IMPROVING MENTAL HEALTH RECOVERY FOLLOWING CRISIS ON A COLLEGE CAMPUS THROUGH POLICY DEVELOPMENT

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A DNP Research Project Submitted to Clarion and Edinboro Universities

In Partial Fulfillment of the Requirements for the Doctor of Nursing Practice Degree

April, 2022

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Improving Mental Health Recovery

Following Crisis on a College Campus Through Policy Development

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Abstract

Background: Crisis events, both manmade and natural, could materialize at any time on the campus of a higher education institution, and often have a detrimental impact to the mental health of those experiencing the event. There is already a high prevalence in mental health disorders in college-age individuals and crisis events can often precipitate immediate and long-lasting effects to mental health regardless of an individual's mental state. Educational institutions have a duty to develop comprehensive crisis management plans that address safety of mental health, as well as physiological, before, during, and after crisis events.

Research question: What is required to develop a policy that addresses mental health recovery during periods of crisis on a college campus?

Objective: The purpose of this project is to develop an evidence-based policy that provides a framework for implementing mitigation efforts for mental health trauma before, during, and immediately after, crisis events on campus or crisis involving campus students, faculty, or staff.

Methods: Action Research Design was used to investigate and develop the proposal for a mental health recovery plan. Through engaging in the cyclic process of action research design, it has been identified that Edinboro University does not currently incorporate mental health recovery into its emergency operations plan, thus leaving the institution and its students, faculty, staff, and administration vulnerable to mental health trauma. The proposed mental health recovery plan was also developed adhering to policy standards provided by the Pennsylvania State System of Higher Education.

Results: The proposed mental health recovery plan addresses components that are reflective of those already in the emergency operations plan including *Purpose and Scope, Roles and Responsibilities, Situations and Assumptions, Concept of Operations, Process, and Organization*.

The proposed plan provides a framework for providing psychological first aid to those experiencing a crisis event associated with Edinboro University. The adoption of the proposed plan would be a proactive response to mental health trauma and impart a more comprehensive approach to Edinboro University's emergency operations plan.

Conclusion: Individuals experiencing crisis are at a high risk of experiencing mental health trauma. Incorporating mental health recovery planning into an institution's crisis plan better prepares the institution to meet the needs of all individuals associated with the organization.

Keywords: disaster, crisis, crisis planning, emergency planning, mental health trauma, mental health recovery, mental health interventions, policy development, policy implementation, higher education.

Dedication

I dedicate this doctorate to my children, Bryce and Bradyn, my husband Scott, and my mother, Angie, who have faithfully ridden the roller coaster of completing this degree with me. Through every up and down, long hours at the computer, absences for clinical hours, good writing and bad, you have been my comfort, support, cheerleaders, listeners, and suppliers of endless patience and encouragement. You have been my everything and I could not have gotten through this and to the end without you. I love you so much.

This is also dedicated to Haylee Flory, who I only got to know for such a short time, but whose loss had such a profound impact that it was the driving force behind this project. You would have been such an amazing nurse and I thought about you every time I wanted to give up on this. I hope you're smiling down and celebrating this ending with me, but still pushing enough that this plan goes forward.

Acknowledgements

I have so many acknowledgements to make. I thank Dr. Colleen R. Bessetti-Barrett, Dr. Meg Larson, and Dr. Jill Rogers for providing me the opportunity to obtain this degree. I owe enormous gratitude to Dr. Susan Maloney for the meticulous revisions and edits these last few months and for her support and encouragement every day since I met her. Thank-you to Jim Dahle for helping me to recognize the need for this project and sitting on my committee. Thank-you to Dr. Maureen Chadwick and Sallie Piazza for guiding me through hundreds of clinical hours, exposing me to an area of nursing that I had no understanding of, and cheering me on always.

I thank the faculty of the Edinboro University Nursing Department who have supported me and taught me so much about what it means to be an educator. First, Dr. Amy Weschler who saw a spark in me 20 years ago and has quietly blew on that spark ever since. Dr. Amy McClune, thank-you for teaching me the inner workings of curriculum development, putting up with my slowness in grasping the concepts, listening to me, and for doing the formatting for this project! Dr. Terri Astorino, for reminding me about "small fish", cheering me on, and always listening to my "mom guilt". Dr. Tom White for ALWAYS making me laugh and sugaring up my boys every chance you get. Dr. Madea Shoff, thank-you for always giving me an extra nudge, reminding me that I'm not saving the world, and just being a partner in crime in general. Thank-you to Dr. Lee Ann Leech for always making me feel better about myself, encouraging me, and setting a wonderful example for me as an educator. To Colleen Acri and Michelle Lingle for being right there in the program with me and reminding me to just take it a day at a time. Thank-you to Dr. Beth Farbotnik for always listening to me no matter what, being a wonderful friend, and keeping me going even when I want to stop.

A very special thank-you to Dr. Viki Hedderick. The Good Lord knew what he was about when he brought you into my life. You believed in me when I didn't believe in myself and you always know when to push and when to ease up. I couldn't have asked for a better mentor, friend, "big sister", and role model. I will never forget everything you've done in the last few years to ease my path to this degree and give me perspective. I honestly don't think I would have gotten here without you.

Thank-you to my sister Ashley for always helping me with the boys, planning our vacations, creating wonderful and relaxing getaways, and keeping me grounded. Thank-you to my dad, Pete and Beth for checking in on me and cheering me on. Thank-you to a very special man, Ed Krasa; you know what you meant to me and the place you have in my heart. I will always regret that I didn't get this finished so you could see me graduate. Thank-you to Bonnie Gross, who has seen me through a very ugly time in my life and given me some valuable perspective. Thank-you to my Uncle Brady and Aunt Tina, Fid and Alverna Hellyer, Lewie, my nephews Roo, Alex, and Abe, Val, Eric, Eli, and Trenton Gates, Kelly, Maggie, Frankie, and Ella Young, Stephanie Donoghue, Maureen and Ken Lowe, Scott and Pam Morton, Joel Alsdorf, Luke Johnson and my entire Valley View church family. You add variety and richness to my life. Last, but not least, thank-you to God whose strength and power has sustained me the last five years.

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Chapter 1 Introduction

Mental health recovery planning should be as important to an institution of higher education as its plan for educating students. Educational institutions routinely engage in crisis management planning with the aim of responding to natural disasters and manmade events, including outlining recovery efforts. However, this planning at Edinboro University (EU), and often globally, does not address the impact of crisis on mental health. With startling increases in mental health disorders in youth and young adults, it is more essential than ever to have a mental health recovery plan in place (Morris et al., 2019). Presently, Edinboro has a robust plan in place to manage a variety of physical and environmental crisis incidents, however there is no plan available that addresses the mental health component of those impacted by crisis. The proposed mental health recovery policy will address strategies for both preventative mental health care and mental health recovery following a crisis incident within the campus community.

Colleges and universities are responsible for much more than educating individuals and conferring degrees; for a large number of the student population, these institutions are responsible for managing physical needs and maintaining safety. Maintaining safety is not limited to physical safety; it is equally imperative to maintain and promote emotional and mental health and safety. Events such as natural disasters, violence, internal disasters, or accidents create crises that institutions must manage efficiently to meet the physiological needs of those impacted. This often requires the use of intensive crisis planning (Skurka et al., 2018). It is the responsibility of university leadership and safety personnel to develop and implement plans that address the physical safety needs of individuals associated with the institution. Leadership and safety personnel should be equally responsible for addressing the mental health needs of those impacted by crisis events.

Booker (2014) notes that an institution of higher education must engage in crisis planning to meet the legal obligation that institution has in protecting employees, staff, and students. Safety includes psychological safety, as well as physical safety, meaning that institutions should plan as much for an individual's emotional wellbeing as their physical wellbeing, particularly after a traumatic event occurs. In order to be anticipatory rather than reactionary, a policy and plan addressing mental health recovery should be as central to an institution's emergency operations plan as those addressing fire safety or a natural disaster. Sound crisis management plans should include preparing for a wide range of events, and incorporate interventions that can be implemented before, during, and after a crisis (McCleary & Aspiranti, 2020; Mitroff et al., 2006; Moerschell & Novak, 2020,). Given that exposure to trauma can have both immediate and long-lasting effects to mental health, crisis planning should also include policy development for addressing the mental health needs of those impacted by crisis (Crepeau-Hobson et al., 2020; Knox & Roberts, 2005; Mincin & Hansen, 2019).

Problem Description

The term "crisis" has several definitions that can be used to describe it. Holzweiss and Walker (2018) use a definition that describes crisis as "an event, often sudden or unexpected, that disrupts the normal operations of the institution or its educational mission and threatens the well-being of personnel, property, financial resources, and/or reputation of the institution" (p. 126). Hoff (2009) simply describes crisis as an emotional upset. Puleo and McGlothlin (2010) use the trilogy definition of crisis: (a) an event that brings anxiety or stress, (b) the perception that an individual has of the event, and (c) the overload experienced from the heightened anxiety and stress which causes a failure of normal coping methods. Using this encompassing definition for crisis, institutions should engage in systematic and comprehensive crisis planning prior to

events occurring, to meet the physiological and/or psychological needs of individuals impacted by crisis.

Crisis events at institutions of higher education can be grouped into two categories: natural disasters and man-made (Lindell et al., 2007; Shaw, 2017). Natural disasters can include winter storms, tornadoes, and hurricanes, and are generally predictable and relatively easy to prepare for, while man-made events such as violent attacks, fire, or accidents, are much less foreseeable (Booker, 2014). Regardless of predictability of events, crisis events can have both an immediate and enduring effect on individuals often resulting in psychological distress (Makwana, 2019). Additionally, literature documents high prevalence rates of mental health problems in college students including reported severe stress, depression and anxiety, and these numbers have increased since the COVID-19 pandemic (Lee et al., 2021). In a separate study conducted at a large public university in Texas, Son and colleagues (2020) surveyed 195 students and found that 71% of students reported feelings of increased stress and anxiety since the COVID-19 pandemic began, but less than 5% of these study participants sought any form of help through college health counseling services. Sudha (2018) notes that it is difficult to predict who will experience serious psychological impact as a result of crisis therefore it is prudent to provide an effective outreach strategy to all individuals impacted by an event. This highlights the need for a mental health recovery plan that is in place for mental health crises.

Various types of disasters can develop into crisis events for a college or university. Crisis events are often unpredictable and thus require thorough crisis management planning to allow for sound implementation when an event occurs (Prywes & Sobel, 2015). The crisis management plan itself should also be routinely evaluated to determine success in meeting outcomes for all individuals and stakeholders. Mitroff, Diamond, and Alpaslan (2006) note that “a successful

crisis management plan exposes weaknesses within the current system and builds capabilities to deal with a wide variety of situations" (p. 62).

The crisis management plan for EU, referred to as the Emergency Operations Plan (EOP), addresses preparedness, response, recovery, and mitigation of crises such as natural disasters, civil unrest, fire, and armed threat. Currently, there is not a specific policy, or intervention, within the EOP that addresses mental health recovery following a crisis event on campus, leaving individuals vulnerable to long-lasting psychological effects. A framework for the use of public health and medical services is in place. However, this speaks primarily to physical health and safety and does not address services necessary to provide mitigation methods for mental health trauma. Additionally, the EOP addresses large scale disasters only. It does not provide a procedure that addresses trauma on a smaller scale, such as a motor vehicle accident, death of a student, staff, or faculty member, or any number of individualized events that could be catalysts for mental health trauma. Therefore, there are unknown resources available for individuals on the Edinboro campus to assist each other with personalized trauma or to provide referral to mental health services.

In consideration of the diversity of the EU community, the variation of risk factors for mental health trauma present on and around the college campus, and the absence of a strategic mental health recovery plan, the following PICO question has been developed as the basis for this project: *What is required to develop a policy that addresses mental health recovery during periods of crisis on a college campus?*

Available Knowledge

Mental health disorders, such as depression, anxiety, and post-traumatic stress disorder (PTSD), as well as self-harm secondary to mental health disorders, are demonstrating an alarming increase in young adults (Auerbach et. al., 2016). Data analyzed from the National Survey on Drug Use and Health, directed by the Substance Abuse and Mental Health Services Administration (SAMHSA), demonstrated a 63% increase in major depression in young adults ages 18 to 25 from 2009 to 2017 and a 47% increase in young adults with suicidal thoughts or suicide-related outcomes from 2008 to 2017 (Twenge et al., 2019). Suicide is the 10th leading cause of death in the United States and the second leading cause of death in those individuals ages 10-34 (Centers for Disease Control and Prevention [CDC], 2021). Kang, Rhodes, Rivers, Thornton, and Rodney (2021) note that the increased prevalence of mental health disorders in undergraduate university students is alarming and that measures for early screening and management of health services in university settings is urgently needed. The National Center for PTSD reports that approximately 8 million adults have PTSD in any given year and that PTSD is most likely to develop after suffering a traumatic event such as rape, abuse, violence, or disasters (U.S. Department of Veterans Affairs, 2019). Recommendations for the prevention of mental health disorders include early detection and intervention to prevent progression along with a number of long-term treatment strategies.

An additional concern is the increased potential for crisis events that can occur on campus or be associated with a college campus. College campuses are certainly not immune to crime and violence and there may be access to alcohol and drugs. In 2017 the CDC found that the top three leading causes of death in age groups 15-24 and 25-34 was unintentional injury (accidents), suicide, and homicide (CDC, 2018). All of these are crisis events and could serve as

triggers for mental health trauma. Natural disasters occur with limited warning and can have devasting effects on the areas in which they occur. It is not possible to estimate the effects of a traumatic event on the campus population. Consequently, there is the potential for a situation to develop in which predisposing risk factors in individuals and uncontrollable events such as violence or natural disasters create an environment where mental health trauma can occur.

Rationale

Several risk factors for the development of serious and chronic mental health disorders are present on the EU campus. The primary risk is the inevitably of a crisis event. Additionally, university students present as a vulnerable population because of the prevalence of mental health disorders within the age group. It is also unknown what an individual's previous exposure to trauma has been. The depth and scope of risk factors for mental health trauma, as well as the variation of populations on a college campus and incidence of traumatic experiences requires an evidence-based approach to mitigation during crisis events (Sheldon et al., 2021). Institutions of higher education cannot realistically prevent most events that might precipitate crisis. However, they can engage in planning to manage the aftereffects of traumatic events that encompass all areas of safety including physical, mental, and emotional, as well as meeting the basic needs of individuals. Educational institutions have emergency management plans for fires, natural disaster evacuation and recovery, and active shooters. There should also have be policies and procedures in place to meet the mental health needs of all individuals including faculty, staff, and the student populations, who may be impacted by crisis.

Specific Aims

The purpose of this project is to develop an evidence-based policy to be added to the EU EOP that provides a framework for implementing mitigation efforts for mental health trauma

during, and immediately after, crisis events on campus or involving campus students, faculty, or staff. This report will utilize the Standards for Quality Improvement Reporting Excellence (SQUIRE, 2020) guidelines to describe the present problem of not having a policy for the mitigation of mental health trauma in place. The need for such a policy in Edinboro's EOP will be explored, and the steps to construct the policy will be followed. Policy development will provide a contextual background for the adoption of the policy and foundation for the development of mitigation interventions to be implemented during crisis events. Hypothetically, these efforts would prevent the development, or exacerbation, of chronic mental health disorders in those who have experienced the traumatic event.

Chapter 2 Methods

Context

Action research design is required to develop a policy that incorporates mental health recovery into crisis management operations and a specific plan to address the problem on a college campus. Action research design is a method utilized in social services research that focuses on problem-solving rather than testing a hypothesis (University of South Carolina [USC], 2022). USC further notes that "action research studies often have direct and obvious relevance to improving practice and advocating for change" (USC, 2022, pg. 2). Such a design is custom fit for the goals of the Doctor of Nursing Practice (DNP) research project, which include focus on change, problem-solving, implementation into practice, and providing a foundation for future research and scholarship (Clarion and Edinboro Universities, 2019). A project utilizing action research design follows a cyclic process that includes exploration, understanding of the problem, plans for intervention, intervention, and evaluation of outcomes. This process is very similar to the nursing process, which has been the basis of nursing practice for over sixty years, beginning with Ida Jean Orlando (Toney-Butler & Thayer, 2021).

Intervention

The intervention for this DNP project is the development of a mental health recovery plan. The development of the proposed mental health recovery plan is outlined in the methods section by following the model of action research design. Additionally, the development incorporates the required components of policy structure from the Pennsylvania State System of Higher Education (PASSHE).

Exploratory Stance

Taking an exploratory stance involves looking at the environment in which one is in and identifying potential areas of improvement (USC, 2022). The DNP student is tasked with the activity of exploration beginning with admission into the doctoral program, when instructed to explore past clinical and professional experiences in order to ascertain potential projects for doctoral research. Discovering the lack of a mental health recovery plan occurred by accident. The EU Nursing Department suffered the loss of a student from acute myeloid leukemia and there were minimal resources available to assist with the grieving process. Counseling and psychological services are available on campus but lack current resources or flexibility to go directly to individuals suffering trauma or crisis on a widespread scale. Further exploration revealed there is a current lack of resources, supports, and services available on this campus to address small and large-scale crisis events. There is nothing in place that specifically addresses mental health recovery following crisis; this DNP project proposes the development of such a policy.

Understanding of a Problem

Understanding the potential impact of mental health response procedures to crisis requires a deeper look into how individuals react to crisis or trauma. The American Psychological Association (APA) defines trauma as an emotional response to a terrible event (APA, 2022). Initial responses may include shock or denial, anger, stress, or a high level of arousal, while long-term responses involve anxiety, flashbacks, behavioral issues, health issues, or cognitive issues. Trauma, much like pain, can be subjective, meaning that what is traumatic to one person may not affect another. It is still unknown why one individual might recover from

trauma, while another suffers long-term effects, but early processing of events and building resilience are tools that may prevent long term effects (Anton, 2015). Left unchecked, exposure to traumatic events may result in mental health disorders such as depression, substance abuse or dependence, and PTSD (National Institute of Mental Health, 2019).

Plans for Intervention

An effective evidence-based or evidence-informed intervention is proposed here to meet the expectations and rigor of the doctoral project. Additionally, the intervention should demonstrate evidence of having been effective in a similar environment. This has been determined through a systematic literature review which identified Psychological First Aid (PFA) as an appropriate evidence-informed intervention (The National Child Traumatic Stress Network, 2012). In order to meet immediate mental health needs of individuals in higher education, PFA has been adopted by Ohio Mental Health and Addiction Services (OhioMHAS) and the Ohio Board of Regents – University Linkages Committee, as shown in their collaboration *A Psychological First Aid Guide for Ohio Colleges and Universities* (OhioMHAS, 2013). To implement PFA during crisis or trauma, a framework and direction for its use must first be established. The development of the crisis response policy will be structured using the same design as other annexes of the EU-EOP. The addition of the mental health crisis response annex to the EOP will establish a standard of response across all aspects of emergency response at EU. This will provide concrete guidance as to when and how PFA will be administered to those experiencing crisis or trauma. Moreover, the EU Mental Health Recovery Plan, utilizing PFA as its primary intervention, will be developed utilizing the *Psychological First Aid Guide for Ohio Colleges and Universities* as a blueprint.

Intervention

The intended intervention is the development of the Mental Health Recovery Plan to be added to the EU EOP. The policy will be created and presented to the EU Emergency Response Team (ERT). If approved by the ERT, further work will need to be done to identify individuals to be trained in PFA, complete training, and begin utilizing the intervention on campus when activated by the ERT. Additionally, individuals trained in PFA could apply the intervention on a smaller scale, using it to help students, faculty, and staff dealing with smaller scale trauma, such as the death of a loved one, violence, or accident.

Evaluation of Outcomes

Evaluating the outcomes of implementing a mental health recovery policy and the PFA intervention represents a challenge for the proposed DNP project. Literature reviews focused on PFA note that there is limited data on successful outcomes utilizing the PFA, however this should not persist as a barrier to universities creating a mental health recover action plan. PFA is the accepted intervention by many organizations, including the World Health Organization (WHO) and the American Red Cross. This project can add to the body of literature in support of the use of PFA in a mental health recovery plan. One potential method of evaluating outcomes would be to monitor the use of the Counseling and Psychological Services (CAPS) department of the student health center, but that would not be definitive as there are many reasons that students use these services. Ongoing evaluation of the mental health recovery plan, as well as the PFA intervention utilized within the plan, will be conducted to add to the body of literature supporting crisis planning.

Edinboro University Policy Requirements

Using standards set forth by PASSHE, the Edinboro University EOP was last revised in 2018. It provides operational processes to respond to a wide array of emergency events, such as natural disasters, violent events, and internal disasters such as fire or utility failure. Any new policies, addendums, or revisions must meet the same standards. Each individual plan contains elements that address the four phases of emergency management: preparedness, response, recovery, and mitigation (Federal Emergency Management Agency [FEMA], n.d.). The goal of addressing all four phases is to decrease the impact of an emergency and its long-term effects, a goal which is congruent with the utilization of PFA for mental health recovery. The EOP is separated into four sections: The Basic Plan, Emergency Support Functions Annex, the Support Annex, and the Hazard-Specific Annex. The proposed mental health recovery policy will be included in the Support Annex, which currently consists of a Crisis Communication Plan and a Mass Shelter Plan.

To meet the PASSHE standards, specific components are required. These components include: *Purpose and Scope, Situations and Assumptions, Concept of Operations,* and *Organization*. These components provide an outline of the basic needs and conditions for implementation of plans. The *Purpose and Scope* section describes the objectives of the plan and the extent of where the plan will be implemented. The *Situations and Assumptions* section describes situations when the plan may be used, and suppositions related to situations and the need for plan implementation. The *Concepts of Operations* section describes the specific steps and actions that will be taken when the plan is implemented and focuses on the phases of mitigation, preparation, response, and recovery. The *Organization* section outlines additional outside bodies (i.e. County Emergency Management Agency, American Red Cross) that would

need notified about the implementation of the plan or would serve as supporting entities for implementation of the plan. Additionally, some of the plans also include *Roles and Responsibilities* and *Process* sections, summarizing specific individuals or internal groups that will need to be part of a plan and their responsibilities within the plan, and a timeline for initiation, implementation, and resolution for the plan. The mental health recovery plan will need to include all listed components to provide a comprehensive blueprint for the use of PFA and mitigation of mental health trauma.

In addition to the proposed policy incorporating mental health recovery into the EOP, a guide for PFA implementation will be developed that is specific to EU. Using the *Psychological First Aid Guide for Ohio Colleges and Universities* as an adaptive framework, a manual for the training, delivery, and implementation of PFA will be developed (OhioMHAS, 2013). This will include agreements for mobilizing supportive community resources in times of crisis where the number of victims overwhelms the resources and abilities of the university and its personnel. It speaks directly to the needs of students, faculty, and staff of colleges and universities, which is unique compared to the wider community or a population at large requiring mental health recovery.

Study of the Intervention

The intervention explored in this project is the development of a mental health recovery plan during crisis events. As the plan is in the proposal stage only, and has not been adopted and implemented, there are no outcomes at this time to evaluate. Therefore, it cannot be assessed for impact. Should the proposed mental health recovery plan be adopted, the approach planned for assessing the impact of the intervention will be follow-up surveys and individual and global assessment of the implementation of the emergency MH recovery plan. Further discussion of

projected outcomes will be provided in the *Interpretation* section of this paper. Study of the relationship between projected outcomes and the intervention cannot occur unless the plan is instituted and a crisis event occurs. One preemptive approach to evaluating the intervention could be incorporating the mental health recovery plan into a campus emergency drill, which is a standard component of emergency preparedness.

Measures

At this time, the intervention cannot be measured. Once the mental health recovery plan is adopted and implemented, measures will need to be taken to assess and evaluate the efficacy of the plan. The approach that will be utilized for assessment and evaluation of the mental health recovery plan is SWOT analysis. SWOT analysis stands for Strengths, Weaknesses, Opportunities, and Threats. This type of analysis is commonly used in an organization's strategic planning process to examine the resources and environment of the organization (Phadermrod et al., 2019). Crisis managers have also used SWOT extensively, both in planning out a crisis response and in adapting that response in the middle of an active emergency (Aljuhmani & Emeagwali, 2017, Crandall & Spillan, 2010). The previous use of SWOT analysis in crisis planning makes it an evidence-informed choice for use in this project.

Ethical Considerations

Human subjects have not been involved in the development of this project, however there are ethical aspects to crisis planning that must be considered. The Institute of Medicine (Ethical Framework, 2009) states that "An ethical framework serves as the bedrock for public policy" (p. 16). Jennings and Arras (2016) note that ethical goals are necessary to emergency preparedness, or crisis planning, in order to assist in reinforcing public trust and establishing legitimacy of the preparedness. Common ethical goals include: harm reduction and benefit promotion, equal

liberty and human rights, distributive justice, public accountability and transparency, community resilience and empowerment, professionalism, and responsible civic response (Middleton, 2019). These ethical goals have been applied to the development of the proposed mental health recovery plan by condensing them into three essential elements: fairness, duty to care, and duty to steward resources.

Fairness is addressed by the overall goal of the plan, which is to promote mental health recovery and mitigate the impact of crisis for all individuals associated with EU regardless of class, race, ethnicity, gender, or previous issues with mental health disorders. The proposed mental health recovery plan is meant for all individuals impacted by a crisis within the EU community, ensuring equal liberty and human rights and to further encourage fairness. Duty to care is perhaps the strongest ethical element and a driving force behind the development of the mental health recovery plan. As healthcare providers and a community, there should be a sense of duty to provide the means to promote and support mental health, particularly during crisis events when many are the most vulnerable. An additional aspect of fairness is recognizing that EU is an environment of diverse backgrounds, resulting in diverse needs. Duty to care is also an underlying principle of practice for those learning and working in the "caring" professions, such as Ghering Health Center, CAPS, Campus Ministry, and the departments of nursing, social work, and psychology. Finally, the duty to steward resources constitutes an obligation to improve campus initiatives to sustain a healthy environment, encompassing mental health and safety as well as physical. Adopting and implementing the mental health recovery plan constitutes the utmost ethical consideration for all students, faculty, staff and global university community. Not having a mental health recovery plan in place, as is the case currently, is unethical as it fails to address an important aspect of human wellbeing: mental health and wellness.

Chapter 3 Results

The purpose of the EU EOP is designed "to enhance the University's ability to protect lives and property in the event of a natural or manmade emergency" (Edinboro University, 2018, p. 6). Additionally, it defines a specific process for responding to a variety of emergencies, ranging from armed threats to hazardous weather. Protecting lives should encompass the mental, and emotional safety of individuals, as well as physical safety (National Institute of Mental Health, 2021). Protection of mental health, and mental health recovery in the face of crisis, is inherent in the development of a university emergency operations plan. This will be addressed by the adoption and addition of the Mental Health Recovery Plan, to be included in the Support Annex of the EOP. The policy for mental health recovery following crisis events has been created using the standards set by PASSHE. See Appendix A for review of the proposed Mental Health Recovery Plan.

Purpose and Scope

Purpose and scope must be established in a policy. The purpose explains the intent of use for the policy. The scope identifies the extent to which the policy will be utilized. The purpose of the mental health recovery plan is to establish a strategy for providing mental health first aid to students, faculty, and staff who have experienced a crisis event at EU. Additionally, it will also provide a framework for an established Crisis Intervention Team (CIT) to coordinate with the ERT and operate with the specific goal of managing the mental health needs of individuals. It will provide guidance for PFA during and after an event, in order to mitigate the effects of the crisis. The mental health recovery plan is designed to aid any individual associated with EU, including but not limited to students, faculty, and staff, who have been impacted by the crisis event.

Roles and Responsibilities

Within all components of a crisis management plan, it is imperative to designate the roles of individuals accountable for overseeing enactment of the plan and describe the tasks and responsibilities of those individuals during the implementation of the plan. There are several key roles vital to the execution of the mental health recovery plan. The main roles in the mental health recovery plan will be that of the ERT and the CIT. The ERT is already in place at EU and oversees all phases of an emergency: preparedness, response, recovery, and mitigation. There are many responsibilities for the ERT within the phases of crisis, beginning with providing guidance, assistance, and oversight in all aspects of the recovery phase and taking steps to prevent negative effects of a crisis, otherwise known as mitigation. The mitigation responsibility of the ERT will be the main focus of its function for the mental health recovery plan. In addition to approving the mental health recovery plan and its inclusion in the EU-EOP, the ERT will fulfill its responsibility to determine the scope and impact of the crisis event, make recommendations to the University President, and determine University response actions. Specific to the mental health recovery plan, the ERT will be responsible for deployment of the CIT, which will act by implementing interventions for mitigation of mental health trauma.

The CIT will deliver interventions to individuals impacted by the crisis event with a specific focus on mental health recovery. After being deployed by the ERT, the CIT will work directly with those experiencing mental health trauma as a result of the crisis event. The CIT will also be directly responsible for determining what mental health first aid interventions will be used, and the need for additional resources from local, state, and federal agencies. The CIT will operate under the five principles of PFA, which are to promote safety and comfort, stabilize, attend to practical needs, enhance coping and resilience, and connect survivors with additional

resources (Nash & Watson, 2012). The CIT will work in partnership with campus health services and engage in mental health triage, assessing stressor exposures and determining who is in need of an initial brief intervention in order to manage acute symptoms. The CIT will also take responsibility for monitoring, reassessment, and follow-up for those experiencing acute mental health trauma during the crisis event. Depending on the extensiveness of the crisis event, the CIT may assist campus health services in the follow-up for those individuals requiring mental health trauma interventions. The CIT may also assist with assessment and monitoring of individuals within the Population Exposure Model, a rippling representation of those with direct experience, indirect experience, those empathizing with known and unknown individuals, and those identifying with a traumatized group (Ohio Mental Health & Addiction Services, 2013).

Situations and Assumptions

Situations and Assumptions refers to the situations in which the ERT and CIT may be deployed and the suppositions regarding those situations. For the purposes of this project, it is anticipated that any crisis for which the ERT has been deployed, the CIT would also be deployed, anticipating that the crisis will induce mental health trauma to some individuals. This includes, but is not limited to, natural disasters and manmade disasters such as armed threat, civil disruption, serious outbreaks of illness, or various types of crime. On a smaller scale, the CIT can be deployed in circumstances where there is the death of a student, faculty, or staff member, an accident in which an individual or small group of individuals has been injured or killed, or when an individual is determined to be found in need based on personal circumstances.

The EOP outlines planning assumptions. These include some generalized statements, but several of these are significant when considering the need for the mental health recovery plan

and must be incorporated into the assumptions specific to the mental health recovery plan. These assumptions include:

- emergencies can occur any time of the day or night,
- emergencies do not follow a set script and the plan can serve only as a guide, or checklist,
- an emergency may not be confined to the University,
- a major disaster or emergency will overwhelm the capabilities of EU,
- there are two levels of emergencies – minor and major,
- assistance from the County and State Emergency Management Agency, will supplement, not substitute, relief provided by EU, and
- initial actions to mitigate the effects of emergency situations will be conducted by properly trained EU personnel as a soon as possible.

Each of these must also be considered assumptions for the mental health recovery plan, but need to be scaled to be specific to the plan.

The assumptions for the mental health recovery plan take those from the basic plan into consideration but are modified to reflect mental health recovery. Emergencies can occur at any time of the day or night therefore the mental health recovery plan will be able to be deployed at any time. Not all individuals react the same to crisis, thus the mental health recovery plan must be flexible and will need to be modified accordingly. The scale of a disaster will vary, requiring different levels of involvement of the CIT. An emergency may not be contained to the University, members of the CIT may need to go off campus to meet the needs of those affected by crisis. Large scale events will overwhelm the capabilities of EU, requiring the assistance and support of outside agencies, further outlined in the *Organization* section of the plan. Members of

the CIT must be trained in the specific PFA intervention in order to provide consistent assistance to those in need.

Additional assumptions which are specific to the mental health recovery plan focus on the need for the plan itself, beginning with the belief that all individuals may be affected by crisis, or disaster, in some way. There is no way to predict which, or how many individuals will require the assistance of the CIT. Members of the CIT may be affected by the crisis event, requiring assistance themselves. Crisis events may occur on a scale too small to deploy the CIT so additional personnel on campus should be trained in the chosen PFA intervention or to make an appropriate referral for assistance. Crisis events on a large scale will require the assistance of outside agencies for additional support. Additional assumptions will be identified when the CIT is established, requiring revision and adaptation of the mental health recovery plan.

Concept of Operations

Concept of Operations speaks directly to the structure and functioning of the CIT, and those items or personnel required for functioning of the mental health recovery plan. It includes an organizational framework such as initial notification, collection of information, selection of a CIT spokesperson, coordination with University health services and outside agencies, authorized locations, and staffing. The CIT will designate its own team lead, who will be responsible for all coordination with the ERT and the University Emergency Operations Center. Initial notification of deployment of the CIT will originate from the leader of the ERT and crisis command. On a smaller scale, deployment of the CIT may come through referral from a concerned individual. Collection of information about the crisis event will be performed by the lead of the CIT, or a designated representative if the lead is not available. The CIT leader will designate a spokesperson from the team who will coordinate with University health services and outside

agencies as needed. In large scale events, the CIT will be stationed near the emergency health services triage area in order to assist in triage and be immediately available to begin providing the PFA intervention. A second group of the CIT members may need to be held in reserve to relieve members or to go directly to those impacted by the event. The CIT members will consist of representatives from Ghering Health Center, CAPS, Campus Ministries, Residence Life and Housing, undergraduate and graduate students and faculty from the departments of nursing, social work, and psychology, and those additional faculty, staff, and students who wish to volunteer. All members must complete the initial training required for the selected mental health recovery intervention and maintain that training while serving on the CIT.

Process

The Process section of the mental health recovery plan outlines the timeline for response and operation of the CIT. For a large-scale event, the CIT will be deployed within the first half hour. Members of the CIT will respond within the first hour and get debriefed on the incident and the role CIT will perform in the incident. Within two hours, members of the CIT will begin mental health triage of victims and initiate a brief intervention for the most seriously affected victims. Within four hours, the CIT will initiate an intervention for those less seriously affected and identify the need for follow-up in these individuals. Additionally, the CIT will continue intervention for those more seriously affected and begin referrals for these individuals. Within eight hours, the CIT will determine the need for ongoing operations and for relief of members. At the conclusion of the event, CIT members will identify individuals who will require follow-up, communicate that information to the ERT and campus health services, and disperse. After the event, the CIT will engage in a debriefing session, identifying strengths and weaknesses related to operation procedures during the event, identify personal needs of the members, and

engage in follow-up when possible. The lead of CIT will complete and submit an event report to the ERT.

Organization

The organization section of the mental health recovery plan refers to organizations which the CIT will partner with, or require assistance from based on the severity of the event. During formation of the CIT and establishment of accepted interventions for mental health recovery, these partnerships may be informal. For example, the CIT may use resources from other universities or large organizations, such as The JED Foundation (2011), to develop its full structure, accepted interventions, and intervention training. For mobilization purposes, the CIT will coordinate with local, state, and federal organizations, as needed, to provide services. Local organizations that the CIT will partner with include the local chapter of the American Red Cross, the local chapter of the National Alliance on Mental Illness (NAMI), local mental health providers, and the Erie County Office of Mental Health and Intellectual Disabilities.

Chapter 4 Discussion

Summary

A mental health recovery plan is crucial to providing comprehensive care for those individuals affected by crisis at higher education institutions (Leider et al., 2017). Rising rates of mental health disorders, coupled with rising incidence of natural and manmade disasters, places individuals at a high risk for a negative impact when exposed to a crisis event. This impact may range from an exacerbation of symptoms in those already suffering from a mental health disorder to new onset of mental health disorders to long-lasting consequences such as the development of post-traumatic stress disorder. Mofatteh (2020) notes that there are six prevalent themes of risk factors for the development of stress, anxiety, and depression in undergraduate university students: psychological, academic, biological, lifestyle, social, and financial. Each of these themes is present on the EU campus and are precursors to more severe problems in the event of a crisis situation on campus. The literature supports the premise that these themes are not only prevalent, but escalating in student populations. Therefore, the lack of a mental health recovery plan is problematic and risks resulting in a reactive rather than proactive approach, failing to have the appropriate strategies and resources in place during a time of need.

The strength of this project is that it is a proactive intervention. To date, EU has had crisis events, such as the death of students, crime, and COVID-19, but these have occurred on a small scale and the effects were managed by CAPS. However, in the event of a large-scale crisis, this resource would be overwhelmed and in need of additional support. The mental health recovery plan provides the strategy for addressing mental health trauma in relationship to a university disaster, and identifies additional resources in the form of community partners that would assist in providing mental health care.

The data related to the prevalence of mental health disorders in college age students, as well as the recommendations of numerous professional organizations, support the need for mental health resources, services, and crisis planning. There are abundant resources available to promote improvement in the overall campus mental health plan, as well as justify planning for mental health recovery following crisis. In a joint collaboration between The JED Foundation and the Education Development Center Inc., strategic planning is identified as key to the development of a comprehensive plan for mental health promotion and suicide prevention (JED Foundation, 2011). The National Council on Disability (2017) notes that "mental health promotion should be mainstreamed into policies and programs in governmental and nongovernmental sectors" (p.12) and provides numerous recommendations to colleges that address a variety of mental health service deficiencies on campuses. The National Collegiate Athletic Association has partnered with twenty-five other organizations to develop the *Inter-Association Consensus Document: Best Practices for Understanding and Supporting Student-Athlete Mental Wellness*, a guideline of best practices to support mental health and wellness in college athletes (NCAA, 2022).

Many states also provide recommendations on best practices for mental health services in their institutions of higher education. For example, the Oklahoma State System of Higher Education notes that schools should have strategies in place to promote mental health and protocols to address crisis situations to ensure the safety of the campus community (Oklahoma State Regents for Higher Education, n.d.). PASSHE does not provide similar best practice recommendations, however the Pennsylvania Department of Education (PDE) notes that it is "critical that institutions of higher education (IHEs) proactively identify and implement policies, practices, and strategies for addressing mental health issues and preventing student suicide" and

encourages institutions to submit mental health and suicide prevention plans (Pennsylvania Department of Education, [PDE], 2022). Each year, the PDE publishes a list of institutions that has submitted their mental health and suicide prevention plans. A plan from EU cannot be found on the list of institutions of higher education for the 2021-2022 academic year. Additionally, the PDE provides links to multiple resources for student mental health and suicide prevention, several of which have been referenced to in this document. These resources should be utilized to strengthen existing practices for mental health promotion on the EU campus, and to support emerging changes, such as the proposed mental health recovery policy.

Interpretation

The focus of this project is to propose a policy to provide strategic planning and intervention for mental health recovery following crisis. Within the context of the SQUIRE research framework (2020), the development of the mental health recovery policy is the proposed intervention to address the lack of a plan for management of crisis events involving EU students, staff, and faculty. Since the policy is proposed at this time, rather than approved and implemented, there are no concrete outcomes to study and report. Therefore, it is not possible at this time to infer the relationship between the intervention and outcomes. Instead, it is important to establish projected outcomes that can be employed as further support for the adoption of the mental health recovery policy. The development of a mental health recovery policy has sustainable and evidence-based support. These anticipated benefits include improved preparation for crisis events, improved general mental health services, decreased mental health trauma following events, and improved retention of students, staff, and faculty.

Effective crisis management begins with effective crisis planning (Prywes & Sobel, 2015). When engaging in crisis planning, institutions should conduct a hazard vulnerability

analysis to determine potential threats, or crisis events, to strengthen preparedness (Fifolt et al., 2016). As the science of crisis preparedness has evolved, increased emphasis has been placed on promotion and protection of both physical and psychological safety, requiring strategies that address mental health recovery (Crepeau-Hobson et al., 2020). It is unknown what type of hazard vulnerability analysis was utilized to develop EU's EOP, but the addition of the proposed mental health recovery plan improves the comprehensiveness of the EOP and provides a preparation framework that addresses physical and psychological safety during crisis events.

The mental health services currently provided by EU may sustain improvements as a result of the adoption of the mental health recovery plan. In order to implement the components of the policy outlined in the results section, it will be necessary to examine EU's current resources and services for mental health care to identify what is available and what would need to be obtained in relation to the policy. This review may identify service gaps or resource deficits requiring upgrades. Such discoveries would provide the opportunity to expand services that would meet the broader mental health needs on campus.

Adopting the mental health recovery policy may assist in the retention and academic success of individuals suffering trauma from the crisis event. Individuals suffering from mental health disorders and distress are at an increased risk for academic impairment, attrition, psychological impairment, and interpersonal dysfunction (Schwitzer et al., 2018). Concerns related to decreased student retention as a result of mental health disorders has prompted many institutions to increase efforts to address mental wellness and its impact on academic success (Eisenburg et al., 2016). Many of these efforts focus on system-wide collaborations, including changes in models of care on campuses, development and promotion of mental health referral networks, and increased faculty knowledge and awareness of mental health disorders to improve

academic practices that are supportive of individuals (Kalkbrenner et al., 2019). Review of current practices and services on the EU campus may identify gaps that would allow for improvements in the overall approach to mental health promotion and improve retention rates and academic success for those suffering from mental health disorders.

The ultimate goal of mental health recovery policy is to mitigate the mental health trauma caused by a crisis event. Literature supports the development of a mental health recovery plan with this goal in mind, identifying certain events as particularly harmful to psychological health. The JED Foundation provides a blueprint for crisis management procedures called the *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student*, and recommends its use to develop comprehensive postvention plans (JED Foundation, 2011). The World Health Organization (WHO) has recognized the need for mental health care during crisis, providing a framework for providing care during crisis titled *Psychological First Aid: A Guide for Field Workers* (Kondro, 2011). Mental health recovery strategies are routinely applied to victims of disaster to mitigate the psychological effects of the event and facilitate resilience (Crumb et al., 2021; Hechanova et al., 2019; Jacobs, et al., 2016; Parel & Balamurugan, 2021; Southwick et al., 2016). Mental health recovery plans have also been adopted and utilized to assist victims of manmade disasters such as violence (Crepeau-Hobson et al., 2020; Jenkins & Goodman, 2015; Kingshott, 2012; Streufert, 2004; Wang & Hutchins, 2010; Wombacher et al., 2017). The common theme throughout literature is to provide an immediate mental health intervention following crisis, which will also assist in determining further needs of the victims and ideally prevent more serious mental health disorders from developing as a result of the trauma.

Limitations

There are limitations to the proposed mental health recovery plan, beginning with the difficulty in gathering concrete data regarding the association between the intervention and outcomes. The intervention is adopting a mental health recovery policy and outcomes related to doing so are projected, not guaranteed. Literature does not provide specific figures related to improvements in mental health related to the adoption of such a policy. It would require significant resources to interview individuals following a crisis event and gather qualitative data related to the efficacy of the policy. Lack of resources, in terms of personnel for implementation, training materials, stakeholder support,-and communication of the plan, would limit the ability to fully utilize the mental health recovery plan during times of crisis. Additionally, continued stigma related to mental health disorders, which is already a barrier for many students, may discourage individuals from seeking assistance during crisis (Turosak & Siwierka, 2021). Finally, lack of information providing a consistent structure for the development of a mental health recovery plan may lead to deficiencies in the plan.

Conclusions

Natural and manmade disasters, as well as rising rates of mental health disorders, have established crisis planning as a necessity in higher education (Holzweiss & Walker, 2018). Crisis plans should be comprehensive and ensure the psychological safety of individuals, as well as physical safety. The lack of a mental health recovery plan in EU's EOP illustrates a gap in thorough preparation and creates an area of vulnerability when the inevitable disaster occurs. The development of the proposed mental health recovery plan represents the first steps towards proactively addressing the psychological needs of the Edinboro campus community. It also

provides the opportunity for EU to become an innovator of crisis planning within PASSHE, offering a blueprint for the provision of mental health resources during crisis.

A considerable amount of work remains to be done. Before proceeding, EU will need to complete a further hazards vulnerability analysis and needs assessment to determine what is the current state of mental health on campus and what additional resources will be required to implement the mental health recovery policy. This process should also include analysis of the current model of care for mental health in order to determine if mental health needs are being met on a day-to-day basis (Downs et al., 2018). Ample opportunity for sustainability is accessible through the deployment of undergraduate and graduate students and faculty in the departments of nursing, social work and psychology, Ghering Health Center, and CAPS. Ongoing monitoring and evaluation of the policy will need to occur upon implementation to provide validity of the efficacy of the plan. Addressing the mental health needs of individuals and providing care before, during, and after crisis, demonstrates progressiveness and provides an inclusive environment for a vulnerable population to learn and grow. Incorporating a mental health recovery plan into the EOP will assist with the psychological safety of individuals, better preparing Edinboro University to meet the needs of all those we serve.

Appendix A – Mental Health Recovery Plan

SECTION 3: SUPPORT ANNEX

MENTAL HEALTH RECOVERY PLAN

I. PURPOSE AND SCOPE

A. Purpose

1. The purpose of this plan is to establish the procedures and methods for providing mental health first aid to students, faculty, and staff experiencing a crisis event on the Edinboro University campus.

2. To provide a framework for establishing a Crisis Intervention Team (CIT).

3. The objectives include:

   a) To work with the university's Emergency Response Team in the case of a major incident or the Administration in the case of other crises to provide mental health first aid to those impacted by the incident.

   b) To assemble a crisis intervention team (CIT) that will make recommendations on appropriate interventions for mental health recovery. This team should include specific university officials with key knowledge about the current physiological and mental health resources on campus and the nature of the incident. Additionally, the team should include representatives from service areas and disciplines campus wide. It may also include representatives from the departments of Nursing, Social Work, and Psychology.

   c) To implement immediate action to:

      (1) Assess the current state of mental health resources on campus.

      (2) Conduct a needs assessment to determine additional resources.

      (3) Identify strategies and interventions to deliver mental health first aid during crisis events.

      (4) Provide mental health triage during crisis events.

      (5) Mitigate the effects of crisis on mental health.

      (6) Promote improved mental health throughout the university.

B. Scope

1. This plan is primarily designed for Edinboro University main campus but can be tailored for emergencies effecting any individual associated with Edinboro University, including those experiencing crisis off-campus.

II. ROLES AND RESPONSIBLITIES

A. Emergency Response Team (ERT)

1. Approve the mental health recovery plan and provide oversight for the Crisis Intervention Team (CIT).

2. Providing the initial emergency notifications to the CIT; and

3. Determine the scope and impact of the crisis event.

4. Deploy the CIT.

B. Crisis Intervention Team (CIT)

1. Partner with the ERT.

2. Partner with current campus health services.

3. Select interventions to deliver mental health first aid.

4. Determine the need for additional resources from supporting agencies.

5. Perform mental health triage during a crisis event.

6. Deliver mental health first aid to those effected by the crisis event.

7. Perform a SWOT analysis after an event to evaluate outcomes and determine improvement strategies.

III. SITUATIONS AND ASSUMPTIONS

A. Situations

1. Natural disasters that include, but are not limited to: Tornado, Fire, Flooding, Blizzards, etc.

2. Manmade disasters that include, but are not limited to: Armed threat, Bomb threat, Dam Failure, Civil disruption, Disease and Illness (Pandemic), Mass casualty incidents, etc.

3. Other: may include death of a student, faculty, or staff member, motor vehicle accidents, individual need based on personal circumstances, etc.

B. Assumptions

1. Emergencies can occur any time of the day or night, the CIT must be prepared to be deployed.

2. Emergencies do not follow a script; the plan can only serve as a guide. Defer to professional guidance if unsure of the situation and needs of an individual

3. An emergency may not be confined to the campus. The CIT should be prepared to go to off-campus sites such as apartments or elsewhere in the Edinboro community.

4. A major disaster or emergency will overwhelm the current resources of Edinboro University. Additional partners must be identified.

5. Members of the CIT may be affected by the crisis event.

IV. CONCEPT OF OPERATIONS

A. Initial Notification

1. In an emergency, the initial communication related to deployment of the CIT will originate from the ERT.

2. Deployment of the CIT may come from an individual referral based on the scale of the crisis.

B. Collection of Information

1. The lead of the CIT will coordinate with the lead of the ERT to collect information related to the crisis event. A designated representative may collect information if the lead is not available. Verification of key facts for immediate distribution and later documentation is essential. Be sure to ask and make note of the answers to these questions:

   a) What happened/is happening?

   b) Is anyone in imminent danger?

   c) How many CIT members will be needed to address the crisis event? This will be a rough estimate and additional members can be deployed as needed.

   d) Where is crisis command for this situation located?

e) Who is serving as lead of ERT at this time?

f) How many individuals may need mental health first aid based on the scale of the event?

g) What is the exact location – including how wide an area is affected or could become affected? Is it isolated to a specific building or facility? One section of campus? The entire campus?

h) Where is triage of victims occurring? This will determine where mental health triage will be conducted.

i) What offices/agencies are involved in the emergency response? Is additional help needed?

j) What is the time sequence, as specifically as can be quickly determined – when it happened, how long it has been going on, how long it is expected to continue?

C. Selection of CIT Lead

1. Any member of the CIT should be able to serve as the lead in an event. Selection of a lead may depend on the nature of the situation, availability to respond, or area of expertise. A minimum of 4 members of the CIT should be identified as acceptable leads and their contact information should be available to the ERT.

D. Selection of CIT Members

1. The CIT should minimally consist of one representative from Ghering Health Center, Counseling and Psychological Services, Campus Ministries, Residence Life and Housing, and the discipline departments of nursing, social work, and psychology.

2. The number of CIT members should not be limited. Any student, staff, or faculty member should be encouraged to volunteer. Undergraduate and Graduate students and faculty from the departments of nursing, social work, and psychology should be recruited for membership.

3. All members of the CIT must undergo training specific to the mental health first aid modality chosen by the team.

4. Ongoing incidents might require CIT members to switch off or require the utilization of outside resources and community partners. The opening of a Media Briefing Area to provide a place where members of the media can work, be accompanied at all times and be communicated with directly as a group.

V. PROCESS

A. Within the first half-hour:

1. CIT should be deployed and the incident lead identified.

2. The CIT lead should be briefed on the event.

3. The role of CIT should be identified based on the scale of the event.

B. Within the first hour:

1. The CIT lead should identify and notify the initial team members of the incident and deploy them to the stablished meeting site for debriefing of the event.

C. Within two hours:

1. Members of the CIT should begin mental health triage.

2. CIT members should begin initiating a brief intervention for those most seriously impacted.

D. Within four hours:

1. The CIT members begin initiating interventions for those less seriously affected.

2. The CIT will begin making referrals for those identified as more seriously impacted by the event.

3. The CIT lead will begin determining the need to provide relief to members who initially responded.

E. With 8-12 hours:

1. The CIT lead will determine need for ongoing operations.

2. If it is determined that there is ongoing need for the CIT, the lead will deploy the relief team and begin contacting additional community resources for ongoing assistance and relief.

F. At conclusion of event:

1. The CIT lead will issue all-clear alert to those members still providing interventions.

2. The CIT members will identify those individuals who will need ongoing intervention.

3. The CIT will engage in a brief debriefing session to identify and address the needs of the responding members.

G. After the Event:

1. The CIT will attempt to follow-up with those individuals receiving intervention during the event.

2. The CIT will engage in a more formal debriefing event.

3. The CIT will engage in a SWOT analysis of the event

4. The CIT lead will complete and submit an event report to the ERT.

VI. ORGANIZATIONEMERGENCY COMMUNICATION TOOLS

A. Development Resources

The CIT will establish which resources and organizations that will be utilized to further develop the response plan and chosen interventions. These may include, but are not limited to:

1. JED Foundation

2. National Alliance on Mental Health

3. National Child Traumatic Stress Network

4. National Center for Post-Traumatic Stress Disorder

5. American Psychiatric Association

6. American Psychological Association

B. Community Resources

The CIT will establish which resources and organizations that will be utilized as community partners and relief services. These may include, but are not limited to:

1. National Alliance on Mental Health – local chapter

2. Erie County Office of Mental Health and Intellectual Disabilities

3. Erie County Emergency Response Team

4. Crawford County Department of Public Safety

5. Local Mental Health Providers

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