MindMatters (Curriculum Corporation, 2000), the Resourceful Adolescent Program (Shochet, Holland and Whitefield, 2000) and Aussie Optimism (Hart, 1998; Quayle, Dziurawiec, Roberts, Kane and Ebsworthy, 2001; Roberts, Kane, Thomson, Bishop and Hart, 2003) are research-based and target positive mental health at different levels of the school population. MindMatters describes a health promoting school as one that takes action and places priority on creating an environment that will have the best possible impact on the health of students, teachers and school community members; and which recognises the interaction and connection between its curriculum, policies, practices and partnerships. The Resourceful Adolescent Program and the Aussie Optimism program build on Seligman's (1995) work on optimism and the notion of 'psychological immunisation' of young people against mental health problems. Although these and other programs have supportive evidence in terms of their

stated aims, they have not been assessed as to effectiveness in making children and young people more able to cope with the impact of crisis events.

Evidence

Prior to the 1970's, psychological trauma was not the major focus following a traumatic event and intervention tended to concentrate on providing food, clothing and reconstruction activities (Pitcher and Poland, 1992). Subsequent to this time, children were recognised as having reactions to traumatic events and consequently that they would benefit from treatment. Mental Health workers had not known how traumatic events would affect children over time but the new information led to changes in the accepted view about how traumatic events affect children (Terr, 1990). Results from Terr's (1990) five-year study, of 26 children who had been kidnapped and then buried alive in their school bus showed they were all affected by the kidnapping. Terr's findings included children recalling experiences such as fear of helplessness, fear of another event, fear of being separated from family and fear of death. Terr's study of the psychological reactions of these children influenced and developed the understanding of children's reactions to trauma.

Crises events affect individuals in different ways. Recovery from a crisis event or a trauma is influenced by complex interactions including the severity of the event, the level of personal threat felt, the nature and magnitude of the events witnessed, the degree of loss of human life and the recurrence of event reminders (Nader and Pynoos, 1993). The most frequently studied risk factor for negative outcomes following disaster events is the severity of the exposure to the event (ie. extent of life threat, loss, injury). The literature examining the role of exposure is definitive. The greater the perceived life threat, and the greater the sensory exposure, ie. the

more an individual sees, smells or hears distressing things, the more likely posttraumatic stress will manifest (NSW Health, 2000). Nader and Pynoos (1993) pointed out that even though child and young person reactions are primarily related to event exposure, the recovery of the adult community will affect the recovery of children and adolescents. According to Nader and Pynoos, community recovery, multiple adversities and family disorder and confusion are critical external factors that affect children and adolescents.

Developmental issues affect a child or young person's experience, symptoms, behaviour and the course of recovery. These same developmental issues are critical in the assessment of the crisis as it unfolds and in evaluating the reactions of those significant adults in the child or young person's life. Children are more likely to cope well if parents and teachers are seen to cope. (Poland and McCormick, 1999; Raphael, 1986). It is important to keep in mind the impact of adult reactions on children's perceptions. Events that are initially not perceived as threatening may become so after observing the reactions of others. Pynoos et al (1987a) reported that children who were dramatically confronted with indications of the severity of a school shooting by having their home used as an emergency base for the police response team, displayed more post traumatic stress reactions than other similarly trauma-exposed children. The children's observations of adult's extreme reactions might have raised their level of threat perceived. Children may also view a crisis as non-threatening because they are too developmentally immature to understand the potential danger. In this situation, an event may become traumatic if the danger is explained (Carlson, 1997). Whereas lack of cognitive development may mean a child does not perceive a threat, a cognitively advanced-for-age child may be more vulnerable to understanding the

magnitude of a threat and be more susceptible to stressors (Masten and Coatsworth, 1998).

"Victim" levels

There is a widespread acceptance that individuals can be affected by a crisis without being directly exposed to the threat although there does seem to be differences in how these other groups are categorised. Family and friends of those primarily involved, emergency services personnel, those who witness an accident involving others can all be affected by the event. One way of classifying those affected by disaster has been proposed by Taylor and Frazer (1981). This can be summarised as:

- *Primary victims*: Those in the front line who have experienced maximum exposure to the catastrophic event.
- *Secondary victims:* Grieving relatives and friends of the primary victims.
- *Third-level victims:* Rescue and recovery personnel who might 'need help to maintain their functional efficiency during any operation and to cope with traumatic psychological effects afterwards'.
- *Fourth-level victims:* The community involved in the disaster, including those who converge, who offer help, who share the grief and loss, or who are in some way responsible.
- *Fifth-level victims:* People who even though not directly involved with the disaster, may still experience states of distress or disturbance.
- *Sixth-level victims:* Those who, but for chance, would have been primary victims themselves, who persuaded others to the course that

made them victims, or who are in some way indirectly or vicariously involved.

Alternatively, Gurwitch, Sitterle, Young, and Pfefferbaum (2002) pointed out that the effects of terrorism extended beyond the primary victims and include both secondary (helpers) and tertiary victims (relatives and friends). With the 'instant' media coverage of national and international events now available, a larger disaster community may exist (Tucker, Pfefferbaum, Nixon and Foy, 1999). When dealing with children and adolescents, it can be easy to overlook those who are not directly involved. In the context of the school setting, children, adolescents and school staff can often be affected by a traumatic event due to the fact that they can be closely associated with primary or secondary victims as described by Gurwitch et al (2002).

The effects of trauma on a child or young person will be influenced by developmental stage, chronological age, proximity to the traumatic event, range of coping mechanisms, available support networks, parent reactions, personality of the individual and their relationship with the victim (Pfohl, Jimerson, & Lazarus, 2002). For the majority of children, the response will be behavioural problems and fears that eventually pass (Auerbach & Spirito, 1986; Pitcher and Poland, 1992). Children's responses to crises are further defined by factors such as their subjective appraisal of the event: they may not understand what is going on so, for example, show no fear or distress (Brock, 2002). Although immaturity can have a protective role in a crisis situation, it can be associated with a higher degree of distress if the child does come to understand what is happening (Carlson, 2000).

Developmentally immature children who are involved in a crisis event may require greater support.

The responses of children and young people will reflect their previous experiences and coping mechanisms. Those who have experienced prior traumatic events that were similar to a newly presenting crisis situation seem to be vulnerable to traumatisation during and following such a new event (Nader and Pynoos, 1993). The relationship between the child's coping and the parent's coping has been pointed out by a number of writers. Children's fear reactions were described as "interwoven" with those of their parents and families (Raphael, 1986). If parents are distressed, their children will most likely become distressed (Aptekar and Boore, 1990). Brock (2000) has pointed out that those children and young people with strong social supports and networks such as friendships, positive adult role models and positive school experiences are likely to have lower levels of acute distress than those without supportive networks and positive experiences.

Post crisis counselling

Brock (2002) noted that media reports on school crises often state that counselling will be available to support distraught students. It might be more appropriate in most instances to simply refer to support being available in that this involves aiding those who are distressed. Actions such as comforting and providing reassurance, helping with practical advice, allowing the person to discuss their experience but only if they feel the need to do so, linking them to support networks, and identifying those at risk who may need follow-up and specialised services are more fundamental needs immediately after a crisis and are useful to the broad range of those who have been involved. Counselling aims to help

people come to terms with the disaster, loss and other distressing events they have suffered in the disaster, with emphasis on enhancing positive coping and facilitating active mastery and involvement in the recovery process (Raphael, 1993). There is evidence to suggest that more focused or in depth counselling is not appropriate in the earliest stages but should be available for those considered at higher risk of adverse mental health outcomes either through their high level of ongoing distress or other risk factors as identified above (Solomon, 1999). Such specialised counselling, provided by appropriately trained professionals, should be provided when it is clear that the post-disaster reactions, for instance to trauma or loss, are not settling or when other factors are present and then not until about 2 weeks or more after the event.

Post crisis support in schools

The notion that particular supports can be made available to students or staff is a key issue. In a large-scale crisis event, a whole school population may be affected, perhaps 2000 individuals or more. What supports can a school realistically provide for such numbers? It is clearly important that any school planning for, or responding to, a crisis situation has achievable expectations in terms of the supports that can be made available. Accordingly, it is essential to clarify supports that require some degree of specialised training and those that can be provided by those with little or no special skills. Raphael and Wilson (1993) contend that crisis intervention work with children and adolescents requires knowledge and experience in child development, psychotherapeutic techniques and children's post-traumatic reactions. This presents difficulties in many instances of school-based crises as individuals with this skill-set are neither likely to present in significant numbers nor be available for extended periods of time. The real issue

here is that those researchers from a psychiatric background tend to focus on psychiatric issues, notably Post Traumatic Stress Disorder and its symptoms. Undoubtedly, there are significant numbers of individuals who can be helped without delving deeply into the toolkit of the psychiatrist. By accepting the view of the National Institute for Mental Health [NIMH] (2002) consensus workshop that a sensible working principle in the immediate post-incident phase is to expect normal recovery, then it becomes apparent that the main task for a school would be to support this normal recovery. Galea et al (2002) stated: *"It is important to recognize from the outset that people's reactions should not necessarily be regarded as pathological responses or even as precursors of subsequent disorder. Nevertheless, some may be experienced with great distress and require community or at times clinical intervention"* Most people are likely to need support and provision of resources to ease the transition to normalcy, rather than traditional diagnosis and clinical treatment. Since it seems that this normal recovery generally occurs without specialised input, it would appear that the school should be able to support such recovery in large numbers of individuals without recourse to those with specialised training if appropriate interventions can be identified.

What supports might schools need after a crisis?

In a study undertaken by Trethowan (2009), 113 school psychologists and school social workers responded with their views concerning crisis management practices and training. Reponses were grouped as follows.

Intervention

counselling skills, communication skills, clear boundaries and ability to follow/develop process/ plan of action;

calm approach, assessment, psychological first aid, nurturing responses;

probably overlaps with grief and loss counselling, practical issues of support to school communities in first day or days;

empathy, capacity to listen non-judgementally, knowing referral avenues for victims, preparedness to follow up;

calmness, empathy, good strategic planning to ensure all affected are assisted in an appropriate manner, awareness of professionals own personal triggers;

calming, organised, communicative, we need to investigate a 'wellness' approach to see if this suits the Department;

calm approach, clear procedures to follow, ensure plan in place initially with clear information;

Theoretical Knowledge

a framework for conceptualising and planning a response;

understanding grief and loss, knowledge of cognitive theory;

understanding some individuals do not want intervention/support, that intervention may not be immediately relevant to all;

be careful with pathology, it is likely to be reasonable reaction to trauma, risk management assessment;

looking at cognitive functioning, emotional reactivity, physical symptoms, behavioural symptoms;

Administrative Skills

team work, having clearly identified leaders;

good management skills;

calm, leadership of team, a coordinated approach to handling counselling demand;

organisation- plan the day, check things off, revise programs, plan the next day;

organisation- skills to assist with administrative issues (Trethowan, 2009)

What is perhaps most interesting from these responses is how few of the actions involves specialised skills such as to require a school psychologist or school social worker. The majority of the actions could be undertaken by teachers and other key staff in schools. There is clearly a need for training of school personnel beyond the school psychologist, social worker or counsellor. Johnson (2000) suggested that schools should take more of a lead role and identified a number of strategies that schools can use to restore normal functioning and manage the effects of a crisis situation including administrative consultation, staff consultation, information sharing, parent meetings, identification of community and school resources and class activities. Ronan and Johnston (2005) suggested that crisis management training requires active participation by all members of the school community and collaborative problem solving between networks within the school system. Nader and Pynoos (1993) indicated that school staff plays a critical role in maintenance and therefore also the recovery of the school climate. Training of school staff in appropriate but essential crisis management practices may provide an invaluable resource for assisting and supporting students from the outset should schools be faced with a significant crisis event.

Timely and appropriate support for students during and following a crisis event is significant and stressed by many authors. What is lacking is agreement and

evidence on what to do, when to do it, and with whom. Failing to assist students in achieving some resolution may lead to disorganisation and potential developmental problems (Peterson & Straub, 1992). Emotional support must be provided to students immediately (Poland & McCormick, 1999). Poland and McCormick (1999) reported poor school crisis responses from schools not adequately planning for crises but the evidence for such an assertion is lacking.

Models for Recovery

There are a number of models which have been documented as methods of providing support following a crisis event.

Critical Incident Stress Debriefing and Critical Incident Stress Management model

Psychological debriefing has been the subject of intense scrutiny for a number of years. Modules 2 and 3 have gone into this in some detail (MacNeil, 2003). A requirement for universal debriefing has been questioned (McNally, 2004). There have been concerns raised about the potential harm resulting from such practices being used with children in a school setting (Raphael et al., 1996). Raphael and Wilson (2000) pointed out the potential for harm associated with talking to children and young people in a group situation if there are differences in the severity of trauma suffered within the group. Wraith (2000) noted that that the practice of using psychological debriefing with children had not been developed, tested or evaluated. Poland and McCormick (1999) also discuss how to respond to those individuals who may be psychologically traumatised. The specific crisis intervention model described is based upon a program developed by the National

Organization for Victim Assistance (NOVA). The model, which advocates group-processing sessions for children and young people, bears striking similarities to the Critical Incident Stress Debriefing/ Critical Incident Stress Management model(s) of Everly and Mitchell (2000) and accordingly should be viewed with some caution.

It is not the intention herein to discuss at length the Critical Incident Stress Debriefing/Critical Incident Stress Management model(s) of Everly and Mitchell (2000) and their colleagues as this has been given attention in earlier modules. Briefly, it has been argued that procedures such as psychological debriefing (Mitchell, 1983) may not be appropriate for providing support to school communities affected by critical incidents (Jackson, 2003). Psychological debriefing was initially intended for use with emergency responders and one of the arguments from its proponents has been that it is often misused, ie undertaken with groups who were never intended as the target audience but it appears that it is commonly used in schools. In a study undertaken by Adamson and Peacock (2007), 228 school psychologists completed a survey regarding crisis intervention teams and plans. The majority of respondents indicated their schools had crisis plans (95.1%) and teams (83.6%). The most common team activities endorsed by participants involved providing direct assistance and services to students, staff and the media. The majority of participants (93%) reported that their schools had experienced and responded to serious crises. Respondents indicated that psychological debriefing was frequently used (generic 49.1% and standardized 17.9%). Stuhlmiller and Dunning (2000) are of the opinion those who debrief have “hidden behind the disease model” and see trauma as a disorder with the “illness” worsening if not treated. Given that psychological debriefing is often

posited for all of those involved in traumatic incidents, it offers an interesting model whereby millions of years of evolution has taken the human race to the point where no-one can cope with the impact of a crisis without external support; survival of the unfittest perhaps! Stuhlmiller and Dunning further contend that practitioners have not kept pace with changing models for trauma treatment that emphasise “wellness over illness”.

Wraith (2000) related an incident from 1996 in which it was decided that all children involved in a crisis event would undertake psychological debriefing. Wraith stated that for many, this systemic approach generated acute stress and distress. Wraith further argued that there are some very concerning stories about the use of group debriefing with children. Wraith cited an example of a case that involved a school debriefing program. Following the death of three 11 year old children as a result of a transport accident, children aged 5-7 years who did not know the children who had been killed and had not witnessed the accident were debriefed as part of a class debriefing. Parents of some of the children reported that problems emerged from the debriefing problems such as clinginess, frightened responses, sleep problems had. Of course, such a use does not meet the standard crisis intervention practice of Critical Incident Stress Management (CISM) of Everly and Mitchell (2000) who are critical of such non-standard practices in rebutting any detractors of their model. Wraith (2000) states that models of group debriefing for children have not been developed, tested or evaluated. It is perhaps unfortunate that Wraith uses anecdote rather than sound evidence to make this case.

A major reason why psychological debriefing (Critical Incident Stress Debriefing and Critical Incident Stress Management [Mitchell, 1983, Mitchell and Everly, 1995; Mitchell, 2003]) has been criticized in recent years is that it serves to enhance arousal in the immediate aftermath of trauma exposure. There is strong evidence that these early interventions are not effective in preventing subsequent psychological disorder, notably Post Traumatic Stress Disorder. McNally, Bryant and Ehlers (2003), in a comprehensive review of whether early psychological intervention promotes recovery from posttraumatic stress, examined in detail the studies claimed as evidence for or against psychological debriefing. McNally, Bryant and Ehlers concluded that *"although psychological debriefing is widely used throughout the world to prevent PTSD, there is no convincing evidence that it does so. RCTs* (randomised control trials) *of individualized debriefing and comparative, nonrandomized studies of group debriefing have failed to confirm the method's efficacy. Some evidence suggests that it may impede natural recovery*" (page 72). *"As the debate about psychological debriefing has shown, plausible ideas about what interventions make sense in the aftermath of trauma do not necessarily mean that these interventions will promote recovery from posttraumatic stress"* (page 68). It has been suggested that requiring people to express their feelings in the immediate aftermath of trauma can increase arousal at a time that when there is a need for calm and stability. It is possible that this increase in arousal may be the reason why debriefing appears to make some people's stress reactions more severe (Bisson, Jenkins, Alexander and Bannister, 1997; Hobbs, Mayou, Harrison and Worlock, 1996). Increasing arousal levels is at odds with a key principle, promoting calming, from the model suggested by Hobfoll et al (Hobfoll, Watson, Bell, Bryant, Brymer, Friedman, Friedman,

Gersons, de Jong, Layne, Maguen, Neria, Norwood, Pynoos, Reissman, Ruzek, Shalev, Solomon, Steinberg and Ursano, 2007) which is considered later.

In summary, Critical Incident Stress Debriefing and Critical Incident Stress Management do not appear as useful for schools most notably because of the specialised training required, that the training is not intended for any group typically associated with a school, and the lack of supportive evidence for the effectiveness of the interventions.

Event Phases

It is useful to consider the phases of disasters and other crisis events and the general responses of individuals and communities. When recovery is considered, there are two post-event phases that provide a broad guideline to what is essentially a developing situation. McManus (2003) identified the Response phase as dealing with immediate issues and the Recovery phase as dealing with long-term issues. The following is suggested by NSW Health (2000) and it is clear from the elements contained therein that recovery is very much a part of the immediate response, most notably, in re-establishing family contacts.

Immediate post-disaster period

This is the phase where there is recoil from the impact and the initial rescue activities commence. During this phase there is also an attempt to build up a picture of what has occurred and to re-establish contact with family and community. The primary helping response by all workers at this stage should be psychological first aid. This aims, like other first aid, to sustain

life, promote safety and survival, comfort and reassure, and provide protection.

Recovery phase

The recovery phase is the prolonged period of return to community and individual adjustment and commences once rescue is completed. Much will depend on the extent of devastation and destruction that has occurred as well as injuries and lives lost. Mental health support services should be available in readily accessible places in the community, or through outreach programs working in collaboration with other community recovery programs. The primary helping response at this time should be supportive counselling and if necessary specialised referral and treatment.

Psychological First Aid

Psychological First Aid aims, like other first aid, to sustain life, promote safety and survival, comfort and reassure, and provide protection. It does not involve probing those affected for their reaction but rather provides a calm, caring and supportive environment to set the scene for psychological recovery (Raphael, 1993). Nader and Muni (2002) suggested strategies such as meeting basic needs, focusing on individual strengths, psychological first aid, promoting social networks, and facilitating activities to assist students with dealing with crisis events. Roberts (2000) viewed school crisis intervention as a number of strategies and practices involved in assisting and supporting individuals and groups. Roberts stated that one of the first stages of crisis intervention includes psychological first aid. There appear to be a number of models for this process but Roberts describes

a practice of establishing rapport, assessing an individual's needs and seeking to reduce the immediate distress. A further stage includes strategies such as listening, reflection on feelings and exploring alternatives. This stage also involves assisting individuals to return to adaptive functioning.

Raphael (1993) presented one model of psychological first aid with components including the following:

Comforting and consoling a distressed person.

Offering human comfort and support is the most important component of psychological first aid. Being with those affected, protecting them from further harm, ensuring basic needs are met, conveying kindness, caring and recognition for what they have been through (Raphael, 1993).

Protecting the person from further threat or distress as far as is possible.

Providing a safe environment is critical. Many survivors may have experienced an overwhelming loss of safety and this needs to be restored. Reuniting individuals with family and friends is important to regaining feelings of safety. When reunion is not possible, information about family and friends should be made available, particularly if the family and friends were also in danger or affected by the trauma (Holloway & Fullerton, 1994; Osterman & Chemtob, 1999).

Furnishing immediate care for physical necessities, including shelter.

Meeting the physical needs of the individual is extremely important and should be done immediately. This includes providing water and food,

warmth and respite. Providing survivors with blankets and food helps reassure them that someone is concerned about them. Medical treatment should be given as needed. Other interventions may be experienced as an intrusion if the individual is exhausted, hungry, and cold. Care must be taken to assure physical needs have the first priority (Holloway & Fullerton, 1994; Osterman & Chemtob, 1999).

Providing goal orientation and support for specific reality-based tasks.

Activity during the acute trauma stage can be productive or non-productive. Productive activity is oriented to the reality of the situation and involves the survivor taking an increasing and active role in his or her own return to functioning. As soon as possible disaster survivors should be encouraged to participate in simple but useful tasks (Di Giovanni, 1999).

Facilitating reunion with loved ones from whom the individual has been separated.

Injured and frightened survivors should not be left alone, and parents should be reunited with their children (Di Giovanni, 1999). Ensuring the reunion of primary attachment figures may be essential to acute recovery and longer-term adaptation. It has been shown that separations of children from parents at this time may have unwanted long-term effects, even when such separations are ostensibly provided in the best interests of the children (McFarlane, 1987a).

Sharing the experience.

Once survival and the safety of loved ones is assured, people may wish to share their experience with others, particularly those who have 'been through it' with them and also those responding. Such natural talking through of what has happened is often the beginning of a process of making meaning of the experience, a giving of testimony, and ventilation of feelings. If it occurs in such natural groups or settings, eg, a shelter, it should be supported but it should not be expected or forced. People vary enormously in the ways they adapt to disaster, both in the immediate aftermath and subsequently. Natural talking through may be part of an adaptive process for those who have the need to do so, but having to talk in groups may be quite inappropriate for others: the timing may be wrong, or different coping styles may have greater validity.

It is important to expect recovery following disaster and to acknowledge a range of reactions that are a normal response to an abnormal life situation (NIMH, 2002). Validation of feelings may be very important in the acute recovery phase following trauma (Holloway & Fullerton, 1994). This is the first stage of telling the story and if dealt with in a caring and supportive manner, may help set the person on the path of psychological recovery.

While many feelings may appear at this stage, there is now much to suggest that these will settle in the following days or weeks. Intervention should only be provided when there is evidence that these feelings are not subsiding and the person appears to be at risk as a consequence. Feelings of fear, guilt, hostility and so forth may or may not be ventilated at this time,

but a more specific exploration of such issues should only occur if these reflect ongoing problems.

Linking the person to systems of support and sources of help that will be ongoing.

It will be important to link survivors to support systems and services that will take over after the acute phase has passed and provide follow-up and assistance to those in need.

One of the most important issues throughout all work conducted is human dignity. The loss of personal possessions, clothes and essential items such as glasses for example, the overwhelming dehumanisation of the disaster experience, the subsequent dependence on others for even the simple basics of everyday life may all be threats to the individual's personal dignity. Wherever possible those caring for survivors should be sensitive to these issues. Handouts of old clothes for which the survivors are expected to be grateful may be the sort of thing that highlights such vulnerability, making them feel ashamed, humiliated or even angry (Raphael, 1993).

Facilitating the beginning of some sense of mastery.

Trauma survivors frequently experience a sense of helplessness and powerlessness. Survivors of human-made trauma may feel particularly valueless and debased. It is critical to provide an opportunity for the survivor to regain a sense of self-esteem and control over their life. Assumptions about personal invulnerability, the existence of a meaningful world, and positive self-perception may have been shattered (Holloway & Fullerton, 1994).

The recovery environment should provide support, protection, containment, and structure and must avoid the further stigmatisation of converting disaster survivors into 'patients' or 'permanent' victims. Stigmatisation isolates survivors at the time when they most need social support (Holloway & Fullerton, 1994).

Identifying need for further counselling or intervention.

Identifying those who are particularly stressed or at risk and ensuring that they are followed up by counsellors or mental health outreach workers is another important part of psychological first aid.

There are other models of psychological first aid. In response to a perceived need for structured guidelines for providing early psychosocial assistance to children, adults and families in the aftermath of disaster and terrorism, the National Child Traumatic Stress Network collaborated with the National Center for Posttraumatic Stress Disorder to develop the Psychological First Aid Field Operations Guide (Brymer et al, 2006). Intervention strategies of psychological first aid are grouped conceptually into eight modules described as core actions (Vernberg et al, 2008). These are: contact and engagement; safety and comfort; stabilisation; information gathering; practical assistance; connection with social supports; information on coping; and, linking with collaborative services. Within each core action, psychological first aid offers a variety of specific recommendations for working with disaster survivors, depending on the individualized needs of the survivors and the context in which services are offered. The rationale for each core action rests on theory and research on stress, coping, and adaptation in the aftermath of extreme events. These principles expounded by Hobfoll et al (2007) were used as

a basis for this model. The principles are considered in more detail in the next section of this module.

In summary, the core components of psychological first aid involve initiating contact and engaging with an affected person in a non-intrusive, compassionate and helpful manner; providing immediate and ongoing safety and both physical and emotional comfort; if necessary, stabilising survivors who are overwhelmed and distraught; gathering information to determine immediate needs and concerns; providing practical assistance in helping address immediate needs and concerns; connecting the individual with social supports by helping to structure opportunities for brief or ongoing contacts with primary support persons and/or community helping services; providing information on coping, including education about stress reactions and coping and linking the individual with collaborative services and providing information about those that may be needed in the future. Thus, psychological first aid is designed to enhance an individuals natural resilience and coping in the face of trauma but as Raphael and Dobson (2001) note, although psychological first-aid interventions *"are intended to be generic and supportive, they have not been subjected to research and evaluation, so that the usefulness and validity of their application needs to be established. Their general supportive nature and non-active intervention suggest that they are unlikely to do harm"* (p. 143).

Hobfoll et al: disaster intervention principles

Hobfoll et al (Hobfoll, Watson, Bell, Bryant, Brymer, Friedman, Friedman, Gersons, de Jong, Layne, Maguen, Neria, Norwood, Pynoos, Reissman, Ruzek,

Shalev, Solomon, Steinberg and Ursano, 2007) were a group of mental health experts who met to determine consensus on broad concepts of disaster intervention approaches as "*to date, no evidence-based consensus has been reached supporting a clear set of recommendations for intervention during the immediate and the mid-term, post mass-trauma phases*". They "identified five empirically supported intervention principles that should be used to guide and inform intervention and prevention efforts at the early to mid-term stages. These are promoting: 1. a sense of safety, 2. calming, 3. a sense of self- and community efficacy, 4. connectedness, and 5. hope." As these principles have an evidence-base unlike much of the recommended actions for crisis response, the principles will be considered at some length.

Interestingly, Vernberg et al. (2008) argued that there were not any strongly validated intervention protocols for responding in the initial hours or days following a large-scale traumatic event. They proposed that there are evidence based principles on which to establish recommendations and identified eight core actions: contact and engagement, safety and comfort, stabilisation, information gathering, practical assistance, connection with social supports, information on coping, linkage with collaborative services and handouts. These have some close similarities to the principles proposed by Hobfoll et al (2007) and to those espoused in Psychological First Aid and so will not be discussed in detail herein.

Caution should be used in generalising the principles espoused by Hobfoll et al (2007) as they focus on those events that are called disasters. Although it has been posited earlier in this paper that plans and responses can be scaled down, Everly, in an individual opinion addendum to the NIMH consensus workshop (NIHM,

2002), makes the important point that evidence-based practice pertaining to mass violence or disasters should reflect research that has direct applicability to these kinds of situations. Disasters are not all the same and nor are those events that might impact on a school.

Hobfoll et al (2007) illustrate ways in which stressful events can create distress for individuals and communities. First, the weight of the physical, social, and psychological demands of situations involving mass casualty may be overpowering. Second, the destruction of resources can diminish or even exhaust the capacity of individuals and communities to cope with a crisis event and recover from its consequences, especially where psychosocial and economic resources have already been stretched due to prior events, psychiatric disorder, or social and economic marginalisation. Third, and linked to the former, is the loss of place or safety within a place, as a previously secure environment succumbs to the pervasive consequences of the event. In many instances of disaster and mass casualty, renewed or ongoing violence, continuing loss and casualties, aftershocks, failure of aid, and the secondary losses that follow the initial phase mean that there may be no clear end to the crisis event. Finally, traumatic events often have profound, extremely stressful and damaging effect on people's sense of meaning, fairness, and order.

Hobfoll et al (2007) identified five intervention principles that they considered to have empirical support to guide evolving intervention practices and programs following disaster and mass violence. Hobfoll et al recommend that these practices and techniques, or their elements, should be contained within intervention and prevention efforts at the early to mid-term stages. Benedek and

Fullerton (2007) state that these principles (safety, calming, efficacy, social connectedness and hope) have gained growing recognition in the mental health community but pointed out that to become the foundation of immediate and mid-term intervention, the principles must become familiar, understood and accepted by a broad range of those who are required to or may have to respond to crises.

Promote a sense of safety.

Hobfoll et al indicate that the principle of promotion of a sense of safety comes from several avenues of investigation relating to both objective reality and perceived reality. When disaster or mass violence occurs in a community, people have to respond to the threat to their lives, their loved ones and the things that are most deeply valued (Basoglu, Salcioglu, Livanou, Kalender, and Acar, 2005). Children, young people, parents, and other caregivers must face the challenges to their safe environment usually afforded by the protection of family and other caring adults, particularly so in regard to those young members of the group (Pynoos, Steinberg and Wraith, 1995). Accordingly, negative post-trauma reactions are common. Disaster-affected populations have been found to have high prevalence rates of mental health problems (Balaban, Steinberg, Brymer, Layne, Jones and Fairbank. 2005). Unsurprisingly, these post-trauma reactions seem to endure when threat or danger continues (de Jong et al, 2001).

Promoting a sense of safety is critical to reduce these biological responses that accompany ongoing fear and anxiety. The implication from this is that promoting safety can reduce some of those biological features of posttraumatic stress reactions (Bryant, 2006). Hobfoll et al (2007) suggest that how to establish safety may seem obvious in that people should be brought to a safe place and have it

made clear that it is safe. Hobfoll et al compare this sense of safety to the principle of re-establishing the protective shield in community and disaster psychiatry on health behaviour change in large populations and communities (Bell, Flay and Paikoff, 2002; Pynoos, Goenjian and Steinberg, 1998) but stress that the restoration of confidence in a protective shield in both adults and children requires repeated attention and can be an extended process (Pynoos et al., 2005)

As safety is established, both physiological and cognitive reactions show a gradual reduction (Ozer, Best, Lipsey, & Weiss, 2003). Where total safety cannot be achieved, enhancing safety will aid people's coping. Even where threat continues, those that can maintain or re-establish a relative sense of safety have considerably lower risk of developing mental health problems (Bleich, Gelkopf and Solomon, 2003.

Cognitive processes that inhibit recovery also occur and are aggravated by ongoing threat. A normal recovery following exposure to a trauma is associated with maintenance of a balanced view about the dangers. A belief in a world full of danger is seen to be a primary mediator for the development of Post Traumatic Stress Disorder (Foa and Rothbaum, 1998). Because trauma memories are often founded in the context of overwhelming emotion and confusion, it is suggested that such memories are easily triggered by a wide range of reminders and often feel to the individual as if they are happening in the present even if safety is restored (Ehlers and Clark 2000). This view suggests that corrective information is needed to ensure that individuals can appraise future threat in a realistic manner. (Ehlers, Mayou, & Bryant, 1998; Smith & Bryant, 2000; Warda & Bryant, 1998). Those who are likely to develop subsequent disorders are more

likely to exaggerate future risk. If actual safety is not restored, reminders will be ubiquitous and contribute to an ongoing sense of inflated threat, delaying or preventing the return of a feeling of safety (Ehlers and Clark, 2000).

Hobfoll et al (2007) suggest that there are intervention strategies that will promote a sense of safety and that these can be instituted on individual, group, organisation, and community levels.

On an individual level, studies have shown that it is valuable to interrupt the process of generalisation that links innocent images, people, and things to those dangerous elements associated with the original crisis event (Bryant, Harvey, Dang, Sackville and Basten, 1998; Resick, Nishith, Weaver, Astin, and Feuer, 2002). This is accomplished using both imagined and real-world, exposure in ways that re-link images, people, and events with safety. Examples appropriate to school settings might be "the school was unsafe that day but it's not unsafe every day" or "the accident on the school bus was frightening but not all bus trips are." Hobfoll et al (2007) also cite the utility of reality reminders, teaching contextual discrimination when encountering past-trauma triggers, assisting in developing adaptive perceptions and coping skills (Hien, Cohen, Miele, Litt, & Capstick, 2004; Najavits, 2002). These kinds of interventions might typically be used by specialist services but would be easily adapted for use by school personnel.

Hobfoll et al (2007) suggest that although social support has a major positive influence, in the aftermath of large-scale community trauma it may have the opposite effect. When information about mass trauma is lacking, people tend to share rumours and other stories about the event. While this may be used as a

means to gain support, it has been found that increasing levels are positively correlated with psychological distress (Hobfoll and London, 1986; Pennebaker and Harber, 1993). The individuals who are sought for support may be most vulnerable to this additional exposure. Intervention should recommend limiting the amount of this type of sharing information about the ordeal if it can be seen as creating more anxiety or depression.

Information about the safety of family and friends is the first to be requested during the immediate aftermath of disasters (Bleich, Gelkopf and Soloman 2003). Because fears concerning the safety of family may be greater than concern for self, intervention must assist in establishing the safety-condition of loved-ones as a priority. School staff are in a position to quickly assure parents as to the safety of the children in their care during crisis events and may also be able to provide re-assurance to children over the well-being of the family.

Safety must be seen to include safety from bad news, rumours, unhelpful or biased commentary and other factors that may add to the perceived level of threat. Those responsible for emergency management must provide accurate and timely information to help in placing limits on threat perception, thus supporting a sense of safety where there is no serious continuing threat (Shalev and Freedman, 2005).

Media coverage and the use of media by Government officials are important facets of intervention. These can be supportive but may also generate fear regarding safety. Although it is generally good intention driving such communication, where the aim is to inform people of the situation, to increase knowledge, and give directions on what to do. These communications need to be

carefully managed as they may increase anxiety, increase dependency and cause confusion over what is expected of individuals. It has been suggested Governmental messages in times of crises events can be used to serve political ends. Cohen, Ogilvie, Solomon, Greenberg and Pyszczynski (2005) suggest that the political response to the terrorist attacks in the United States in September 2001 remained a significant factor through to the Presidential election some years later. Communities may have difficulty maintaining a sense of safety in the aftermath of major crisis events if government agencies and political strategists strive to raise the community perception of threat in order to gain an electoral advantage. Television, radio and other media may also reflect their own organisational aims and accordingly events may be reported in ways that inadvertently decrease a sense of safety or that are provoke uncertainty over the ongoing threat as doubt and fear promote increased viewing of the news. Repeatedly displaying images of destruction or threat can act to reduce the perception of safety. The media may impede recovery: multiple studies link dose-related exposure to televised images of a traumatic event to greater psychological distress (for example, Ahern et al., 2002; Neria et al., 2006; Torabi and Seo, 2004). Hobfoll et al (2007) indicate that although it is difficult to determine the causal relationship between media viewing and fear, such findings are consistent with the notion that media exposure influences fear in the community. Hobfoll et al (2007) also suggest young children may not grasp that a crisis incident has ended when televised replays can suggest an ongoing event and continued threat (Lengua, Long, Smith and Meltzoff, 2005). Hobfoll et al also suggest that following disasters, intervention should include encouraging individuals to limit exposure to news media overall and to avoid media that contain graphic film or

photos if these result in increased distress. This includes education of parents regarding limiting and monitoring news exposure to children.

Promoting a sense of safety seems to be a task that would readily fall within the skills of most school personnel. Schools in many countries have roles which specifically address safety. For example, in Australia implementation of the National Safe Schools Framework (Curriculum Corporation, 2003; Education Services Australia, 2011) which addresses bullying, harassment, aggression, violence and child protection is mandatory for all schools. In the United States, the No Child Left Behind legislation (United States Government, 2002) aims to support programs that prevent violence in and around schools; that prevent the illegal use of alcohol, tobacco, and drugs; that involve parents and communities; and that are coordinated with related federal, state, school, and community efforts and resources to foster a safe and drug-free learning environment that supports student academic achievement. The Scottish Executive provides an array of information in areas such as safe routes to school and child protection procedures in the *Safe and Well Pocketbook* (Scottish Executive, 2005 [A]) and the more comprehensive *Safe and Well Handbook: Schools and Education Authorities Good Practice in Schools and Education Authorities for Keeping Children Safe and Well* (Scottish Executive, 2005 [B]) addressing good practice for staff, schools and education authorities which states that children and young people who need help may be experiencing physical harm or injury; emotional hurt; fear; living conditions that are unacceptable; risk of long-term harm or immediate danger to health and mental and emotional wellbeing. Accordingly, undertaking tasks with children and young people such as to promote a sense of safety after a crisis event should fit well with tasks already undertaken in schools. Following a

crisis event, children, young people, parents and the broader community should be encouraged to view the school as a place of continuing safety. When a crisis directly impacts on the safety of a school, it would seem vital to restore the safety-state as soon as possible and to send strong messages to the community members that school is again a safe environment.

2. Promote calming.

Exposure to mass trauma often results in those involved presenting with heightened emotional reactions at the initial stages. Some anxiety is a normal and healthy, adaptive response demonstrated when people are alert of watchful for threat or danger. Heightened levels of arousal or, paradoxically, numbing responses that provide some needed emotional protection during the initial period of responding are not a cause for undue concern (Bryant, Harvey, Guthrie and Moulds, 2003). Most individuals return to more manageable levels of emotion within days or weeks. Those that do not return to these lower manageable levels of responding are at considerable risk for eventual development of mental health problems. A difficulty may arise when the arousal or numbing functions increase and remain at a level that can interfere with normal life functions such as sleeping, eating, fluid intake, decision-making, and performance of other tasks. The disruptions of these normal activities are not only impairing, but potential triggers of debilitating anxiety that may lead to anxiety disorders. Such extremely high levels of emotional response may lead to panic attacks, dissociation and later Post Traumatic Stress Disorder (Bryant, Harvey, Guthrie and Moulds, 2003). Prolonged states of heightened emotional responding may lead to agitation, depression, and somatic problems (Shalev and Freedman, 2005). Given such

problems, it is important that intervention includes calming as an essential process.

Studies of personal trauma demonstrate that the majority of individuals initially show symptoms that, if they continued, would be indicators of Post Traumatic Stress Disorder. This initial, severe emotionality is a normal way of responding and most individuals return to more manageable levels of emotions within a relatively short time. Those who remain at high emotional levels are at significant risk to development of Post Traumatic Stress Disorder (Shalev and Freedman, 2005). Even if hyperarousal, emotional levels and distress symptoms do diminish, such heightened emotional states are likely to have interfered with sleep, concentration, daily functioning and social interaction (DeViva, Zayfert, Pigeon and Mellman, 2005; Meewisse et al., 2005). This hyperarousal can have a major effect on risk perception, such that the external environment is perceived as potentially harmful beyond any proportion to the available objective information. Having initially perceived a situation as threatening, neutral or ambiguous events are more likely to be interpreted as dangerous. In response to elevated levels of fear, avoidance behaviours may begin that initially may be adaptive but any increase in these may strongly interfere with individuals' and families' abilities to engage in activities that promote heath and wellbeing (Shalev and Freedman, 2005).

Anxiety management can be a key treatment for patients (Foa et al., 1999; National Institute for Clinical Excellence, 2005). Most successful trauma-related treatments address calming of extreme emotions associated with trauma as an key therapeutic aim (Davidson, Landerman, Farfel, & Clary, 2002). Even treatments

that focus on exposure do not conclude until the individual has attained a state of mastery or calming over the aversive memory (Foa & Rothbaum, 1998; Jaycox, Zoellner & Foa, 2002).

Direct approaches for creating calming are generally for those with severe agitation and "racing" emotions or extreme numbing reactions. Grounding is used to remind individuals that they are no longer in the threat or trauma circumstance and that their thoughts and feelings are not brought on by the danger as happened during the crisis event. Continuing to experience the trauma in imagination or dreams can be precursor to Post Traumatic Stress Disorder. Deep breathing is one way to counter anxiety and helps individuals to control breathing and avoid hyperventilating or dissociating (Foa and Rothbaum, 1998). Relaxation training is included in stress inoculation training (Foa and Rothbaum, 1998).

Stress inoculation training is a type of cognitive behavioral therapy that can be viewed as a set of skills for managing anxiety and stress (Hembree and Foa, 2000). Stress inoculation training typically consists of education and training of coping skills, including deep muscle relaxation, breathing control, assertiveness, thought stopping, positive thinking, and self-talk. The rationale for this treatment is that trauma-related anxiety can generalise to many situations (Rothbaum, Meadows, Resick and Foy, 2000).

Normalisation of stress reactions is a key intervention principle to enhance calming in those who have experienced a traumatic event. When individuals interpret their experience in negative and distressing ways, thinking perhaps that they’re going mad or that there is something wrong with them, such as to

pathologise common responses, it is likely to increase their anxieties. Stuhlmiller and Dunning (2000) pointed out that crisis intervention or treatment should emphasise wellness over illness using brief involvements, optimistic messages and strong social supports. The management of acute stress reactions can be assisted communicating that the individual is neither sick nor mad, but having gone through a crisis, is reacting in a normal way to an abnormal situation (Solomon, 2003). Provision of accurate information and education about reactions may help calm survivors by helping challenge negative thinking.

Interventions that focus on strengths and positive emotions can be as effective in treating the disorder stemming from negative life events (Seligman, Steen, Park, and Peterson, 2005). Positive Psychology was described by Seligman and Csikszentmihalyi (2000) as "a psychology of positive human functioning…. which achieves a scientific understanding and effective interventions to build thriving in individuals, families, and communities". In 2008, a whole-of-school implementation of Positive Psychology was undertaken by Geelong Grammar School, Victoria, Australia in conjunction with the Positive Psychology Center at the University of Pennsylvania (Seligman et al. 2008). Studies have examined the role of positive emotions in coping with stress, trauma, and adverse life circumstances and have implications for intervention. Fredrickson (2001) and Fredrickson, Tugade, Waugh and Larkin (2003) suggest that positive emotions have a capacity to broaden a thought-to-action skillset and lead to effective coping. It may help to encourage people to increase activities that foster positive emotions as well as reduce or eliminate intake of information that produces negative emotional states. This may be difficult if individuals feel a need to be

vigilant. For those with minor to mid-level problems of anxiety, limiting media exposure may be sufficient.

Hobfoll, Spielberger, Breznitz et al (1991) highlighted that following mass trauma people are likely to interpret the challenges faced as unsolvable. Breaking down the problem into small, manageable units will increase sense of control, provide more opportunities for gains, and decrease the real problems people are facing (Baum, Cohen and Hall, 1993). Problem-solving appraisal is associated with a positive self-concept, less depression and anxiety, and occupational adjustment. It has potential as an area for intervention development (Silver et al., 2002). Once new skills are learned, encouraging individuals to apply skills can increase and sustain the efforts needed for recovery.

It should be noted further that some frequent ways of calming might be counter-productive and eventually increase distress and decrease the sense of mastery and control. Those with pre-crisis anxiety disorders are at particular risk for further negative psychological impact if exposed to trauma. Alcohol and other drugs can be used to self-medicate and lead to potential misuse and other drug and alcohol-related behaviors.

In summary, many of the interventions discussed in this section are of an individual nature but many can be transferred to group and community-based interventions. Psycho-education has been central to a number of post-disaster interventions that have been shown to be effective in reducing the incidence of Post Traumatic Stress Disorder (Goenjian et al., 2005). Psycho-education serves to normalise reactions and to help individuals see their feelings and behaviours as

understandable and expected. Trauma survivors should avoid pathologising their inability to remain calm and free of the expected intense emotions that are the natural consequences of threatening and often tragic events. These goals can be accomplished to a significant extent within a school community where, with support, psycho-education might readily be provided by teaching staff and where further appropriate actions can support the wellbeing of students, staff, parents and the broader community. Specific programs such as Friends for Life (Barrett, 2005 to 2008) or Aussie Optimism (Roberts, Kane, Thomson, Bishop and Hart, 2003) address anxiety and depression in children and are widely used in schools.

Anxiety management techniques can be taught that are directly linked with specific post-disaster reactions (eg, sleep problems, reactivity to reminders, startle reactions, incident-specific new fears). For instance, suggestions for media exposure management and relaxation training techniques can readily be made available through many schools using existing resources. This may be especially valuable as movements may be limited in the immediate to mid-term post-trauma phase. It will be critical in this regard to communicate at the same time what the signs of more severe dysfunction are so that people also do not disregard significant symptoms and know when and where to seek professional support

In any such intervention, it should not be underestimated that people's agitation and anxiety are due to real concerns, and actions that help them directly solve these concerns can be the best antidote for the vast majority. Initial losses and those losses that occur at some time on from the crisis event are the best predictors of psychological distress (Freedy, Shaw, Jarrell and Masters, 1992; Galea et al., 2002; Hobfoll, Canetti-Nisim, & Johnson, 2006). Psychological

intervention should not be seen as a substitute for interventions that directly relieve threat, make people safe or that provide resources needed for recovery.

Promote sense of self and collective efficacy.

Self-efficacy is an individual's belief that his or her actions are likely to lead to generally positive outcomes (Bandura, 1997) principally through self-regulation of thought, emotions, and behavior (Carver and Scheier, 1998). Self-efficacy is concerned not with the skills one has but with judgments of what one can do with whatever skills one possesses (Bandura, 1985). This can be extended to collective efficacy, which is the sense of belonging to a group that is likely to experience positive outcomes (Benight, 2004).

Following crises events, people may lose the sense of being able to handle the situations they will encounter. Initially this relates to the events of the original trauma but then is followed by a generalisation to a more basic sense of being unable to manage or cope. The aim of intervention is to reverse this negative view. Since it can be assumed that most individuals were living normal lives prior to the disaster or trauma, the task may be more of reminding people of their efficacy than of building efficacy where there was none. Evidence indicates that it is not so much general self-efficacy, but the specific sense that one can cope with trauma-related events that has been found to be beneficial (Benight and Harper, 2002). Crisis or trauma-related self-efficacy concerns the perceived capacity to control distressing emotions and to solve problems that follow in the domains of relationships, rebuilding, relocating, finding work or training for new work, and other trauma-related tasks (Benight et al., 2000; Benight, Swift, Sanger, Smith, & Zeppelin, 1999). In line with this thinking, treatments ranging from prevention of

burnout (Freedy & Hobfoll, 1994) to work with victims of trauma (Resick et al., 2002) are based at least in part on the principle that people must feel that they have the skills to cope with threat and to solve their problems (Saltzman et al. 2006).

A number of interventions can be applied to post-disaster and trauma environments and to the individual, group, organization, and community levels. Treatments such as Cognitive Behavioural Therapy often involve individual work with a trained mental health professional, focusing on imparting skills to the individual. Cognitive Behavioural Therapy encourages active coping and good judgment about when and how to cope, elements that are critical in raising or regaining self-efficacy. Providing individual support to all those who may be in need is obviously not feasible in large-scale events. Assuming infrastructure remains intact, online evidence-based programs such as MoodGYM and e-couch developed by staff at the Centre for Mental Health Research at the Australian National University may be helpful to address anxiety, depression and stress-related concerns without the need for a one-to-one interaction (Christensen, Griffiths, Mackinnon and Brittliffe, 2006).

With children and adolescents, there is a developmental progression in the acquisition of self-efficacy that can be interrupted by threatening events. Overcoming developmental disruptions and promoting normal and adaptive progression is an important part of post-disaster or trauma, childhood interventions (Saltzman, Layne, Steinberg and Pynoos, 2006). Teaching children emotional regulation skills when faced by trauma reminders and enhancing problem-solving skills in regard to post-disaster adversities are especially

important components of post-disaster interventions that have been shown to be effective (Goenjian et al., 1997, 2005). There are programs available for use in schools that specifically address the development of social-emotional skills. The Promoting Alternative Thinking Strategies program (Greenberg and Kusche, 1993), which is used in many schools across the world, has sound evidence as to its effectiveness (eg, Greenberg, Kusche, Cook and Quamma, 1993; Domitrovich, Cortes, Greenberg, 2006) and may have significant value when used in post-trauma situations.

Self-efficacy cannot occur in a vacuum; it requires successful partners with whom to collaborate, join, and solve the often large-scale problems that are beyond the reach of any individual (e.g., when larger systems fail or create bureaucratic obstacles to recovery). Linked to perceived self-efficacy is the notion of collective efficacy (Benight, 2004; Sampson, Raudenbush, & Earls, 1997). People in mass casualty situations can recognize a co-dependency, that they are “all in this together”. When called upon to provide assistance, the World Health Organization endorses a key principle of service delivery in the promotion of self-sufficiency and self-government (de Jong and Clarke, 1996). Hobfoll et al (2007) stress the importance of activities that are designed and implemented by the community itself and how these may contribute to a sense of community efficacy. This may include religious activities, meetings, rallies, or the use of collective healing and mourning rituals (de Jong, 2002b). For children and adolescents, restoration of the school community is recognised by the World Health Organization and the United Nations Children's Fund as an essential step in re-establishing a sense of self-efficacy through renewed learning opportunities, engagement in age-appropriate, adult-guided memorial rituals, and school-based pro-social activity, where

children can be part of an appropriately modeled grieving process and participate in the planning and implementation of activities (Saltzman et al., 2006).

A well-functioning community provides safety, has materials available for rebuilding, resources for restoring order and shares hope for the future. Families are often the main source of social capital within any community, and the main provider of mental health care after disasters, especially among rural populations (de Jong, 2002b). Hobfoll et al (2207) argue that the family must often substitute for professional care and so should be considered a primary axis for intervention. In recent years, schools have increasingly become a source of mental health promotion and support with programs such as MindMatters (Curriculum Corporation, 2000) playing a significant role in address key issues such as anxiety, depression, grief and loss. Hobfoll et al summarise the competent communities as promoting perceptions of self-efficacy among members, fostering the perception that others are available to provide support, and supporting families who, in turn, provide care and encouragement to other members. The perception that others can be called upon for support reduces the perception of vulnerability and encourages individuals to engage in adaptive activities that might otherwise be consider too much of a risk (Layne et al., 2007).

Hobfoll et al (2007) describe aspects of self-efficacy and collective efficacy that they consider are critical, but are often omitted from intervention and planning. The first of these is that self and collective efficacy require behaviours and skills that are the basis of the efficacy beliefs (Bandura, 1997). Bandura (1985) asserted the importance of the judgments made by the individual of what can be done with the skills that he or she possesses. Saltzman et al (2006) found that people must

feel they have the skills to overcome threat and solve their problems. Self-efficacy beliefs that are not strengthened by ongoing, successful action are likely to be quickly compromised (Bandura, 1997). The second aspect of self- and collective efficacy is that empowerment without resources is counter-productive and demoralizing. A substantial amount of research has accrued showing that psychosocial resources, such as hardiness, perceived control, and social support, afford vital protection for disaster victims (Norris et al, 2006b). An important development in disaster research has been the recognition that the protection afforded by psychosocial resources is limited because resources are themselves vulnerable to the impact of disasters. Work in this area attempts to import theory into the understanding of disaster-related stress. Two studies were critical in bringing the idea of resource loss to the fore. Freedy and colleagues (1992) tested hypotheses derived from Hobfoll's theory of Conservation of Resources (1989, 2001). Freedy et al showed that post-disaster resource loss (assessed globally across a range of resources) is a powerful predictor of post-disaster distress. Kaniasty and Norris (1993) introduced a more specific theory, the "social support deterioration model." In their initial test, as well as in subsequent ones that have spanned 6 disasters in 3 countries, declines in perceived social support and social embeddedness explained much of the mental health consequences of natural disasters.

Hobfoll et al (2007) indicate that research on disasters and trauma has repeatedly found that those who lose the most personal, social, and economic resources are the most devastated by event (Galea et al., 2002; Neria et al., 2006) while those who are able to sustain their resources have the best ability to recover (Benight, 2004; Galea et al., 2003).

In relation to these two critical points, Hobfoll et al (2007) note that a lack of understanding of the link between efficacy beliefs, behaviours, and skillsets as well as access to resources leads to serious intervention issues. People will wrongly assume that they, and not circumstances, are the failure, and interventions will be based on erroneous estimates of people's capabilities. People not only need the belief that they can effectively undertake critical tasks but also they require connection to resources to act on these beliefs and the skills required to meet their goals. Hobfoll et al state that it is not surprising that attempts to send trauma victims home with self-help pamphlets are likely to backfire (Turpin, Downs and Mason, 2005), as it assumes that they possess the skills and resources necessary to undertake what is suggested in the form of self-help. These outcomes will, therefore, be greatly influenced by population vulnerability factors, such as poverty, ethnic minority status, and already depleted resources (Hobfoll, 1998).

Hobfoll et al (2007) highlight that because disasters and other large-scale trauma events may undermine already fragile economies, efforts to return things to "normal" may be destined to fail. Because of this, de Jong (2002b) suggests that public mental health programs need to collaborate with development initiatives to help local populations enhance their survival capacities and increase their resiliency and quality of life.

It has been noted that the more that victims of mass disaster or trauma are empowered, the sooner is the move from victim to survivor status (Benight, 2004; Benight et al., 2000). This may be especially true of children. While parents and society typically try to protect children and to shield them from distressing

situations, the principle should be to encourage as much self and collective efficacy as possible and for intervention to be conscious of the dangers of over-protectiveness. Adolescents, in particular, can play a key role in community recovery. Although the evidence supporting promotion of enabling the self-development of the community is mainly qualitative (de Jong, 1995), the principle underpinning this approach has empirical support.

Norris (2005) notes that " *a focus on self-efficacy does not mean that mental health services are not needed but rather that such services should be delivered in a way that provides resources without seeming threatening. Some people are more likely to accept help for 'problems in living' than to accept help for 'mental health problems.' In exercising good intentions to help victims, it is important not to inadvertently rob them of the very psychological resources they need to persevere over the long term*."

There are many ways that schools can promote self-efficacy after crises. MindMatters (Curriculum Corporation, 2000) has already been cited as a resource for mental health promotion in schools. Promotion of skills such as the development of problem-solving, promotion of self-confidence and self-esteem and maintaining an internal locus of control are areas which schools might see as part of the process of learning for students. A number of other areas where schools can serve to enhance self-efficacy have already been mentioned within this section.

Promote connectedness.

Hobfoll et al (2007) note that there is an extensive body of research on the central importance of social support and sustained attachments to loved ones and social groups in combating stress and trauma (Norris, Friedman and Watson, 2002; Vaux, 1988). Supporting social connections is critical to individual, family, and community wellbeing (Wandersman and Nation, 1998; Landau and Saul, 2004). Social connectedness increases the opportunities to acquire and share the knowledge essential to disaster response and survival (eg, "Is the water safe to drink? Where are food and shelter available?"). It also provides opportunities for a range of social support activities, including practical problem solving, emotion and experience sharing and acceptance, normalisation of reactions, and mutual support and advice about coping. There is little by way research based evidence that provides guidance on how to translate this into effective treatments.

Lack of social connections has been found to be a risk factor in the onset of Post Traumatic Stress Disorder (Solomon, Mikulincer, and Hobfoll 1986). Following the attack of September 11th in New York, one of the most common coping responses was to identify and link with loved ones (Stein et al., 2004). Similar results were found following the London bombings of 2005 where delay in making connections to loved ones was a major risk factor for adverse outcomes (Rubin, Brewin, Greenberg, Simpson and Wessely, 2005). Research on disasters and terrorist attacks around the world (eg, Galea et al., 2002; Norris, Baker, Murphy and Kaniasty, 2005; Hobfoll et al., 2006), indicates that social support is related to better emotional wellbeing and recovery following mass trauma. The key role of supporting wellbeing that is played by social support is sustained through the post-crisis period and may even extend for years (Solomon et al, 2005). It has been found to be critical to recovery to foster connections as quickly

as possible and to assist people in maintaining that contact following disaster or mass trauma (Shalev, Tuval-Mashiach and Hadar, 2004). Connecting with others, particularly family, is of vital importance to children and adolescents and facilitating their reunion with parents and parental figures is a critical task in disaster-related interventions (Hagan, 2005).

Kaniasty and Norris (1993) note that although social support facilitates wellbeing and limits psychological distress following mass trauma, there are cycles where the available support level declines. Initially following the crisis event, there is a characteristically high degree of support but support systems quickly deteriorate under the pressure of overuse and the need of those providing the support to get on with their own lives (Raphael, 1986). Accordingly, those who begin with borderline levels of social support can quickly become exposed to a full range of pressures as the crisis-related supports diminish. Those viewed as supporters may actually act in an undermining, rather than a supportive fashion, and this can be particularly damaging. Adverse social support, such as dismissing problems and needs or promoting unrealistic expectations regarding recovery, is a strong predictor of ongoing post-trauma distress. (Andrews, Brewin and Rose, 2003; Hobfoll and London, 1986).

When relating these findings to intervention, it is important to identify those who lack strong social support, who are likely to be socially isolated, or whose support systems might fail by providing negative or disheartening messages. It is important to have treatments that function towards keeping these individuals connected, providing direction or training in how to access and maintain support, and providing formalised support where personal social support is insufficient.

When events lead to destruction such that homes are destroyed or evacuation is needed, it is more difficult for people to connect to their social structures so assistance becomes even more vital in these instances. (de Jong, 2002; Sattler et al., 2002).

There can a negative face to the model in that social divisiveness can become apparent. Giel (1990) noted that previous in-group/out-group divisions might again come to the fore as people use power to access resources. Racial, religious, ethnic and social divisions can become prominent in the process of competing for a favourable share of resources. People can become increasingly distrustful of those who may appear different, more antagonistic and less tolerant as death and dying become more likely (Landau, Solomon, Greenberg, Cohen and Pyszczynski, 2004). Instead of social support happening, social undermining may occur instead. Supporting this theory, Hobfoll, Canetti-Nisim and Johnson (2006) noted that during a period of high levels of terrorism in Israel, both Jews and Arabs became more xenophobic as Post Traumatic Stress Disorder increased.

Schools can play a significant role in promoting connectedness simply be remaining open during crises, encouraging attendance and allowing children and young people to maintain connections with friends and key adults within the school community. Reconnection with family is an obvious goal when a crisis is school-related. Social support is a critical factor in managing stressful situations. Caring and supportive relationships can provide emotional support that may cushion the effects of stressful and crises situations and allow for expression of difficult emotions. For children and young people, parents and close friends represent primary sources of support. Research evidence highlights the

importance of support from parents and family members, support from classmates and close friends, and maintaining ties to such institutions as social, educational, sport and religious groups

Promote hope.

Hobfoll et al (2007) note there is evidence that maintaining hope can play a significant role following a disaster or mass trauma. Individuals who are able to remain positive (Carver and Scheier, 1998) are likely to have more favourable outcomes as it seems that they are able to sustain a measure of realistic hope and a positive outlook for the future. Following a significant crisis event, a negative outlook often affects people. A person's beliefs and assumptions about the world can be disrupted, replaced by a view that the world is no longer a fair and equitable place (Department of Education, Employment and Training, State of Victoria, Australia, 1997) and have a vision of a diminished future (American Psychiatric Association, 1994) which tend to undermine hope and lead to reactions of despair, futility, and a feeling that there is no longer any point. Because disasters, mass trauma and other crisis events are usually events that are outside of normal experience or training for most people, usual coping mechanisms can be overwhelmed leaving individuals with no sense of hope and no sense of the future.

Hope has been defined as a thinking process that taps a sense of agency, or will, and the awareness of the steps necessary to achieve goals (Snyder et al., 1991). Hope for many people in the world has a religious connotation. Even those who are down-trodden, victimized or at 'rock-bottom' often retain a sense of optimism, an internal belief in their own abilities, and belief in strong and caring others, a

responsive government and a God who will intervene on their behalf (Antonovsky, 1979; Shmotkin, Blumstein and Modan, 2003).

Hobfoll et al (2007) note that the danger of hinging hope on an internal sense of agency alone was made apparent after Hurricane Katrina, where a natural disaster coupled with a technological disaster in responding dealt a dual blow to those poorer residents of New Orleans in particular. Many did not evacuate, not because they lacked internal agency, but because they had little reason to hope for a positive outcome of evacuating due to a lack of external resources. It appears as critical to provide services to individuals that help them get their lives back in place, such as housing, employment, relocation, replacement of household goods, and insurance payouts for losses. In a study of veterans with combat-related Post Traumatic Stress Disorder, employment status was found to be the primary predictor of hope (Crowson, Frueh, and Snyder, 2001). Ironson et al. (1997) report that one of the strongest predictors of Post Traumatic Stress Disorder for victims of Hurricane Andrew was the inability to secure finance for individuals to rebuild their homes. These kind of supportive actions (such as having secure employment and access to rebuilding finance) can be viewed as critical mental health interventions. A range of professionals can advocate for those who are victims of disasters and other crisis events to work through what can be complex, bureaucratic processes involved in the rebuilding tasks that follow disasters and other crisis events. Working with individuals, rather than just doing things for them, serves to raise self-efficacy as well as a sense of hope.

Hope can be facilitated by a wide range of interventions On an individual level, several studies have shown that those showing early signs of severe distress

benefit from Cognitive Behavioural Therapy that reduces the individual's exaggeration of personal responsibility due to fear of continuing to manage poorly because the problem is an internal trait (Bryant et al., 1998; Foa et al., 1995). The Learned Optimism and Positive Psychology Model (Seligman, Steen, Park and Peterson, 2005) adopts the goals of identifying, amplifying, and, concentrating on building strengths in people at risk. They identified factors that concentrate on enhancing hope and act to counter the catastrophic thinking that can undermine an individual's feelings of competency. It is important to normalise people's responses and to indicate that most people recover spontaneously (National Institute for Mental Health [NIMH], 2002), as this in itself instills hope and can ward-off distress.

Cognitive Processing Therapy (Resick et al., 2002) works to correct false understandings related to catastrophizing and self-labeling with traits that spell ultimate failure in coping. It seems that envisioning a difficult but realistic outcome may actually reduce people's distress, compared to envisioning an exaggerated, catastrophic outcome. Accordingly, intervention should indicate that 'thinking the worst' is natural but that it should be challenged by more realistic thinking.

Seeing the up-side or the benefit arising from a disaster or other crisis event appears to be common and has been shown to predict mental health adaptation both in the short and longer term (King and Miner, 2000; McMillen, Smith, & Fisher, 1997). Caution should be taken in designing interventions that promote seeing benefit in trauma as these can be seen as an attempt to minimise the challenges that need to be overcome. Some research has found benefit-finding to

be related to negative outcomes such as greater Post Traumatic Stress Disorder, xenophobia and support for retaliatory violence (Hobfoll et al., 2006).

Group or large-scale interventions may be more effective than individual interventions following disasters or mass trauma events. Group interventions offer the advantage that many of the problems are shared by large numbers of people, and so hand-outs on coping that identify common problems gain efficiency that might otherwise take many sessions in individual therapy. However, this should be undertaken with caution as it has already been noted that attempts to send trauma victims home with self-help pamphlets are likely to backfire (Turpin, Downs and Mason, 2005), as it assumes that they possess the skills and resources necessary to undertake what is suggested in the form of self-help. Adger at al (2005) point out that social-ecological resilience can be a determining factor in recovery from disasters, particularly the ability of communities to mobilise assets, networks, and social capital to prepare for and respond to disasters.

Those who are leaders or exemplars in the community can enhance hope by helping focus on more realistic views of the issues, positive goals, building strengths that they have as individuals and communities, and using the learned optimism and the positive psychology model (Seligman et al 2005). The Learned Optimism and Positive Psychology Models have been shown to be effective methods that can be used across the whole school (Seligman, Steen, Park, & Peterson, 2005; Seligman, Ernst, Gillham, Reivich and Link, 2009) The advantage of a community model over the individual is that the group (eg, school, business or organisation,) can develop hope-building interventions using practical and achievable tasks such as helping others clean up and rebuild, making home visits,

providing meals, organising blood donors, sharing spare furniture or clothing and involving members of the community who feel they cannot act or be effective on an individual basis because of the sheer scale of the problem.

Summary of the Principles of Hobfoll et al (2007)

Hobfoll et al (2007) outlined five key principles of early to mid-level intervention following disaster and mass violence. These principles are seen as central elements of intervention and may help in the process of establishing policy intervention frameworks. They apply to all levels of intervention, from the individual to the community based. Psychiatric disorders emerge in the aftermath of crises events both in affected community members and in those who are emergency and other community services responders (Fullerton, Ursano and Wang, 2004). The extent to which implementation of the principles outlined by Hobfoll et al (2007) may prevent such disorders remains unclear. The public health value of these principles lies in their efficacy in reducing distress reactions and related risk behaviours and in promoting resiliency in the larger portion of the population who will not develop psychiatric disorders. There are already some effective clinical interventions for those who develop Post Traumatic Stress Disorder (Foa et al., 1999; Resick et al., 2002). What is still needed are the broader interventions that inform primary and secondary prevention, psychological first-aid, family and community support, and community support functioning (de Jong, 2002a; Eisenbruch, de Jong and van de Put, 2004)

The scale of disasters and mass violence events reinforces the importance of interactions that can be available to large numbers of individuals as the need can quickly surpass the ability of individual-based responding. What Hobfoll et al

(2007) envisage as intervention must go well beyond the bounds of therapy and must be undertaken not only by medical and mental health professionals, but also by gatekeepers (e.g., civic leaders, emergency responders, teachers) and lay members of the community. Stopping the cycle of resource loss is a key element of intervention and must become the focus of both prevention and treatment of victims of disaster and mass trauma, and this includes loss of psychosocial, personal, material, and structural resources (Hobfoll, 1998)

Each of the principles detailed by Hobfoll et al (2007) reflects an important outcome in its own right. Interventions that enhance and preserve sense of safety, calming, self and communal efficacy, connectedness and hope can achieve important successes in the post-disaster period. While interventions based on these principles seem likely to be effective, it is unknown to what extent such interventions will be associated with significant improvements in functioning of individuals or communities. Hobfoll et al note that, as in the case of the critical incident stress debriefing (Mitchell, 1983), overstatement of the proposed effects of an intervention before there is evidence of its impact may lead to implementation of programs with limited effectiveness (Raphael and Wilson, 2000) or those that lead to adverse outcomes and block the development of more effective interventions.

Hobfoll et al (2007) indicate that the major weakness of their recommendations is that there are few clinical trials or direct examinations of the principles recommended in disaster or mass violence contexts. Hobfoll et al (2007) state that many feel that the chaotic and varied nature of disasters and mass casualty situations will prevent there ever being a clear, articulated blueprint based on

strong, direct, empirical evidence and that their empirically informed review and principles are the best strategy for the near and medium range future. Of course, another potential issue with these principles is that they are based on disaster and mass-trauma events and therefore may not readily transfer to lesser events such as those more commonly encountered in schools.

Some additional issues

There are a number of issues that have relevance not only to schools but also to recovery in other domains. Some of these are given attention below because they are pertinent to schools.

Factors particular to children

Children and young people often have different needs to adults. During crisis events, these differences can easily be overlooked as attention is given to what may be, or maybe perceived, as more critical issues. The crisis management literature contains a wealth of information relating to children and young people yet it seems that only a limited amount transfers into either broad policy or to ground-level action. Barenbaum et al (2004, p 42) state "*It is generally accepted now that children represent a highly vulnerable population, for whom levels of symptoms may often be higher than for adults.*" "*Recent literature also suggests that childhood trauma can have a lasting impact on child cognitive, moral, and personality development, and coping abilities.*"

Although Hobfoll et al (2007) and Raphael (1993) give attention to children's needs in addressing their respective five principles and psychological first aid, it is apparent in much of the literature that these needs are seen as a small, perhaps less

relevant or important, part of a big picture. Generally this might be true but for schools, the picture is reversed and the needs of children and young people are uppermost. The following section will address some of the issues particular to children and young people.

The Sphere Project (2004) has collated a corporate and clinical governance framework. Launched in 1997 by a group of humanitarian nongovernmental organizations, the Red Cross and the Red Crescent, the project comprises a handbook, a broad process of collaboration and a commitment to quality and accountability. Sphere is based on the following core beliefs:

> *All possible steps should be taken to alleviate human suffering arising from calamity and conflict.*
>
> *Those people who are affected by disaster have a right to life with dignity and a right to assistance.*

With regard to children, Sphere advises that *'Special measures must be taken to ensure the protection from harm of all children and their equitable access to basic services. As children often form the larger part of an affected population, it is crucial that their views and experiences are not only elicited during emergency assessments and planning but that they also influence humanitarian service delivery and its monitoring and evaluation. Although vulnerability in certain specificities (e.g. malnutrition, exploitation, abduction and recruitment into fighting forces, sexual violence and lack of opportunity to participate in decision-making) can also apply to the wider population, the most harmful impact is felt by children and young people'. 'It is essential that a thorough analysis of how a*

client community defines children be undertaken, to ensure that no child or young person is excluded from humanitarian services'.

Children's reactions may reflect the direct impact of events on them or be consequent on the burden that falls on their parents, family members and caregivers (Angold, Messer Stangl et al, 1998; MacLeod, McNamee, Boyle at al, 1999). Children's fear reactions were described as "interwoven" with those of their parents and families by Raphael (1986). Poland and McCormick (1999) claimed that while many children are resilient, they also benefit from having an opportunity to talk about a traumatic event and that this is important for their wellbeing. Research shows that, in ordinary circumstances, adults have different sensitivities to recognising young people's internalising problems as compared with recognising their externalising problems. Given their own problems in the face of disaster, adults' sensitivity to their children's needs may be heightened or lowered (Williams, Rawlinson, Davies and Barber, 2005; Zwaanswiik, Verhaak, Bensing et al, 2003). Direct impacts on adults and the additional burden on them of caring for their children are powerful influences such that the needs of children are easily eclipsed. McDermott and Palmer (1999) have suggested that reliance on parental reports of children's distress may not be valid as parents tend to under-report internalising symptoms compared with child and adolescent self-report in mental health surveys. McDermott and Palmer suggested that the disaster context may compound this as children may try not to reveal their distress so as not to add to their parents' worries. Additionally, parents may not be in a condition in which they are able to identify or attend to their children's distress. On this basis, McDermott and Palmer advocated for an active approach of school-based screening. McDermott and Palmer found that emotional distress six months after

bushfires was associated with trait anxiety, evacuation experience, perceived threat to parents and depressive symptoms. The perception that a parent may have died was more strongly associated with emotional distress at this stage than perceived threat to the child's own life.

Many children and young people are remarkably resilient and others may show so-called 'normal' reactions, but some children may develop overt problems, sometimes amounting to mental or psychiatric disorders. Children may experience 'shock', numbness, may feel upset varying from unhappiness and nervousness to overt distress, and, are likely to undergo bereavement for lost people, safety and possessions. When children and their families are involved in crisis events they may be exposed to a wide range of stressors including separation, loss, dislocation and trauma. Even within a single event, children's experiences may be different and these may shape their reactions. Pynoos et al (1987a and 1987b) found that in a primary-school sample, exposure to life threat was most strongly correlated with posttraumatic stress. A close relationship with a deceased student was correlated with grief and with subsequent onset of a depressive episode or adjustment reaction. Worry about a sibling or other significant figure or sudden separation from them were associated with persistent separation anxiety.

Barenbaum et al (2004) recognise that in children, "*population-based surveys ...may overestimate the prevalence of PTSD*". "*Symptoms of distress represent natural reactions to trauma; thus, studies of war-affected children face the challenging task of differentiating pathological from normal reactions ...that represent either realistic adaptations or disorder-related impairment."* Barenbaum et al quote studies showing relatively little impact of Post Traumatic

Stress Disorder on how some young people function and others showing much more serious, persistent or delayed impacts. Barenbaum et al express the opinion that "*an increasing amount of research suggests that whether or not psychological symptoms will be perceived as distressing is greatly influenced by the individual interpretations of the traumatic experience and the context in which it occurs*".

Nader (1999) has some particular suggestions for psychological first aid when applicable to children.

> "*Recognize the impact of the event on life and the child's development. Seek skilled intervention and assistance. Be a supportive presence. Listen without judging, without interrupting, without probing. With the child's permission: comfort; record important details of his/her story. When indicated or requested: provide age appropriate factual information. Recognize regressions. When indicated: be gently firm; set reasonable limits; reduce stress. Be patient. Recognize individuality. Honor individual differences. Err toward caution in providing safety until judgement is restored. Know your limitations. Seek appropriate assistance.*"

It is clear that children and young people are able to cope better with a traumatic event if parents, friends, family, teachers and other adults support and help them with their experiences. "*Parental attention and support are among the factors that may be most amenable to early intervention efforts as well as most salient in prevention of poor outcomes for children... This role is especially important when children encounter novel and potentially threatening experience*s…" (Berkowitz,

2003, p. 297). Provision of information is critical both in practical terms and because it can help to diminish levels of stress. Links with families and significant others should be ensured whenever possible and support provided while there is separation. Involvement of parents and carers, school supports and normalising the child's responses to crisis or trauma through psycho-educational approaches are core components of intervention. Additional specialised interventions may be necessary for more complex problematic responses such as depression or indicators of stress disorders.

Trauma and Neurobiology

Abuse and neglect; domestic or community violence; caregivers impaired by illness, drugs or depression; being involved in a major community trauma; these are but some of the ordeals to which children and young people may be victim. Trauma changes the way children and young people understand their world, the people in it, and how and where they belong. A range of studies have established that childhood stressors such as abuse or witnessing domestic violence can lead to a variety of negative health outcomes and behaviours such as substance abuse, suicide attempts, and depressive disorders (eg, Brodsky, Malone, Ellis, Dulit and Mann, 1997; van der Kolk, Perry and Herman 1991; Putnam 2003). Schools may be in the position of having to manage the consequences of such trauma without even being aware that the trauma has occurred.

Recent research into child development has increasingly focused on the role of the attachment relationships in children's lives. Attachment is the capacity to form and maintain healthy emotional relationships (Perry, 2001). Babies and children

need a secure emotional relationship, usually with a mother and a father but also with other caregivers, in order to grow and develop physically, emotionally and intellectually. Babies and children need to feel safe, protected and nurtured by their caregivers so that they can gradually make sense of the world around them. This secure relationship with a main caregiver is essential for the child's development.

Babies are born with 25 per cent of their brains developed. There is then a period of rapid growth so that by the age of 3 years, brain development has reached 80 per cent. During this time, neglect, the wrong type of parenting and other adverse childhood experiences can have a profound effect on how children are emotionally 'wired' (Allen, 2011). "*Because children's brains are still developing, trauma has a much more pervasive and long-range influence on their self-concept, on their sense of the world and on their ability to regulate themselves*" (van der Kolk, 2007).

Trauma during childhood has been linked to changes in brain structure and function and stress-responsive neurobiological systems. The developmental and environmental experiences that influence genetic expression are vulnerable to stress during critical periods of childhood brain development. This can impair the activity of major neuroregulatory systems with lasting neurobehavioural consequences (Teicher 2000; Repetti, Taylor and Seeman 2002; De Bellis and Thomas 2003a; Bremner and Vermetten 2001). Van der Kolk (2003) described the developmental neurobiology of trauma as having impact on three interrelated developmental pathways: on the maturation of specific brain structures at particular ages; on physiologic and neuroendocrinologic responses; and, on the

capacity to coordinate cognition, emotion regulation, and behavior. The differing rates of maturation of areas of the brain can affect post-trauma reactions in the developing child. The human brain develops sequentially, organising in a use-dependent manner and altering neuronal migration, differentiation, synaptogenesis, apoptosis and other processes of neurophysiological organisation in response to external molecular cues, eg, nerve growth factor, cellular adhesion molecules, pattern, and quantity of neurotransmitter receptor stimulation (Pathak and Perry, 2005).

The damaging effects of traumatic stress on developing neural networks and on the neuroendocrine systems that regulate them have remained hidden until recently. An expanding body of evidence suggests that early stressors cause long-term changes in multiple brain circuits and systems. Tucci (2011) has summarised this as follows.

- The brain's primary function is to integrate sensory data to enable the individual to adapt successfully to their environment
- Sensory data is integrated horizontally and laterally by the brain in real time
- Sensory integration is achieved through the brain's biological drive toward efficiency
- Integration is achieved through a balance of inhibition and amplification systems

Impact of Trauma overall

- If the primary purpose of the brain is to integrate sensory data, then trauma is a disintegrative experience
- Trauma reduces the capacity of the brain to achieve complex adaptive self regulatory states
- Trauma changes the architecture of the brain
- Trauma changes the connectivity between brain structures

Impact on Vertical structures and function

- Trauma switches 'on' specific circuits of avoidance and inhibition as a means of surviving recurring experiences of abuse and violence
- Trauma switches 'off' specific circuits that can offer resources to the brain to enable it to move to more helpful states of being and functioning
- Trauma elevates physiological arousal levels in children by interrupting the circuits which are responsible for recalibrating them
- Trauma disrupts the circuitry which connects specific structures of the brain and relay of sensory data from the nervous system collected throughout the body
- Trauma reduces cortical influence of subcortical functioning
- Trauma amplifies the activation of subcortical circuitry
- Trauma primes the vertical circuitry of the brain to process threatened and actual threat in the same way all the time

Impact on Horizontal structures and function

- Hemisphere activation is kept separate with impaired growth and activity of the corpus callosum

- The two hemispheres do not establish circuits of connectivity leaving the experiences of living separate from the capacity to describe them using language
- As separate units, the two hemispheres struggle to offer resources to engage in meaningful and connecting social exchanges
- Impaired hemispheric connection is reflected in learning difficulties, particularly with problem solving and social tasks.

Traumatic childhood stressors such as abuse, witnessing or being the victim of domestic violence and related types of adverse childhood experiences tend to be remain private and go unrecognised by those outside of the situation. The fight-or-flight response among children exposed to these types of stressors and the consequent release of catecholamine and adrenal corticosteroids are uncontrollable and unseen (eg, Perry and Pollard,1998; Teicher, Anderson, Polcari, Anderson and Navalta, 2002; De Bellis, Baum, Birmaher and Ryan, 1997). This can lead to a variety of important long-term behavioural, health, and social problems. The original traumatic damage may be not be expressed until much later in life (Brown 2001; Putnam 1998), when it can be overlooked by clinicians who may only consider more recent determinants of well-being. This can lead to treatment of presenting symptoms without a full understanding of the potential origins in stressor-affected, childhood neurodevelopment.

Information is being gathered on interventions for use with children and young people who have experienced childhood trauma that may have impacted on brain development. One treatment described by Pynoos (2007) teaches children self-regulation skills, helping them to understand how they have adapted in the face of

trauma. The treatment helps modify those adaptations in creative ways so children can move out of survival mode and into one more appropriate to their developmental stage. Similar therapies focusing on self-regulation help children to achieve developmental competencies that they were unable to acquire previously. Although there are now a wide range of commercial programs, (eg, Promoting Alternate Thinking Strategies [Greenberg, Kusche, Cook and Quamma, 1995]) that may in part serve this purpose, parents and teachers may help children deal with extreme stress by providing a physical sense of safety and demonstrating that when the child's own resources fail, someone else is there to take over to reestablish a sense of safety and predictability. Programs such as Circle of Security (Hoffman, Marvin, Cooper and Powell, 2006) can help parents and teachers recognise and understand the stressors that lead to children's maladaptive behaviour. In the absence of such calming and reassuring presences, children are likely to demonstrate difficulties with cognition, impulse control, aggression, and emotional regulation. (van der Kolk, 2003). Perry (2009) has described a Neurosequential Model of Therapeutics which allows identification of the key systems and areas in the brain which have been impacted by adverse developmental experiences and helps target the selection and sequence of therapeutic, enrichment, and educational activities. The principle of use-dependence is the basis of this therapy. It aims to modify the brain by providing experiences that create patterned, repetitive activation in the neural systems that mediate the function/dysfunction that is the target of therapy. This is a high intensity approach and Perry says '*1 hour of therapy a week is insufficient to alter the accumulated impact of years of chaos, threat, loss, and humiliation*" (page 244). This of course poses its own questions, for example, how much time is needed, and, how much change is sufficient.

Cross-cultural factors

Stevenson (2002) pointed out that goals defined for effective crisis management must reflect the physical, emotional and educational needs of the school community. School communities are increasingly becoming culturally diverse (Sandoval and Lewis, 2002). Numerous definitions and terms for multiculturalism, culture, and human diversity focus on human differences ranging from the more visible categories of skin color, language, and socioeconomic status to the less visible, though powerful, influences of spirituality and personal belief systems. Locke (2003) identified more than 150 definitions of ‘‘culture’’ in the literature. Many schools now support students who have been refugees and may have experienced crisis events such as war, killings, torture and loss of family in their home country. Individuals from some cultures may be potentially more vulnerable in the wake of a traumatic event. Sandoval and Lewis (2002) argue that culture determines how individuals act and interact and that relationship between culture and crisis may be a critical factor in what is perceived as a crisis and how it is managed. Interest in multicultural issues in the field of school-based crisis intervention is not only appropriate but necessary in providing services that are acceptable-to and aligned-with the needs of individuals and groups from diverse backgrounds (Kemple et al, 2006; National Association of School Psychologists, 2004a, 2004b; Silva and Klotz, 2006). These authors not only highlight the need for cross-cultural considerations in school crisis intervention but also provide specific recommendations for improving multicultural sensitivity when responding to a school crisis.

There is debate on whether Western approaches to assessment, diagnosis and treatment are appropriate for use in non-Western cultures. One view is that

syndromes hold true across cultures whereas the opposing view argues that the significance of experiences and 'symptoms' should be understood in relation to the culture from which individuals come. Those who support the former view maintain that signs of emotional distress are expressed similarly by children of different cultures and that Post Traumatic Stress Disorder, for example, crosses culture and language. The proponents of the latter approach maintain that there is a broader range of posttraumatic responses. Rosner (2003) argues that "*even if posttraumatic stress can be identified in many cultures, it does not mean that it is the most appropriate of all possible categories in each of the cultures*".

It has already been noted that Barenbaum et al (2004) state "*an increasing amount of research suggests that whether or not psychological symptoms will be perceived as distressing is greatly influenced by the individual interpretations of the traumatic experience and the context in which it occurs.*" Barenbaum et al further indicate that "*in order to provide culturally sensitive assessment and treatment, it is essential to understand cultural practices and to have local knowledge of community. Delivery of mental health interventions in non-Western settings needs to incorporate prevailing cultural norms, including spiritual or religious involvement, basic ontological beliefs, and related issues (eg, personhood and social connectedness, community and illness)*". They conclude that "*optimal approaches to understanding and treating war-exposed children draw both on the principles of cultural specificity, and cross-cultural universality. Recognition of cultural differences in social support systems is important, as they carry direct implications for intervention strategies, but biology and culture are co-constitutive rather than separate and additive*"

Grief and loss

Trauma results from a experiencing an event that is far outside of the usual human experiences, overwhelming coping responses of individuals and groups, causing severe disruption to functioning and involving a perception of fear and helplessness (Raphael, 1986). Grief results, for example, from the death of a loved one and evokes an emotional or psychological suffering. Trauma and grief can both involve loss but grief is generally a function of a life-cycle event, tending to diminish in intensity over time but perhaps never disappearing entirely. Grief and trauma appear to have been studied largely independently. According to Raphael (1999) the immediate response to those both traumatised and bereaved should include providing safety, comfort and support. Silverman (2000) noted that children construct their own meaning of death and the support from a parent is critical to the child's adaptation and coping with the loss.

Bereavement has long been recognised as one of the most stressful of life's experiences, leading to distress and the complex effects referred to as grief. Recovery from, or adjustment to, this common experience is usual for most people but some are at risk for pathological outcomes. In situations of traumatic or catastrophic loss the bereaved person may demonstrate both traumatic stress reaction and bereavement symptoms (Raphael, 1997). Traumatic bereavements include those that encompass the additional element of sudden and, perhaps, horrific, shocking encounters with death and trauma, with the death of a loved one. Descriptions of traumatic bereavements stand in marked contrast to the experiences of quiet death in the home, without mutilation, bodily distortion, shock, threat, horror and helplessness. Both bereaved and traumatised people are likely to experience similar symptoms in terms of intrusive recollections,

persistent thoughts and images, avoidance reactions and high levels of arousal. (Raphael and Martinek, 1997).

On October 29, 1998, around 400 young people were gathered in an old warehouse in Gothenburg, Sweden, for a discotheque party. A fire erupted and spread explosively. Adolescents were exposed to dreadful scenes inside and outside the building. In all, 63 young people were killed and 213 physically injured. A follow-up was undertaken with 275 adolescents (126 girls) who survived the fire, regarding the effects of the fire on symptoms of posttraumatic stress, school adjustment and performance About two years after the fire, surviving adolescents were interviewed and answered questionnaires about their experiences during and following the fire. It was shown that the trauma had a significant impact on their school performance (Broberg, Dyregrov and Lilled, 2005). In all, 23 per cent of the victims (girls 19 per cent, boys 27 per cent) indicated that they had either dropped out of school because of the fire or that they had to repeat a class. Only 17 per cent said that schoolwork had not become more difficult after the fire. These measures of school adjustment relied on self-reports which limits the conclusions that can be drawn

Broberg, Dyregrov and Lilled (2005) note that the most negative influence on schoolwork was reported for those subjects that they deemed as demanding high concentration such as mathematics and science. Sports had become more difficult, especially for girls who were physically injured in the fire. Consistent with the experience that schoolwork had become harder was the finding that exam results, and consequently grades, had gone down for 59 per cent of respondents. A minority reported that schoolwork had become more important to them (13 per

cent) and even fewer that it had become better (8 per cent). Broberg, Dyregrov and Lilled (2005) note a number of methodological difficulties with the study so the results should be viewed with some caution. It should be noted that 59 per cent of the young people had an immigrant background and that 43 per cent had experienced previous trauma, confounding factors that in the absence of appropriate control groups made it difficult to gauge whether the results were truly representative of young people who had undergone serious trauma.

Although there were few fatalities in this event, Yule and Gold (1993) found a decline in academic performance in the survivors of the sinking of the cruise ship Jupiter in the year following the disaster. When they compared the end of year exam results for the three years before the disaster with the end of term results 10 months after the sinking they found that the accident had a significant effect on their performance. This effect persisted through the following year and resulted in lower national exam results than had been originally predicted.

Saltzman, Pynoos, Steinberg, Eisenberg and Layne (2001), in a study of children who had been exposed to community violence, also found that there was a suggested link between trauma severity and school performance. Group members whose Post Traumatic Stress Disorder scores fell in the severe to very severe range had a significantly lower mean grade point average than members whose Post Traumatic Stress Disorder scores fell in the moderate range. In this study, children were screened for trauma and entered trauma and grief-focused therapy groups. It was found that a pre to post reduction in Post Traumatic Stress Disorder was correlated with a pre to post improvement in grade point average for all group members. The findings were taken as an indication that traumatised young people

may experience breakdowns in key attentional and task-related skills that can jeopardise academic performance. The beneficial effects of the focused school-based groups, as used by Saltzman et al, on both post-traumatic traumatic symptoms and associated grief symptoms show this may be viable way of developing school-based therapy for traumatised children. Goenjian et al (1997) examined the effectiveness of school-based grief and trauma focussed psychotherapy in reducing chronic Post Traumatic Stress Disorder and depressive symptoms in adolescents following an earthquake in Armenia. These authors argued that exploration, relaxation and desensitisation procedures and group support might be important therapeutic factors. A cognitive-behavioural-oriented group program delivered in schools, for children and adolescents with mild to moderately severe Post Traumatic Stress Disorder associated with a range of single-incident events, was followed by decreased scores on measures of Post Traumatic Stress Disorder, depression, anxiety and anger post-treatment and, at follow-up, internalising of locus of control (March et al, 1998). These interventions, however, involved specialists with skills in delivering therapeutic interventions for children and young people and, as such, are generally not readily or widely available to or within schools.

There are programs used in schools which are specifically directed towards the issues associated with grief and loss. Notable among these are the Rainbows program and Seasons for Growth. Rainbows started in 1983 (http://www.rainbows.org) and Seasons for Growth commenced in the mid-1990's (http://www.goodgrief.org.au). Neither program is specifically intended to assist children who have been involved directly or indirectly in crisis events. Although both programs receive positive affirmations and report measured positive change

in children and young people, neither program appears to have yet undertaken randomised control trials that would provide sound evidence as to effectiveness. Accordingly, schools should be cautious in using such programs to address grief and loss issues.

Conclusion

In these modules, 7 and 8, Recovery has been considered with a view to identifying practical strategies that a school might undertake in responding to a crisis event. It was seen as particularly important to identify activities that could be undertaken by the majority of staff in schools, ie, not those such as school psychologists or social workers whose typical work involves a specialised, mental health component. Much of the literature focuses on large-scale disasters and mass-trauma events whereas school related crises are typically of lesser magnitude. When planning, schools are generally encouraged to focus on realistic events (eg, Paton 1992) and to plan for multiple casualties (Poland and McCormick, 1999). There are a number of untested assumptions here. First, it is assumed that it is easier to scale-down a planned response, which may change the fundamental nature and effectiveness of the intervention, than to scale-up. Second, there is an unaddressed assumption that individual and group responses and needs are very much the same regardless of the scale of the event and whether ten or ten thousand people are involved. Finally, there is an assumption that focussing on realistic events is the best way to plan.

A number of studies of disasters and effects were reviewed and this led into some consideration of evidence, particularly of how children and young people are

affected, and models for recovery. The Critical Incident Stress Debriefing/ Critical Incident Stress Management model(s) of Everly and Mitchell (2000) were considered only briefly. Psychological First Aid (Raphael, 1986) and the Disaster Intervention Principles of Hobfoll et al (2007) were considered in some detail. Although there is clear overlap with elements of these models, they fit well with the conception of McManus (1993) as dealing respectively with immediate and then long-term recovery issues. There are a number of variations of the Psychological First Aid model with some variants seeming to stray into the realm of psychological debriefing (Mitchell, 1983) so some caution is advised as necessary in choosing a model. Hoboll et al (2007) draw attention to some of the weaknesses of their principles such as that there are few clinical trials or direct examinations of the principles in disaster or mass violence contexts. Of course, another weakness may well be that that the principles are directed at disasters and mass-casualty events and are not also targeted at lesser events. In spite of some areas of concern, Psychological First Aid and the Disaster Intervention Principles look to be useful strategies for guiding school recovery efforts following crisis events.

Some attention was given to studies that highlighted that children and young people often have different needs to adults. For schools particularly, attending to the needs of children and young people is paramount whereas in many other situations these needs are seen as secondary if they are considered at all.

Multi-cultural issues were looked at briefly. This is an important issue in many countries. In Australia, for example, information form the 2006 Census indicated that approximately 22% of Australia's population were born overseas, that there

were 8,048,204 Australians who stated that one or both parents were born overseas (40% of the total population), that 15.8% of Australians spoke a language other than English in their homes, and, that collectively, Australians speak over 200 languages (Australian Human Rights Commission, 2008). Culturally sensitive interventions are essential and it cannot be assumed that what is appropriate for those from one culture will be appropriate for those from another.

Some attention was given to grief and loss and how this can affect children. A few key studies were considered that investigated loss of friends and family, looking at, for example, the development of post traumatic stress disorder and school achievement. Some attention was given to interventions of both a specialist nature and those which were more generic and suitable for use by teachers and others without specialist skills in mental health.

In ending this module, it is appropriate to reiterate a comment made earlier. It has been noted that the responses of children and adolescents to disaster is a neglected area and that many of the studies that have been conducted are limited by a narrow focus on Post Traumatic Stress Disorder and its symptoms (Centre for Mental Health and NSW Institute of Psychiatry, 2000). This continuing focus certainly means that other important issues are being overlooked.

Where to from here

In undertaking this study, one of the primary aims was to derive materials that would have practical uses for schools. The intention had been to undertake some

empirical study in the latter modules of the thesis. Unfortunately, time limits on the study and too much time given to earlier modules prevented this from occurring. Nevertheless, there are a number of issues that can be addressed in moving forward.

As has been noted, very little sound research has taken place in relation to schools and crises. Crises in schools are generally at the 'micro' end of the scale and do not seem to attract much attention from researchers. This isn't intended as criticism but rather a reflection of the reality of undertaking study of crises that may be the consequence of a student suicide or a fatality from a road traffic accident. These are relatively rare events and although they may have profound effects on the school's students, staff and broader community, they are not circumstances that readily allow for randomised control trials of effective actions or interventions. It can be argued that looking at larger events, disasters or mass-violence invoked crises, allows some options for good research but the ability to generalise from these to lesser events has already been questioned.

There are actions that can be undertaken to investigate these smaller-scale crises. It had been the intention for the latter part of this thesis, to undertake a survey of schools asking what actions were felt to have been effective in managing past crises. By using this information to assist schools, it would be possible to achieve a degree of validation of actions-taken by looking at data such as attendance records for staff and students, reasons for absence due to sickness, examination and assignment results, enrolment and transfer data all of which would reflect the pre and post-trauma state of the school. For example, if a school found it useful to allow students to create an impromptu memorial with flowers, personal messages

and the like, then this strategy could be trialled in other schools and assessed using some of the aforementioned measures. There are other factors that could be addressed by looking at the same data set. A number of approaches have been mentioned throughout this thesis that address issues under the umbrella of Mental Health promotion. It would be enlightening to investigate the extent to which programs that, for example, develop resiliency and help children and young people cope with challenge and change are useful in helping cope with demands of a crisis situation.

Finally and briefly, an important question to consider is whether present-day crises are developing with new and qualitatively different characteristics consequent to changes in how we live and, particularly, how we use technology. It is already apparent that it has become much more difficult for schools to exercise control over information-flow in relation to everyday events. The rise of the 'smart-phone' and the lure of social media makes for the rapid spread of news of an evolving crisis in a school. Schools will need answers to the problems created by these and other developing technologies. At present, it appears that the only way to get such answers is by sharing strategies and evaluating outcomes at the school level and this may prove to be a very valuable approach.

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