Psychology in the Schools, Vol. 52(7), 2015
View this article online at wileyonlinelibrary.com/journal/pits
© 2015 Wiley Periodicals, Inc.
DOI: 10.1002/pits.21850

TEAM CRISIS: SCHOOL PSYCHOLOGISTS AND NURSES WORKING TOGETHER

KEVIN P. DWYER

Child Education and Mental Health Consultant, Bethesda, MD

DAVID OSHER

American Institutes for Research

ERIN D. MAUGHAN

National Association of School Nurses

CHRISTINE TUCK

Seaman Unified School District #345, Topeka, KS

KATHLEEN PATRICK

Colorado Department of Education

Schools are often the geographic and sociological center of a community. Given modern community emergencies and challenges, schools should make the most of this role and best allocate their resources to maximize the positive impact they have during difficult times. This article uses the vantage point of school psychologists and school nurses from across the country, discussing real life examples of community crises to focus on lessons learned and the "best practices" that can be replicated. This article provides information concerning the skills incorporated to protect and support children in schools and to prevent and respond to school crises. It focuses on the strength of teaming, coordination, and collaboration of school and community in team crisis prevention, response and intervention, with a focus on the professions of school psychology and nursing. This information is important to ensure that all schools have appropriately utilized school nurses and school psychologists in their community's emergency response teams. © 2015 Wiley Periodicals, Inc.

Each school day, families entrust the nation's schools to provide safe and healthy learning environments for approximately 55 million elementary and secondary school students in public and nonpublic schools (U.S. Department of Education [USDOE], 2013). Schools are made up of teachers, students, staff, families, and visitors, who ideally work as a team to ensure student success.

School nurses and school psychologists are key staff who should interact regularly in their support roles for teachers, children, families, and other school staff. They should team with others to promote a caring school climate. They may work together to provide in-service training to staff on issues that vary from reducing accidents during recess to classroom management strategies for bullying. Additionally, when they work together on school crises, there can be even greater benefit to the community.

School nurses and school psychologists are natural partners supporting and focusing on the health and education of children in schools and the wider school community. Together, they share information and knowledge to address the physical, mental, emotional, and social health needs of students, as well as address communicable diseases and chronic and acute physical problems. Their practices also address cognitive, learning, behavioral and mental health problems that put children at risk for school failure (Board et al., 2011; Wiley & Cory, 2013). Through historical examples and first-hand accounts of school crises across the country, this article describes successful school

Correspondence to: Erin D. Maughan, National Association of School Nurses, 1100 Wayne Ave., Ste. 925, Silver Spring, MD 20910. E-mail: emaughan@nasn.org

nurse–school psychologist partnerships in emergency management response plans and suggests ways these relationships can be developed in other districts that lack this asset.

History

Over time, the focus of health care providers in mainstream education has shifted dramatically. In the early 20th century, school nursing and school health focused on immunizations, physical hygiene, vision, and hearing screenings to address these barriers to learning, and these services continue. The passage of Federal Special Education Legislation (Education for All Handicapped Children Act, 1975) and the now renamed Individuals with Disabilities Education Act (IDEA, 2004) defined both school nursing and school psychology as critical *related services* needed to enable children with disabilities to access effective education within schools (USDE, 1977). Special education law is believed to be the catalyst for expanding the numbers and roles of school psychologists and nurses among other school and agency personnel. For example, prior to 1977, there were about 5,000 school psychologists employed nationally in our schools, and by 1990, the estimate increased to 22,000 (Fagan & Wise, 2000).

During this same time and into the present, the Centers for Disease Control and Prevention (CDC, 2014), using the Youth Risk Behavior Surveillance System (YRBSS), found that most risky behaviors in youth remain a serious concern among professionals and advocates. Behaviors such as driving and drinking, unprotected sex, fighting, bullying, and attempted suicide are not only barriers to learning, but they are also life- threatening. YRBSS data informs policymakers and advocates, and supports a stronger emphasis on the prevention roles of schools, including the services of school psychologists and nurses, counselors, and social workers, among others. Comprehensive school policies to address both physical and behavioral health barriers to learning are proposed by the Institute of Medicine and a coalition of national associations representing child advocates and professionals, including the National Association of School Nurses and the National Association of School Psychologists (Allensworth, Lawson, Nicholson, & Wyche, 1997).

Man-made violent tragedies and terrorist threats present a set of potential crises requiring new prevention and response plans and a more intensive need for school nurses and psychologists to function as a team. School shootings or other violent acts, although rare, are extremely traumatizing. More likely, school crisis events result from a sudden student or staff death, with accidents being the most common cause and suicide in teenagers (CDC, 2014). For example, a 40,000-student urban school system set up a crisis hotline and responded to more than 600 crisis calls during the 2013–2014 school year, 52% involving suicidal threats or attempts (Cleveland Metropolitan School District, 2014). During the past decades, school psychologists and nurses have become partners in crisis prevention/intervention planning and practices (e.g., USDOE, 2003).

One of the first violent tragedies requiring a very strong post-crisis mental health response was the Oklahoma City bombing of a federal building in 1995. Evaluation of this largest-ever mental health immediate and long-term response led to a standard for crisis plans to include such services (Office for Victims of Crime Resource Center, 2004). Comprehensive school system prevention and crisis plans continued to develop as lessons were learned from tragic school shootings

On May 21, 1998, a school shooting occurred at Thurston High School in Springfield, Oregon, that left two students dead and 24 injured. Within a month of this occurrence, and in response to this as well as other shootings, President Clinton directed the Departments of Education and Justice to develop an early warning guide to help "adults reach out to troubled children quickly and effectively to prevent such tragedies." (Center for Effective Collaboration and Practice, 1998, June 13, 1998 heading X, para. 1). By August 22, President Clinton released (Dwyer, Osher, & Warger, 1998), an evidence-based guide reflecting the deliberation of an expert panel, which was distributed to every school nationwide. The guide focused on creating a universal, safe, and

caring school climate in which staff were connected and available to students, discipline was positive, social and emotional skill development was supported, equal respect was endorsed, and pedagogy supported academic achievement for all. Warning signs were identified to help identify students who needed additional supportive interventions and those needing comprehensive intensive interventions. This framework was based on the public health model of prevention and early and intensive intervention, as well as crisis intervention. The guide provided a framework for a school crisis response plan that addressed violent trauma (see Sections 5 & 6). A year and a half later, Secretary of Education Riley and Attorney General Reno released *Safeguarding Our Children: An Action Guide* (Dwyer & Osher, 2000), which elaborated on and operationalized this framework. The guide expanded on this to include more information on crisis planning and support in two subsequent publications (Dwyer & Osher, 2005; Osher, Dwyer, & Jackson, 2004).

Based on the lessons from these tragedies, many school districts developed school crisis plans that included these key elements. Brock (2002) indicated that a comprehensive plan, which includes an interprofessional team, should address all phases of an event from prevention to recovery and should include the specific physical and mental health needs of the school's population. This includes establishing a cohesive multidisciplinary crisis team that operates within a common framework (based on the Incident Command System) which, according to Brock (2008), addresses eight elements:

1. Develop a comprehensive school crisis plan, including drills and skills to practice and test the plan.
2. Integrate planning with community-based emergency response services.
3. Assess vulnerabilities and the traumatic potential of crisis events.
4. Protect physical and psychological safety.
5. Promote recovery and a return to learning through school-wide, classroom-based, and individualized interventions.
6. Provide care-for-the-caregiver strategies to support school staff.
7. Align crisis prevention and intervention with existing service delivery models.
8. Support ongoing positive behavior and school climate.

School nurses and school psychologists can play a key part in addressing each element. The roles and expertise of the school psychologist and school nurse should be clear and communicated to all other multidisciplinary team members, as well as to those affected by a crisis event in the school and the school community.

Examples of Collaboration

There are many examples of these collaborations. The authors collected examples from a group of school psychologists and school nurses to illustrate, in their voices, how schools react to crises and how school psychologists and school nurses successfully worked together during crises. These vignettes are included here, followed by a discussion of some of the common themes identified as critical for school nurses and school psychologist.

Springfield, Oregon (by Cathy Kennedy-Paine, MS, School Psychologist)

> The Springfield School District in Springfield, Oregon, has experienced its share of crises over the past 25 years. We have had multiple student deaths, a half dozen teacher deaths, student suicides, threats of violence, a flood, and a fatal high-profile school shooting at a high school.

In May 1998, a freshman at Thurston High shot and killed two students and injured 25 other students, some critically. During the school year following the shooting, we noticed that visits to the school nurse by many students increased dramatically over the previous year. Students experienced post-traumatic symptoms, such as headaches, stomachaches, nausea, lack of appetite, weight loss (or weight gain), sleeplessness, panic attacks, and lethargy. Our mental health providers worked with the nurses at the school to support these students. Together, the team members contacted the families and community mental health professionals to obtain services for the students. Through it all, our school and district crisis teams have responded to each crisis by following our district crisis plan.

What works to make school psychologists and nurses work as a team:

- Working together on a day-to-day basis, which provides the foundation for teaming during a crisis.
- Clear roles and responsibilities as described in a district crisis plan.
- Attending crisis training as a team to gain common knowledge.
- Regular meetings to triage the needs of students during the recovery phase of the crisis.

One of the biggest challenges for our psychologists and nurses providing crisis support following a tragedy is time. An essential component in all of our responses has been our team approach. Each school has a school-based Crisis Team, comprising the principal, school psychologist, school counselor (if one is assigned), teachers, office staff, and classified staff members. This team plans and prepares prior to a crisis and responds during a crisis. In addition, a District Crisis Team comprising district administrators, school psychologists, school counselors, and district health nurses supports the schools during the crisis, coming together on an ad hoc basis.

Columbine, Colorado (by Betty Fitzpatrick RN, MS, SNP, Director of Health Services, 1989–2002)

In April of 1999, I was the Director of Health Services in Jefferson County Schools, where the Columbine shootings would take place on April 20 of that year. One of my administrative responsibilities was coordination of crisis response teams for the school district. Our school district at the time had 120 nurses, 85,000 students, with over 150 schools. We had crisis teams in place, but they were experienced in single incidents, i.e., death of a school student, faculty member, etc. Teams were multidisciplinary professionals: school psychologists, social workers, school counselors, administrators, school faculty, and other support staff. We had never envisioned that we would be called upon to react to such a massive crisis with multiple victims, nor the length of time this crisis support would be needed.

In looking back (or forward), it is important to recognize the things that are valuable in crisis response. The school nurse is uniquely qualified and positioned to serve and or coordinate the school-based crisis teams. She is the one who more likely has contact with all the students in day-to-day activities. She is usually viewed as caring and nonthreatening. But it is incumbent that she works collaboratively with school psychologists, counselors, social workers, and school faculty, both professional and support staff. Teams should be trained in modalities of crisis response and should be allowed the time to build trust and collaborative strategies so they all know their roles and can respond immediately. School districts must also be aware and supportive of time commitments to build these strong teams. Those teams then must be able to communicate and train the staff in the school so they all know what to do when (not if) the crisis occurs.

What worked well:

- Clear communication and trust between all parties before the event was essential.
- Shared goal to help all begin to heal in the aftermath. Conversations were ongoing and all team members were on board to identify students and staff at risk.
- Administrative support and assistance for our teams from community mental health service.
- It is also important to remember this is not a sprint; it is a marathon. Support services went on for several years after the event.

Vestavia, Alabama (by Julie Ward Corley, BSN, RN, School Nurse)

Tuesday, January 28, 2014, began as any other school day at Vestavia Hills Elementary Cahaba Heights. When the snow started falling around 9:00 a.m., most of us thought it would dust and then melt, as usual in Alabama. Man, were we wrong! By 11:00 a.m., the icy roads were impassable, businesses were closing, and schools were being dismissed. News anchors and authorities were advising everyone to stay off the roads. It was quickly apparent that both children and employees would be spending the night at school.

As the nurse, I was quickly assessing the health needs of my remaining students, which included a student with diabetes, a first grader with a high fever, and others with minor health concerns. Thank goodness, I had all the supplies I needed to take care of my students. Our cafeteria workers stayed, providing pizza for dinner as well as breakfast the next morning. Teachers entertained kids with games. Students and staff members enjoyed snowball fights together. Nearby parents brought pillows, blankets, and stuffed animals to the school. We passed the time in the library by watching movies, eating popcorn, reading books, and making forts.

Students were able to call and talk to their parents whenever they wanted, but as it grew darker, many began getting anxious about spending the night at school. Some of these students had never spent the night away from home. A kindergartner said, "I've never spent the night with anyone else, not even my teacher. A fifth grader thought "it was cool" to spend the night at school. Working together, we all comforted these students with smiles, laughter and love.

The next morning, we all enjoyed breakfast, while school administrators and local law enforcement officials were making plans to transport students and faculty to their homes and families. Officers with SUVs and snow chains were greeted by students excited to ride in a police car and eager to get home. By lunchtime, the school was empty. Afterwards, I had time to think about all of our extensive crisis plans, the ones we continually update and strive to improve. I thought about the FEMA (Federal Emergency Management Agency) training I received last summer, which concentrated on school emergencies. I can't think of one thing that we as a school could have done differently. In the end, the key is to work together, to combine all resources to make the best of your individual situation.

We are no stranger to weather emergencies. In April of 2011, an F2 tornado devastated our community. Many families were impacted by the destruction of homes and businesses in our area. Even though the school only received minor structural damage, because of power outages, downed trees, extensive debris, busted water lines, and gas leaks, we were forced to relocate to the middle school, where classes were held for a week. Three years later, many children are still traumatized, terrified that storm clouds or loud noises mean another tornado is barreling down on them. It has been through these storms that we have pulled together. The storms remind us of the undying commitment and selflessness of teachers, counselors, nurses, bus drivers, administrators, school resource officers, office staff, and paraeducators, all of whom did whatever they could to comfort and protect our students. It is our everyday job. We are a family. We all work together for the good of our children. Why it was successful: Communication and preparation are the key components to any emergency plan.

Cleveland, Ohio (by William J. Stencil, MEd, Psychologist and Administrator, Humanware/Social Emotional Learning Department, Internal Operations; Debbie Aloshen, RN, MEd, Manager, Health and Nursing Services; Juliette Madigan, MEd, NCSP, School Psychologist, Rapid Response Coordinator)

In general, the Rapid Response Desk deals with all requests concerning the emotional and physical health needs of students and staff. Our Rapid Response Staff comprises two coordinators. School psychologists are the primary responders to all levels of reported crisis. Nurses are included for response to all physical health needs, as well as first responders to self-harm and grief-related situations. All of the CMSD [Cleveland Metropolitan School District] school counselors are located at the high school level and are often one of the first to be contacted when a reported incident involves a high school student. We have developed a written protocol to address situations where our community agency therapists have an open case with a student or family in crisis. Many types of calls are taken from suicidal thoughts, self-harm, child abuse and neglect, homelessness, depression, and the need for community resources

Other than minor changes, over decades, the entire process has remained the same in order to embed it in the culture of CMSD and promote district-wide consistency. Internal support staff are typically first responders and include CMSD school psychologists, school counselors, school nurses, and security staff. Additional internal resources may include attendance liaisons, linkage coordinators from CTAG (Closing the Achievement Gap), and Planning Center Instructional Assistants (paraprofessionals).

External responders include, but are not limited to, district community partners, mental health intervention specialists currently providing service in all CMSD schools, Mobile Crisis Services, and Hospice of the Western Reserve. It is truly a team effort, coordinated by the Rapid Response Desk that has proven successful for nearly 25 years.

What works well:

- All responders (including nurses and school psychologists work well together due to consistent written procedures on roles and responsibilities, group training sessions, distribution of consistent materials, ongoing assessments, and up-to-date resource information.
- The desk is always available for informal consultation when concerns arise.

Cedar Rapids, Iowa (by Laura Wheeler, MEd, BSN, RN NCSN, School Nurse)

In 2008, when the Cedar River, which flows through the center of Cedar Rapids, crested at 33.5 feet above flood stage, it extended well beyond the 500-year flood plain covering more than 10 square miles of the city. The flood water overtook neighborhoods no one ever dreamed would flood; it flowed through nearly every downtown business and most public buildings, displacing city and county services. Keep in mind this included the central fire, police, and sheriff departments. Taylor Elementary School is located seven city blocks from the river but was still impacted with 3.5 feet of flood water. The school was a vital place for the neighborhood families who were already living in an impoverished area. Over 50% of the school population's homes were also flooded.

One of the most important things learned from this experience is that people needed to be able to tell their stories from the flood. Our community mental health center received a FEMA grant to help train personnel in Crisis Counseling. I personally participated in this training and went door to door to meet with those who were affected by the flood to offer assistance, to listen to their stories, and to give handouts with written information about resources they could utilize. Iowans are resilient, hard-working people who do not always want to seek help. It was important to make people aware of where they could turn for assistance when needed, not just in the short term but for the long term.

> As a school nurse, families trusted me to provide them with resource information to assist with counseling, finances, housing, and medical care.
>
> Our school nurses set up an electronic system to track those students who were flood affected within our health clinic database to follow-up on reasons for their visits to the clinic. We are able to assess whether a student affected by the flood is having frequent physical or emotional concerns exhibited by frequent health office visits. Our secondary school nurses participated in a Psychological First Aid program to assist students who went through the trauma of the flood.
>
> Keep in mind this recovery is a long process. A year after the flood, thousands of residents were struggling to rebuild and even now, 6 years after the flood, there are houses and businesses still in the rebuilding process. Recovery, however, is not just in the physical aspects, but also the social–emotional and behavioral. Often, students still relive the experiences they had during the flood when we have thunderstorms, a large amount of snow with rain in the spring, or when they become aware that the Cedar River is rising close to flood stage again.
>
> It is difficult to prepare for this type of a natural disaster. In the future, if there is enough notice that flooding will occur, it is important to remove important documents, such as health records. Have an emergency preparedness kit together to take if evacuation is needed. Fortunately, school was out for the year when the flooding occurred in Cedar Rapids, but it is imperative to have emergency protocol treatments available for students with specific health needs, along with emergency contact information for families. Have emergency management plans and run practice drills! The greatest challenges were ensuring confidentiality and having enough immediate resources. What worked well: working together with a common goal.

Effective Practice

These examples suggest the importance of communication and trust between school psychologists and school nurses before crises occur. It is also important to realize that efforts do not end after the crises, but communication and teamwork must continue for months and years after events. In addition, three practices were identified and continue to be important to have in place: developing a school crisis plan through collaboration with community emergency response partners, training for all professionals involved, and drills and skills conducted before an event. Each practice will be described and contextualized below.

Crisis Response Team Roles

Until recently, most school nurses and psychologists were not formally trained in crisis prevention and response strategies. Although school psychologists are trained and prepared to address the mental health needs resulting from personal trauma (such as death of a child), most are not trained or experienced in crisis response through an incident command system. School nurses address physical health issues, including somatic complaints that may be secondary to a crisis situation, and their role has expanded with the increase in crisis incidents that have occurred in recent years (Tuck, Haynie, & Davis, 2014). Both professions understand that training requires learning new skills, integrating those skills with existing ones, and applying those skills as a team member assumes a new role. This need was addressed by professional associations and state education agencies, which encouraged and provided training

The *PREPaRE School Crisis Prevention and Intervention Training Curriculum* developed by the National Association of School Psychologists (2014), emphasizes the need for school safety and crisis teams that address both overall school safety and crisis planning. It is important that these

teams include members who can address both the physical and psychological needs of students, for example, school psychologists or counselors and school nurses.

In addition, in 2013, the National Association of School Psychologists partnered with five organizations and collectively developed *A Framework for Safe and Successful Schools* (Cowan, Vaillancourt, Rossen, & Pollitt, 2013). Co-authored with the American School Counselor Association, the National Association of Elementary School Principals, the National Association of School Resource Officers, the National Association of Secondary School Principals, and the School Social Work Association of America, this framework describes how teams can work together to support students' physical and psychological well-being. It is endorsed by 23 national organizations, including the National Association of School Nurses.

In some cases, when the nurse or school psychologist is on-site full time, he or she may be designated by the school principal to lead the school's crisis response team, and that team may (in some cases) be subsumed under a larger community incident response team at the time of a crisis. Although members of both professions have general expertise that can support this work, it is important for education systems and schools to ensure that these selected professionals receive training and administrative supports for their leadership role.

As school-based crisis team members who play a role in both prevention and response, school psychologists and school nurses should be represented on the team that designs the system's crisis plan, as well as the individual school's implementation of that plan. Once a plan is developed, nurses and school psychologists may lead and participate with others in staff training on various crisis responses that ensure the physical and psychological safety of the children and school staff. Working together will also assist in strengthening the communication and trust that is so critical to have between these groups. School psychologists and nurses, together with counselors and social workers, are frequently called on to assist staff in learning how to calm children down, manage discipline problems, and know what to say and do to maximize safety and reduce trauma. These professions can also assist staff in learning what to look for and what to do when children appear stressed, when a traumatic death is reported to them, or when a student shares thoughts of suicide or violence. Crisis prevention training and skills have been shown to be an effective way of appropriately responding to an adverse incident (Brock, Sandoval, & Lewis, 2001). When this training is provided by familiar student services staff who know the school community, it can reassure trainees and reduce anxiety and chaos.

Another form of training these professionals provide is helping staff to develop and sustain the caring and connectedness with students that enable them to support their resilience and to incorporate social and emotional learning into that process. They can help educators use class-wide, advisory, and school-wide meetings to help children re-enter the school and the normal educational day after a crisis. They can also help teachers, staff, and families to recognize signs of stress in children that may require further assessment and treatment, as well as to respond to these students' problematic behavior in a restorative manner (National Association of School Psychologists, 2011). When training is carried out using a team approach (school nurse and psychologist), it provides a resource model that teachers, staff, and community can replicate. This has happened in Cleveland, where a school nurse and school psychologist play a key role in the "humanware" team, which was created based on recommendations of an independent audit commissioned after a 2007 shooting (Osher et al., 2008).

Collaboration and Coordination Role

Collaboration with other agencies is necessary to prevent and address crises and their impacts (Dwyer & Osher, 2005). As leaders in addressing physical and mental health crisis situations,

school nurses and psychologists may be responsible for establishing relationships with community emergency response partners, including fire, police, rescue, and physical/mental health agencies. These professionals know how to prepare for and respond to a crisis. School psychologists, school nurses, and other staff can help improve their response in addressing the particular unique needs of the school environment and student population. School nurses and school psychologists can collaborate on information, supporting common terminology, and collaborative training when a crisis happens in the school.

School psychologists and school nurses can assist responders in being aware of the unique physical conditions and disabilities of the school's student and staff population that may require adaptations of procedures in an evacuation or lock-down. In some cases, the school nurse or school psychologist may be assigned by the principal the responsibility of leading the school's crisis team. In that role, he or she would make sure community responders are part of the collaborative process in developing the school's crisis plan and, when appropriate, participating in any crisis plan training and drills.

It is strongly suggested by experts that all community responders be part of the crisis planning process, and this includes both physical and mental health contacts for all phases, including incidence interventions and short- and long-term mental health supports (USDOE, 2003). The planned coordination with external partners is best carried out with their skilled school partners, including representation of school psychologists and nurses.

Most state laws for crisis response plans reviewed for this article emphasize immediate protective measures and coordinated responses by public safety, fire, medical rescue, and school leadership. Some mandates require drills and sharing plans with public safety and other agencies (e.g., Minnesota Statutes, Section 121A.035) (National Association of State Boards of Education, n.d.). Rather than prescribing specifics, most states provide a "model" crisis response plan that gives local latitude to boards of education. However, each state "model" is comprehensive. State legislated models are applauded when they include requirements for short- and long-term health and mental health interventions following a crisis.

Teamwork and Training among Health and Mental Health School Staff

All school staff collaboration is important, and active teaming among staff responsible for the physical and mental health should be an ongoing process. The nurse may seek peer support from the counselor, school psychologist, and other mental health professionals about frequent recess injuries that may be related to bullying. As groups work together, they will better understand each other, build trust, and strengthen communication skills. Interprofessional team consultations can be also more formal, as when the issues are addressed by a School Improvement Team (SIT; other titles include School Management Team, Schoolwide Team, or School Climate Team), led by the principal.

The SIT generally has the responsibility to decide how to best develop and implement the educational programs for the entire school and to make sure that all children receive the best education possible within a safe and caring environment. The SIT also ensures that the system's policies and procedures are followed in daily practices. When the SIT includes school health and mental health professionals, it is more likely to address these critical issues as part of the school climate. Working together, school psychologists and nurses assigned to the school SIT can ensure that health and social and emotional factors are embedded into the school plans and practices that support student academic success.

National experts have recommended that the most effective school team that addresses the universal school programs and climate responsibility of the SIT be connected to the Student Support Team (SST) (Dwyer & Osher, 2000). The SST is responsible for assisting students who need

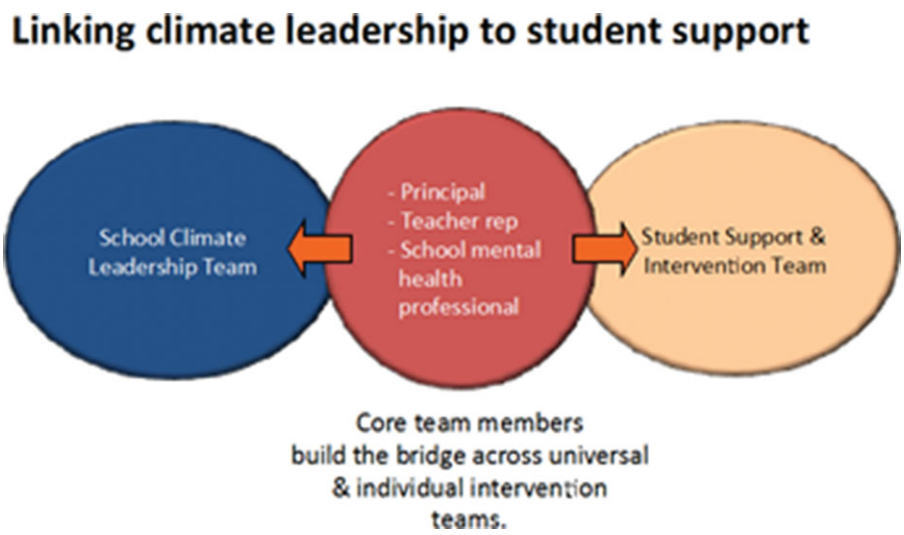


FIGURE 1. The most effective school team consists of core members who address the whole child in the context of the school's universal program (Osher et al., 2004).

additional supports and services to benefit from the regular instruction and related initiatives, through conjoint membership of a few key personnel representing administration, instruction, and physical/mental health (Osher et al., 2004). This is reflected in Figure 1. This approach enables the SIT to see how its instructional and social–emotional programs address the problems of individual students who are not benefiting from those universal programs and for the SST to best understand how their recommendations enable the individual students to gain from the universal programs and instruction. In practice, these core members address the whole child in the context of the school's universal program. This is facilitated by the inclusion of the school psychologist and school nurse as part of the core of the Venn diagram.

The Complementary Roles of School Nurses and School Psychologists

Most school nurses and school psychologists understand and appreciate their complementary roles. They are familiar with the lead that each takes in service delivery. Early identification and treatment of problems place school nurses on the forefront of identifying students struggling with mental, psychosocial, or emotional issues, which, when not recognized, may affect educational achievement and development of full academic potential (Stevenson, 2010). The nurse may quickly seek the help of the school psychologist when a crying child comes to the health room and reveals he is too sad to go on living. A school psychologist is likely to seek out the nurse when a child is referred for being "hyperactive," who is also taking medication for asthma.

In many cases, there is role sharing, particularly in operationalizing consultation with teachers, staff, and families. Part of that teaming is clarifying lead roles in various situations. For example, in developing individual health care plans for students with known health problems, the school nurse would be the expected lead. Yet, the school psychologist may be requested to team with the nurse to assist the teacher in best addressing the learning problems and mood swings related to the child's physical challenges and medications. Team planning thus addresses the whole child and not just the physical condition. Similarly, the school psychologist may be the expected lead team member to address a suicidal threat. Yet, when not immediately available, the nurse may be the appropriate contact and responder (see example from Cleveland) until mental health arrives. In these cases and

others, the important step is for the two professional groups to work together and ask questions to ensure understanding of the situation and who will take the lead.

Working together may not always be easy. Time, communication, and funding for trainings (including substitutes for school nurses or school psychologist to be away from their duty day) are challenges to working together. Yet, school nurses and psychologists can strengthen collaboration and communication by establishing meetings or regular e-mail exchanges to regularly touch base about student or school concerns. The meetings could discuss approaches for behavioral concerns, inservices on medications that may be causing emotional side effects, or understanding what to report and when. This provides an opportunity to learn more about each other's roles and approach to situations and build rapport; celebrating the success of these activities will also strengthen teams (Llopis, 2012). Eating lunch together or attending other school activities will provide additional opportunities to learn about each other's strengths and roles. Technological advances may also be used to improve communication between groups by using a central reporting system that allows school psychologists, nurses, and others to read the professional notes of each team member to keep abreast of activities related to specific children. For example, Montgomery County Public Schools (n.d.) in Maryland uses a centralized form to assist members of the education management team to communicate.

In addition to the everyday activities, teamwork for an emergency can be strengthened by developing crisis plans together and in conjunction with all emergency response partners and by writing policies that clearly state the roles and responsibilities of each person. This builds teamwork and also ensures consistent policies and procedures across professions. Crisis training should also be conducted as a team in order to better understand each other's roles and ensure distribution of consistent evidenced-based materials. After a crisis, continuing regular meetings to triage the needs of students during the recovery phase of the crisis is important for a unified team approach, as well as ongoing assessment and debriefing with up-to-date resource information.

Conclusion

The school psychologist and school nurse, by virtue of their education and experience, are key school staff personnel to provide direct support, as well as a liaison to community resources, for both short- and long-term recovery of their school community following a crisis event. However, they must work together to ensure a strong, collaborative, interprofessional approach to daily, as well as emergency, crises. This can be done by improving regular communication, developing a crisis plan, coordinating efforts, and conducting joint training exercises. Although the purpose of this article was to focus on school psychologists and school nurses, other personnel such as social workers and community mental health providers are also involved, and the same principles outlined in this article could be used to strengthen the communication and trust among everyone. As Betty Fitzpatrick reflected after Columbine:

> We could not have done what we did without the continued help of community mental health services, community organizations, non-profits, faith-based communities, and individual volunteers both professional and non-professional. "It takes a village"... and for that we will be ever grateful!

References

Allensworth, D., Lawson, E., Nicholson, L., Wyche, J. (Eds.), & Committee on Comprehensive School Health Programs in Grades K-12, Institute of Medicine. (1997). School & health: Our nation's investment. Washington, DC: National Academy Press.

Board, C., Bushmiaer, M., Davis-Alldritt, L., Fekaris, N., Morgitan, J., Murphy, K., & Yow, B. (2011). Position statement: Role of the school nurse. Retrieved from http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/smid/824/ArticleID/87/Default.aspx

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

Brock, S. E. (2002). Crisis theory: A foundation for the comprehensive crisis prevention and intervention team. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), Best practices in school crisis prevention and intervention (pp. 5–17). Bethesda, MD: National Association of School Psychologists.

Brock, S. E., Nickerson, A. B., Reeves, M. A., & Jimerson, S. R. (2008). Best practices for school psychologists as members of crisis teams: The PREPaRE model. In A. Thomas, & J. Grimes (Eds.), Best practices in school psychology V (pp. 1487–1504). Bethesda, MD: National Association of School Psychologists.

Center for Effective Collaboration and Practice. (2001). Safeguard our children: An action guide. Retrieved from http://cecp.air.org/guide/actionguide/Action_Guide.asp

Centers for Disease Control and Prevention. (2014). Youth Risk Behavior Surveillance-United States, 2013. Morbidity, Mortality Weekly Report: Surveillance Summary Report, 63(4). Retrieved from http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf

Cleveland Municipal School District. (2014). Response Annual Report – 2014. Cleveland, OH: Author.

Cowan, K. C., Vaillancourt, K., Rossen, E., & Pollitt, K. (2013). A framework for safe and successful schools [Brief]. Bethesda, MD: National Association of School Psychologists.

Dwyer, K., & Osher, D. (2000). Safeguarding our children: An action guide. Washington, DC: U.S. Department of Education & U.S. Department of Justice.

Dwyer, K., & Osher, D. (2005). Safeguarding our children: An action guide revised and. expanded. Longmont, CO: Sopris West.

Dwyer, K., Osher, D., & Warger, C. (1998). Early warning, timely response: A guide to safe schools. Washington, DC: U. S. Department of Education.

Education for All Handicapped Children Act, Pub. L. No. 94–142 (1975).

Fagan, T., & Wise, P. S. (2000). School psychology: Past, present and future. Bethesda, MD: National Association of School Psychologists.

Individuals with Disabilities Education Act. 20 U.S.C. 1400, § 602 (26). CFR, part 300 (2004).

Llopis, G. (2012). 6 ways to successful teams are built to last. Forbes. Retrieved from http://www.forbes.com/sites/glennllopis/2012/10/01/6-ways-successful-teams-are-built-to-last/

Montgomery County Public Schools. (n.d.). Problem Solving for Student Success. Retrieved from http://www.montgomeryschoolsmd.org/departments/specialed/resources/ProbSolv.pdf

National Association of School Psychologists. (2011). Crisis and loss: Information for families. Bethesda, MD.

National Association of State Boards of Education. (n.d.). Crisis management/emergency response [website]. Retrieved from http://www.nasbe.org/healthy_schools/hs/bytopics.php?topicid=3140

National Association of School Psychologists. (2014). The PREPaRE School Crisis Prevention and Intervention Training Curriculum. Bethesda, MD: Author

Office for Victims of Crime Resource Center. (2004). Mental health response to mass violence and terrorism: A training manual (NCJ 205451). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Osher, D., Dwyer, K., & Jackson, S. (2004). Safe, supportive, and successful schools: Step by step. Longmont, CO: Sopris West.

Osher, D., Poirier, J. M., Dwyer, K. P., Hicks, R., Brown, L. J., Lamrpon, S., & Rodrigquez, C. (2008). Cleveland Metropolitan School District human ware audit: Findings and recommendations. Retrieved from http://www.air.org/sites/default/files/downloads/report/AIR_Cleveland_8-20-0821_0.pdf

Stevenson, B. A. (2010). Evolving roles for school nurses. NASN School Nurse 25(1), 30–33.

Tuck, C., Haynie, K., & Davis, C. (2014). Position statement: Emergency preparedness and response in the school setting-the role of the schol nurse. Retrieved from http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/117/Emergency-Preparedness-The-Role-of-the-School-Nurse-Adopted-2011

Wiley, D. C., & Cory, A. C. (Eds.). (2013). Encyclopedia of school health. Los Angeles, CA: Sage.

U.S. Department of Education. (1977). Education of handicapped children: Implementation of Part B of the Education of the Handicapped Act. Federal Register: 42. Washington, DC: Author.

U.S. Department of Education. (2003). Practical information on crisis planning: A guide for schools and communities. Washington, DC: Author.

U.S. Department of Education. (2013). Digest of education statistics. Table 105.20. Retrieved from http://nces.ed.gov/programs/digest/d13/tables/dt13_105.20.asp

Copyright of Psychology in the Schools is the property of John Wiley & Sons, Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.