My name is Dr. Tom Demaria and I am a psychologist and professor in the Doctoral Psychology Program at Long Island University Post, and I serve on the advisory board of the National Center for School Crisis and Bereavement. Thank you for the opportunity to speak to you about the importance of mental health supports both before and following a crisis. During my 26-year career, I have responded locally and nationally to several hundred small and large disasters as a community mental health provider.

New crises faced by our children in recent years, while rare, necessitate a reexamination of the vital partnership of schools with community mental health providers in the prevention, mitigation, and recovery from traumatic stress and loss. Our school-employed mental health staff, such as school counselors, psychologists, and social workers, are critical partners in providing necessary support services, but they cannot always do it alone. Community mental health professionals provide important and unique roles which can complement the efforts of school-employed mental health professionals in promoting psychological safety and wellness in schools.

We can never be fully prepared for the unthinkable. When a tragedy that affects the entire school community occurs, emerging mental health needs can quickly outpace the capacity of school mental health services. Requests for psychological first-aid, risk assessments, and crisis counseling interventions for students must be juggled along with other functions, including the development and dissemination of recovery information for all members of the school community as well as the support of teachers and school leadership. In addition, the personal cost and emotional toll of providing a variety of interventions following a disaster can quickly escalate when counseling multiple victims of a tragedy without relief. Their emotional response is often “super-sized” because school-employed mental health professionals, who are embedded in the same school community, often share the victimization experience with the rest of their fellow school staff. All these new pressures are added to an existing workload which includes care and advocacy for the most vulnerable children in the school.

Following the 9/11 terrorist attacks, I consulted with school-employed mental health staff who heroically provided counseling to large numbers of at-risk children shaken by this ambush of our country. Many of these school-employed mental health staff had family members who worked at the World Trade Center. Despite their own heart-wrenching despair, they provided emotional support to young children who constructed large towers out of building blocks which were knocked down again and again and older children who held onto hope that their daddy was alive in the rubble at Ground Zero since they could still hear his voice message when they called his cell phone.

The common practice of reassigning school-employed mental health staff from other buildings within the school district who can serve as relief staff presupposes that these temporarily assigned staff are not personally impacted by the crisis, have resources in their own building which can address tasks associated with their job responsibilities, and that the mental health needs in the afflicted school will quickly diminish. We know that the initial stabilization period may take months but that full recovery can require years. The many losses that occur following school violence leave lasting marks that cannot be
washed away by tears. Children not only grieve the loss of their loved ones but also their innocence and perception of a safe, predictable, and trusting world.

Children do show incredible resilience following hardships. We know that children respond well to evidence-based school mental health interventions and the comforting structure, routine, care, and relationships which schools offer. However, we are also aware that children can have lingering emotional and psychological difficulties which remain hidden below the surface. This can occur because many children do not share concerns which they do not understand, or hold in rather than express their emotions.

A great deal of our mental health resources are correctly allocated in schools to assure the psychological safety and emotional recovery of students during a time of crisis. Certainly, these remain important considerations for the general welfare of our youth, and a particular focus of my work. But if we fail to provide ongoing, coordinated, sustainable, and accessible mental health services that address threatening and stressful school environments that can affect their learning and development, we are doing a disservice to our children. Recent research in the field of neuropsychology provides a clear warning that a sustained increase in the levels of stress hormones influences child and adolescent brain development, potentially causing future problems with can hinder a young person’s ability to manage his or her emotions and impulses. This can result in the degradation of the quality of life for these children and the future of our country. We can do better. We can foster prevention and early intervention when we ensure the access to qualified school-employed mental health professionals every day and community mental health services when needed.

In my experience, there are three vital components to ensuring ongoing psychological safety in schools, which also support recovery in the aftermath of a crisis:

1. An intentional, clearly defined process to integrate community mental health supports within the school, with identifiable conditions for when to engage community mental health supports
2. A thoughtful transition plan to allow school-employed mental health supports to provide consistent, sustainable mental health services once community supports leave
3. A collaborative relationship among school-employed mental health providers and community mental health providers that exists before the time of crisis

After being notified by the police of a family murder–suicide involving one of their middle school students, I was invited by school leadership to help prepare teachers and school-employed mental health staff for the disclosure of this horrific information in the media. For the past several years, I had provided a number of workshops for both teachers and parents in this school building and had been involved in school responses following sudden deaths of members of the school community. My existing relationships with the school staff became a critical component to my effectiveness in addressing this situation. As I walked into the building that early morning, I was warmly greeted by many familiar faces who tearfully expressed gratitude that I would be at the school that day. The school-employed mental health team had already activated their school disaster plan and developed a list of students who were close friends with the murdered girl. They asked for time with me later on that so that they could share their own personal heartbreak caused by their connections with this beloved student.

Later in the day after the announcement was made public, the school was besieged by well-intentioned but unknown community mental health professionals offering their support, parents worried about how they should explain this tragedy to their families, and members of the media looking for children to interview. The intrusion of strangers in the school community and contradictory communications from their different caregivers can frighten children who are already confused by the disruption in their lives following school crises. I helped school leadership sort out the various offers of assistance, prepared handouts on child bereavement for school staff and families so that there would be consistency in messages delivered, coached staff on media communications, and coordinated outreach out to community faith-based leaders. In the weeks that followed, I provided training on traumatic violence and
loss for the school staff, helped guide memorial efforts, and collaborated with school-employed mental health staff about individual child intervention strategies and self-care issues. Finally, I helped outline long-term recovery plans, such as the inclusion of students in the planning process for upcoming commemorative events, and offered a schedule for my follow-up consultations at important milestones associated with this tragedy. My experiences as a community mental health provider during this tragedy highlight some important challenges faced in a partnership with schools.

Community mental health providers are most effective when they have pre-established relationships with schools before a time of crisis and are recognized by the school as a trusted ally who can positively contribute to their school mental health plan. Being introduced, establishing credibility, and building trust at a time when school gatekeepers look to protect their children from additional harm is a formidable task. In addition, community mental health providers should have an understanding of ways they can best offer services which can bolster confidence of school staff and the school community in the school’s ability to handle destabilizing events. Community mental health providers must also have skills which both complement and optimize existing school mental health resources. For example, I purposely did not provide individual counseling with children in the school but did help colead brief groups along with a member of the school-employed mental health staff. This partnership leveraged both of our unique skillsets while reinforcing student perceptions that there was a trusted adult in the school who would be consistently available for their emotional needs on a daily basis.

In order for schools to most effectively meet the mental health needs of students on a daily basis, and in the aftermath of a crisis, there must be public policies that support school–community mental health collaboration, as well as a dedicated and consistent funding stream to ensure that students have consistent access to school-employed mental health professionals, and that there are an adequate number of community mental health professionals to meet the needs of students and families. Such funding streams could also help support the development of national networks that reinforce such collaboration by identifying best practices and providing resources.