Dawson College Shooting, September 13, 2006:

SECURE (Support, Evaluation and Coordination United for Recovery and Education): a multimodal psychological intervention plan

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A very special thank you to all those who agreed to participate in remembering these tragic events: the students, the support staff, the teachers, the professionals, the administrators and the first responders and mental health professionals, the parents, and especially, the family of Anastasia De Sousa.

To the Honourable Jean-Marc Fournier,

Minister of Justice for Quebec

On September 13, 2006, an armed individual burst into Dawson College, killing one person, wounding 19 others, and subsequently killing himself. It was the third tragedy of this kind to occur in Quebec; a tragedy that has left its mark in our collective memory.

It was the hope of Dawson College, in accordance with its teaching mission, that an analysis of the intervention would improve the psychosocial support offered in the event that such an incident were ever to occur again.

It is in this context that the Research Institute of the McGill University Health Centre (MUHC) received funding in 2007 from the Government of Quebec to study the psychological impact of this dramatic event. In order to do so, a dynamic inter-academic collaboration was created with McGill University, the Université de Montréal and the Université du Québec en Outaouais, as well as with Dawson College. In addition to examining the psychological impact of this dramatic event on the population exposed to the event, the study allowed for the evaluation of the existing emergency psychological intervention plan and for the proposal of an intervention plan model for responding to similar situations.

Under the scientific direction of Dr. Alain Lesage, our team, made up of researchers from the Fernand-Seguin Research Centre of Louis-H. Lafontaine Hospital, the McGill Group for Suicide Studies and the Research Institute of the McGill University Health Centre, would like to present to you the following four documents:

- Evaluation of the emergency psychological intervention plan;
- Report on a study conducted with students and staff of Dawson College on the psychological impact of the incident and the search for support;
- SECURE (Support, Evaluation and Coordination United for Recovery and Education): a multimodal psychological intervention program;
- Summary and recommendations.

By presenting these documents, the associated researchers wish to bring the necessary information to the health, education, justice and public security networks so that they may intervene efficiently in the context of a dramatic event such as the one experienced on September 13, 2006 at Dawson College.

Dr. Pierre Bleau
Medical Director of the Anxiety Disorders Program,
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SUMMARY

In the last decade, posttraumatic intervention plans have been developed at the local, national and international levels to provide strategies to the survivors of violent and traumatic acts.

These programs are based on a medical approach to emergency interventions. Therefore, most programs are created to identify acute psychological problems with observable symptomatology, generally on a short-term basis. While several programs take into consideration the psychological impact of traumatic events, the detection and identification of problems remain focused primarily on the symptoms of posttraumatic stress or acute stress disorders. Only a few programs have developed strategies to detect and identify chronic problems appearing over the long-term which systematically include, not only detection, but also actively searching for individuals with simple or concomitant depression/anxiety disorders or substance abuse/dependency problems which either may have worsened because of the trauma or which appear more than one year after the trauma.

The SECURE psychological intervention program proposes a shift in paradigm. It is rooted in the community's capacity to detect, identify and respond to common mental health disorders. This paradigm shift must include various psychological interventions, with built-in flexibility during the period of detection and intervention for acute disorders as well as for disorders which may develop over a longer period of time. This program must include an empowerment and relying on people's resilience, without assuming that everyone will heal with time. Psychosocial education and a watchful attitude improve the likelihood of detection. Along with social networking initiatives, vulnerable students would possibly be more likely to seek help, even if months have passed since the traumatic event. This program will also need to adapt the types of mental health interventions to the needs of the specific population.

The SECURE plan emphasizes basic detection and intervention for common mental health disorders associated with the preparation of a psychological intervention protocol integrated into emergency and crisis protocols in school communities. Regular revisions of the protocol and frequent training sessions for school employees and partners would optimize the functioning of such a program once implemented.

In the event of a school shooting, this multimodal program for psychological intervention proposes sequential planning based on the specific areas of intervention:

1. Preparation of the psychological intervention plan and ensuring that knowledge and protocols are up-to-date;

2. Emergency interventions at the time of the event;

3. Post-immediate interventions to identify disorders associated with the trauma and to support resilience;

4. Interventions to be conducted on a short-term basis to identify acute mental health disorders;

5. Interventions to be conducted on a medium- and long-term basis to detect chronic disorders.

It is rooted in the community's capacity to detect, identify and respond to common mental health disorders.

PREAMBLE

In a news article published in *La Presse* on March 13, 2009, Marie-Claude Lortie reported that since the Dawson College shooting in September 2006, no fewer than six shooting incidents had taken place in educational institutions around the world, killing 34 people and wounding some 60 others. Between 1999 and 2009, there were approximately 60 shootings within school communities, with 181 deaths. In Quebec, the collective memory remains scarred by the École Polytechnique shooting at the Université de Montréal in 1989, as well as by the shooting at Concordia University in 1992.

In addition to the consequences associated with loss of human life, the repercussions of these events are important in terms of people who were injured, lives which were disrupted, emotional upheaval, the mourning and pain of families and loved ones, the destruction of property, the impact on students' academic performance, etc. It is recognized that psychological and social damage after exposure to the trauma of violence is actually more significant than physical damage (Shultz *et al.,* 2006).

It is recognized that psychological and social damage after exposure to the trauma of violence is actually more significant than physical damage.

In the last decade, psychological intervention programs following disasters have been developed at local, national and international levels to offer support to survivors. These include the International Crisis Response Network (ICRN) developed by the International School Psychology Association (Jimerson *et al.,* 2005), the National Organization for Victim Assistance (NOVA), the Community Crisis Response Team Protocol (Young, 2002), the Multi-Modal Intervention, known as BASIC ID and BASIC Ph (Lahad, 1997), as well as the Psychological First Aid (PFA) Field Operations Guide developed by the National Child Traumatic Stress Network of the National Center for PTSD (Vernberg *et al.,* 2008), and the organisation de la sécurité civile du Québec (Laurendeau *et al.,* 2007).

In Quebec, the 1989 massacre at the École Polytechnique prompted the development of a psychosocial approach to public security (MSSS, 1994a, b). The DeCoster investigation team, mandated by the Government of Quebec, defined the roles and responsibilities of the health and social services centres (CSSS) in order to guarantee that there would be psychological support after a traumatic event. To be considered successful, a psychosocial intervention must have (1) an action and direction unit, (2) planning, (3) rapid intervention, (4) the ability to predict reactions to the event, (5) adequate resources, (6) media relations and (7) a simple, mobile and supportive structure (Martel, 2000; Laurendeau *et al.,* 2007).

Despite the fact that each program has a different and specific emphasis, they share a common foundation: (1) they are based on theories of stress, coping, adaptation and resilience after exposure to a traumatic event; (2) the programs are applicable and can be implemented in almost any environment (school, community or other); (3) the programs are adapted to different types of clientele and the different developmental stages of life, even though there are specific indications for children, teenagers and the elderly; and (4) the programs are sensitive to different cultural contexts, allowing for flexible and adapted intervention (Pynoos *et al.,* 2008).

Generally, current programs are organized temporally. Brock & Jimerson (2004) suggested a planning model in five stages: pre-impact, impact, immediately after impact, post-impact and long-term follow-up (see Table I), which elaborates the different activities and interventions that must be planned within a timeframe. The table presents interventions carried out according to temporal phases and specific areas of intervention, including emergency, medical, support and psychological interventions, psychological education, detection and referrals, as well as rituals and commemorations.

Despite the relatively wide distribution of these posttrauma programs, none was validated empirically. This is understandable, as the methodological challenges are enormous. However, some studies have measured the efficacy of certain interventions in traumatic contexts, and the state of knowledge permits the identification of basic principles for interventions following a violent and traumatic event.

Table I

Summary Of The Types Of Interventions Phase By Phase

Pre-impact ***The period before crisis***	***Impact*** ***The period during crisis***	***Recoil*** ***Immediately after the crisis***	***Post impact*** ***Days to weeks after the crisis***	***Recovery/*** ***Reconstruction*** ***Months or years after crisis***
Crisis preparedness - Crisis education - Crisis drills - Crisis planning	*Immediate prevention* - Protect from harm and danger - Crisis intervention	- Minimize crisis exposure - Ensure actual and perceived safety		
Crisis planning • Establish an inter-agency task force • Establish a school crisis response team • Develop a directory of resources • Establish funds • Establish guidelines for identifying high-risk populations • Specify response facilities • Identify appropriate lodging and shelter • Design materials to identify crisis responders • Develop an information decimation system • Develop a plan for dealing with deaths • Plan for medical assistance		*Medical intervention* - First aid - Isolate medical triage	- Ensure treatment of pre-existing conditions	
		Support systems - Reunite with/ locate caregivers and loved ones	- Reunite with friends and teachers - Return to school	
		Psychological interventions - Psychological first aid	- Psychological first aid - Group crisis debriefings - Psychotherapy - Crisis prevention/ preparedness	- Crisis prevention/ preparedness - Anniversary reaction support - Psychotherapy
		Psychological education - Psycho-education groups - Caregiver trainings informational flyers	- Psycho-education groups - Caregiver trainings - Informational flyers	- Anniversary preparedness - Caregiver training - Informational flyers
		Risk screening and referral - Initial screening	- Individual screening - Referral procedures - School wide screening	- Individual screening
			Rituals and memorials - Ritual participation - Memorial development	- Ritual participation - Memorial implementation

Source : Brock & Jimerson (2004)

Posttrauma and post-critical incident programs are based on a medical model for emergency intervention. In this context, psychological interventions are also drawn from psychosocial emergency interventions based on stress, crisis and trauma theories, and require quick short-term interventions. Therefore, most programs are created to identify acute psychological problems with observable symptomatology, generally on a short-term basis. Even though several programs underscore the repercussions of traumatic events in the long-term, the detection and identification of difficulties remain in the realm of stress, acute stress and posttraumatic stress disorders.

Only a few programs systematically include detection and active identification of individuals who may have developed more common mental health disorders. The results of the study following the Dawson College shooting indicate a high rate of pre-existing mental disorders that were exacerbated, as well as the significant emergence of new disorders among the collegiate community of student and employees (Boyer *et al.,* 2010). This supports the need to include detection and identification of chronic problems or those emerging over the long-term in any posttraumatic intervention.

Posttraumatic interventions must therefore be adapted to detect and intervene on a very wide range of difficulties, from acute and temporary disorders to severe chronic disorders. In fact, all interventions within a school community must include the detection of the following mental health difficulties: mood disorders, adjustment disorders, aggression, substance abuse and dependency disorders as well as acute anxiety disorders (both short-term and long-term, including posttraumatic stress disorder).

Posttrauma and post-critical incident programs are based on a medical model for emergency intervention.

ELABORATION OF THE MULTIMODAL PSYCHOLOGICAL INTERVENTION PROGRAM

I- Evaluation And Analysis: Lessons Learned From The Intervention Program Implemented After The Dawson College Shooting

The intervention plan implemented at Dawson College after the shooting of September 13, although created ad hoc, was based upon a theoretical framework focusing on crisis intervention and resilience.

However, not all mental health professionals had had training or expertise in posttraumatic or crisis intervention.

Intervention Philosophy

The intervention plan implemented at Dawson College after the shooting of September 13, although created ad hoc, was based upon a theoretical framework focusing on crisis intervention and resilience. The crisis intervention team relied on the students' and employees' capacity for resilience as a major variable in their recovery. Shared attitudes of non-stigmatization and non-dramatization were reflected in how services were organized and offered.

Taking these factors into consideration, the following interventions were put into place: initially, the preparation of the College for the return of first the employees and then the students several days later (as quickly as possible in order to re-establish a support structure); the re-appropriation of the campus by the College population; the presence of numerous mental health professionals on site to support anyone requiring intervention; the possibility of meeting with mental health professionals upon request in the days and weeks after classes resumed; and the planning of rituals and commemorations, to name a few. Throughout these activities of reintegration on campus and the return to school, a culture of collective resilience emerged that provided strength to the campus community as well as the sense that they had the ability to overcome adversity.

Access to services

In the days and weeks after the return to the College, the students and employees were invited to consult mental health professionals on the premises. Consultation in mental health services was presented as an adapted solution to the inhabitual stress that some had experienced. Because the lack of space did not permit closed offices to be available for everyone, during the first week, mental health professionals were set-up in the Library and received "patients" in semi-open cubicles. It was felt that this set-up lent a tone of openness to the consultation and encouraged an attitude of non-dramatization and normalization to the consultation process, which might have been seen as natural under the circumstances. While some people understood this approach and were comfortable with this arrangement, others felt too exposed, and that they had little or no privacy. Some people chose not to consult, concerned with the lack of confidentiality.

For some teachers as well as for other employees who wanted to be perceived by students as potential sources of support, it was felt that having to consult mental health professionals in the same place as students undermined or discredited this role. Some teachers also said they needed to be supported in that role by professionals who had not been affected by the shooting. Therefore, two core values were at odds: normalization associated with the request for support, and wanting to maintain a supportive role with the students. This example illustrates the potential problems that can arise when services are offered using a single mode of intervention. A multimodal approach would have better met the needs of the various subgroups.

Training Of Mental Health Professionals

During the period of re-appropriation of the College, several mental health professionals were solicited to offer consultations to the Dawson College community. This approach was intended to foster timely interventions to address emerging problems. However, not all mental health professionals had training or expertise in posttraumatic or crisis intervention. Conducting interviews in such a context may be different from what they do in their usual practice. Mental health professionals must be more active and directive, and must target their diagnostic evaluations toward the detection of specific risk factors. It is possible that several professionals, without the proper training, felt overwhelmed in these first weeks and, may explain why some respondents indicated that some psychological needs were not met.

Ongoing Offer Of Services

Gradually, according to reduced requests for support, the mental health professionals still at the College moved from cubicles to enclosed offices; some remained on the premises for six months following the shooting. These mental health professionals were less visible, and therefore not as sought out. In this context, their presence became of secondary importance.

This illustrates the difficulties of continuous accessibility to services specialized in mental health. The regular presence of professionals trained in detecting and treating common mental health disorders in the school and workplace should encourage students to form the habit of consulting when necessary, a habit which would not have to be developed only during critical situations. Moreover, detection activities in an outreach mode would have allowed some people to be referred to mental health services. Also, unknown to mental health professionals, there was extensive use of the Internet; more than 14% of students and employees sought and received information on mental health issues by visiting various websites (Roy *et al.,* 2010; Boyer *et al.,* 2010). However, the Internet was not used by mental health professionals to provide confidential detection tools or offer consultation services.

Detection And Identification Of Individuals in Need And Outreach

The philosophy of the crisis intervention team relied on the capacity for resilience of the College community and on their ability to express their needs and to request psychological help. There were very few detection, identification and outreach activities. It would probably have been preferable to develop detection activities specifically for the groups at risk, i.e., systematic detection activities for people directly exposed to the shooting, as well as education and psychosocial education based on theoretical knowledge such as information about mental disorders and the efficacy of psychotherapy. These activities might have been beneficial and would have fostered a greater capacity for detection by teachers, friends, parents, etc. and self-detection. Consequently, this would have encouraged the community to make greater use of the psychological services offered.

Finally, along the same lines, the lack of structured, specific outreach activities did not facilitate interventions for follow-up and case management for the wounded students, their families, or especially vulnerable students. It should be noted, however, that numerous interventions were made in an informal way, either by a teacher toward a student, or a manager towards a student or staff member. In some cases, more formal and structured interventions were offered by mental health professionals. It is therefore necessary to set up a formal model of prevention and intervention in mental health in a school or workplace community.

Findings Regarding The Health Of The Community 18 Months After The Shooting (Boyer et al., 2010; Roy et al., 2010)

After the shooting, nearly 18% of respondents developed a mental health disorder even though they had never experienced one previously. While new cases of posttraumatic stress disorders (PTSD; 2%) were expected, others were also observed, such as major depression (5%), alcohol dependency (5%), and social phobia (3%). Moreover, some people with pre-existing mental disorders continued to experience them in the 18 months following the shooting.

In total, 30% of respondents presented with one of the aforementioned mental disorders. This rate is at least twice as high as was observed in Quebec during the Canadian Community Health Survey cycle 1.2 (CCHS 1.2) . The exposure to the shooting seems to have triggered suicidal thoughts (7%) and suicide attempts (1%), a rate twice as high as in the CCHS 1.2. Psychological repercussions were still present 18 months after the event, and the respondents reported having a poorer perception of their mental health compared to that reported in the CCHS 1.2. More than 7% continued to present symptoms of posttraumatic distress.

Those who were exposed to a greater degree of severity in the shooting ran a greater risk of developing PTSD, an anxiety or depressive disorder or alcohol dependency. Nearly 5% of the Dawson College population consulted a mental health professional for the first time in their lives after the shooting, and among those who had consulted, the percentage who consulted again was greater.

In the 18 months following September 13, 2006, close to 13% consulted a mental health professional (for example, 6% consulted a psychiatrist; 7% saw a general practitioner; 7% consulted a psychologist). In this regard, the population of Dawson College was no different than the Quebec population in 2002, with the exception of greater accessibility to psychiatrists, due to their unique role in the psychological response to the event. However, almost 14% of respondents indicated that they used the Internet to search for information about mental health issues during the period following the shooting. This differs significantly from the 2002 Quebec population (0.5%). More than 80% of those who had consulted at least one resource reported that they had received at least one satisfactory service, but close to half said they would have needed additional services. Among the additional services needed, information and psychotherapy/counselling were most often cited. The majority of people presenting with a mental disorder after the shooting did not consult any mental health professional. This is consistent with the findings of the CCHS 1.2. The reason most often cited was one of acceptability (the problem will go away by itself...), even though this was clearly not the case after 18 months for many respondents. Reasons of accessibility to services were also mentioned by the 14% of respondents who felt their needs went unmet.

Among the additional services needed, information and psychotherapy/counselling were most often cited.

These results points to the need for long-term support. It must be expected that there will be variations in symptomatology between the post-immediate period and the medium- and long-term. Some authors have described the posttraumatic social climate as a membrane that envelops and protects some victims by allowing them to withdraw into themselves or, in some cases, to withdraw into the social climate of the institution. In such a context, some vulnerable people can feed on the posttraumatic social climate, which often favours a feeling of unity, renewed strength coming from the community, mobilization of social support, empowerment, etc. Some individuals can be nourished by this atmosphere, feeling fulfilled by this social climate, which is only temporary. This feeling of support can prevent acknowledgment of personal difficulties. When the temporary social climate dissipates, some students and employees will interpret this new loss as institutional abandonment and will experience more difficulties, believing that the source of their problems stems from the traumatic events that occurred months before. The information gathered in the interviews shows that some individuals remained dependent on this climate. An intervention theory based on resilience can be perfectly adapted in the post-immediate period, but the theoretical framework must evolve to adapt itself to the changing needs of the population and integrate new modes of intervention, especially, the detection of people in need of psychological help.

Based on the programs documented in the literature, the intervention made at Dawson College after the shooting and the analysis of the health status of people 18 months after the shooting, a multimodal intervention plan is suggested. It has four major axes:

- The theoretical models on which it is based;
- The people targeted for an intervention;
- The people responsible for those interventions;
- The actions to be taken.

Based on the current knowledge in emergency intervention and the results of clinical research that have shown treatment efficacy, the suggested program takes into account suggestions from other known programs, including some of those from the Dawson College study.

II- Theoretical Models To Orient Action Over a Long Period

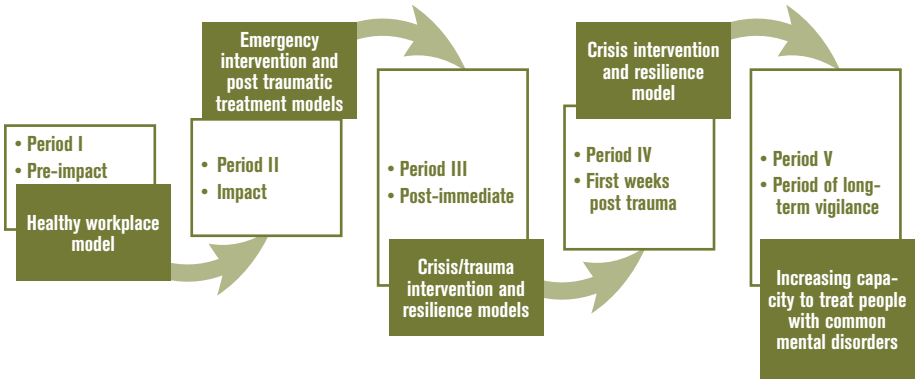
Any intervention must be guided by a theoretical framework which allows for the justification of a model of intervention. In the case of a long-term intervention plan dealing with a violent and traumatic event, no single theoretical model can support and orient actions over a long period.

The SECURE program proposes a sequential process over time, with interventions specific to each phase. A combination of theoretical models allows to better conceptualize the needs for each phase in the intervention process. As the needs of people evolve, it is appropriate to adopt different theoretical models in order to better respond to the needs of the population at risk. Over time, the actions to be taken and the people responsible for these interventions will change

Period I (Pre-Impact)

This period is based on a healthy workplace model that enhances resilience among individuals and prevents the development of new cases of mental disorders and substance abuse by acting on psychosocial factors present in the work organization (Vézina *et al.,* 2004; *Institute of Health Economics & Mental Health Commission of Canada,* 2008). Some models are proposed for professional environments and developed in Quebec with the help of employers, unions and the Institut national de santé publique du Québec. They are illustrated by the Workplace Health Standard (BNQ, 2008).

This standard proposes the creation of a Health and Safety committee to evaluate the health status and risk factors before proposing any intervention linked to the promotion, prevention and recommendation of proactive treatments. This innovative approach implemented within a school community is expected to have an impact on both students and employees. The Ministère de la Santé et des Services sociaux du Québec is currently considering implementing the BNQ standard (2008) for the Ministère's employees in Quebec City (MSSS, personal communication).



Through the activities set up by a workplace Health and Safety committee, school communities would be better prepared for emergency interventions. Moreover, an intervention plan framework for crises integrating the multimodal psychological intervention plan suggested here would also be developed and made available to all educational institutions. Training would need to be provided on an ongoing basis. In Quebec, as well as other provinces or states, each level of education (elementary, secondary, post secondary) may develop different types of emergency intervention plans. However, some of these plans do not integrate psychological intervention measures. A plan including psychological intervention must be developed by an inter-ministerial (departmental) committee of the province or state comprising the relevant government bodies with jurisdiction over such matters. This can include education, public health and social services, public security, and justice (in Quebec, these are the ministère de l'Éducation, du Loisir et du Sport, the ministère de la Santé et des Services Sociaux, the ministère de la Sécurité publique and the ministère de la Justice). This intervention plan would be made available to educational institutions, ensuring that they have access to a plan they can implement immediately during a critical incident, rather than having to create their own.

Based on the current knowledge in emergency intervention and the results of clinical research that have shown treatment efficacy, the suggested program takes into account suggestions from other known programs, including some of those from the Dawson College study.

In an emergency, the urgent use of a multimodal psychological intervention plan presupposes that a protocol already exists.

During an emergency intervention, the priority should be to attend to the direct victims of the traumatic incident and to transmit a feeling of safety as quickly as possible.

In an emergency, the urgent use of a multimodal psychological intervention plan presupposes that a protocol already exists. During the planning period, institutions must: (1) train personnel for logistical and psychosocial needs; (2) update emergency protocols regularly; (3) ensure, with local and regional authorities (in Quebec, the Centres de Santé et Services sociaux (CSSS)), that they have access to the necessary material (psychological intervention kits); and (4) maintain links with their partners who will have to intervene in the event that an emergency plan is set in motion.

Period II (Impact)

Period II is the period of the impact, during which the emergency intervention plan must be implemented. Emergency intervention and posttraumatic treatment models must take precedence during this period: helping people in danger, making them feel safe, securing the premises, filling practical needs and dealing with the surge of people converging on the school and local hospitals to receive help or obtain information about a loved one. Care for the victims and their loved ones must be a priority.

This intense police intervention period also requires emergency, medical and psychosocial interventions that aim to bring immediate assistance to those who have been physically or psychologically wounded. Different types of emergency procedures are planned in the hours and days following a traumatic event. The interventions during the first moments after the shooting are generally coordinated with emergency services (police, medical emergency services, etc.) and their goal is to ensure immediate medical help for the wounded, securing the premises, etc.

During this period, hospitals often experience a surge, consisting of the arrival of victims and family members and friends seeking information about their loved ones. Hospitals must include a plan to provide psychological support to those who will learn of the death or precarious health status of a loved one in their emergency medical protocols (Code Orange). This plan must also provide care for psychologically traumatized people who will show up. Families, visitors and onlookers must be separated into subgroups.

Clear directives must be given to those arriving at the hospital or assembling near the hospital. Separate rooms must be planned for families, for those with minor wounds and for those experiencing psychological trauma. It is important that psychological and social support be given to victims and their loved ones first and foremost. Confidentiality, as always, must be respected.

In the first hours of a crisis, assistance often takes the form of informal emotional support centered on management of the emergency. Formal support needs can be met by designating a place to receive people fleeing the scene, providing warm blankets, making telephones available for those wishing to contact loved ones, etc.

During an emergency intervention, the priority should be to attend to the direct victims of the traumatic incident and to transmit a feeling of safety as quickly as possible. These people must be directed away from the scene and kept informed. During this period, it is often difficult to organize massive psychological services, as those at the centre of the event attempt to flee and to re-group in a safe place. Psychological interventions will be more crucial during the subsequent period.

Period III (Post-Immediate)

During Period III, the days following the impact, actions must be guided by a crisis/trauma intervention model as well as the enhancing resilience in the community, to ensure the identification of people recognized as presenting a higher risk of psychological trauma and their follow-up.(International Crisis Response Network (ICRN)). This model, developed by the International School Psychology Association (Jimerson *et al.,* 2005), aims for the re-appropriation of premises, the return to school, the identification of subgroups at risk, etc.

After the period of impact, the repercussions of the events become more real. Temporary stress reactions can be relatively frequent and are normal during the first days following a violent and

traumatic event. One of the basic principles of the psychological aspect of public security is that people have the ability to deal with stressful situations: the vast majority of members of the academic community will have temporary reactions to stress and will be in a state of disequilibrium, but most will have the internal and external resources to face the tragedy. Most of those affected will use compensation strategies and will have a realistic perception of the event, an appropriate social support network and the necessary capacity to adapt.

However, some will not have the individual and social resources to face these events, and the initial reaction to stress will not fade. These people need to be identified through screening activities, and must be offered assistance through outreach. The study and the discussion groups which were conducted with employees and students of Dawson College confirmed that the greater the proximity to the shooting, the greater the risk of psychological trauma (Boyer *et al.,* 2010; Roy *et al.,* 2010). Moreover, people who had previously experienced mental health problems were more at risk of being affected. The primary, secondary and tertiary groups most at risk will be specified later in this report, as will the interventions strategies, such as screening, proactive follow-up of the groups most at risk, and identification of a clinical case manager.

It is during this stressful period that the return to school is organized. In general, the organization of activities aims to support the resilience of individuals, while recognizing that the community is and will be stronger than the tragedy it has just experienced. The goal of the psychosocial intervention is to support the recovery of emotional equilibrium. It therefore encourages feelings of security, trust, competence, self-esteem, self-reliance and assertiveness as well as the process of integration of the event. Through these activities of resilience, the organization of informational activities can already be introduced: providing information on the signs and symptoms associated with the risk of posttraumatic stress disorder, depression, etc.; promoting the presence of psychological services; encouraging people to consult these services.

In general, the organization of activities aims to support the resilience of individuals, while recognizing that the community is and will be stronger than the tragedy it has just experienced.

During this period, most people will get through this temporary stress with the help of their peers, family, etc. However, a certain number of individuals will not be able to overcome it and will develop acute stress reactions and, possibly posttraumatic stress reactions. It will be necessary during these first days to start identifying the subgroups at risk. With the support of teachers, managers and mental health professionals, it will then be possible to elaborate an initial list of subgroups at risk and to establish a culture of looking out for individuals presenting certain symptoms and risk factors, with the aim of ensuring timely interventions.

The school employees (teachers, managers, counsellors, support staff, etc.), who will be in position to provide assistance must meet with and be debriefed by the psychosocial intervention team. They must be supported and given guidance prior to the return of the students. It is important to be able to rely on adults who can give a feeling of security and protection to the school community. However, in some cases, these adults must also be offered support to address their own vulnerability and/or to support colleagues and students.

During this period, the psychosocial intervention must take place “in the field”, not “in offices” (Martel, 2000). Mental health professionals must be able to offer their services by interacting with students and suggesting that they participate in appropriate activities, such as information sessions and meetings for parents, sessions specifically for those who were direct witnesses, etc. This is the time when mental health professionals begin to identify the subgroups at risk and determine the types of psychological interventions that will be required. For people having been more directly exposed to the event, a more elaborate evaluation must be conducted. The planning for this type of consultation will allow mental health professionals to follow up with people who are potentially at risk.

Psychological intervention services may be offered at the school upon request. Identification forms and record-keeping of people soliciting a consultation will facilitate follow-up in the weeks following the event.

Finally, during this period, it may be necessary to develop support, information and referral services for parents, families and loved ones, tailored to the type of educational institution. Online

consultation tools will be crucial in providing information about symptoms people may potentially experience and the biopsychosocial services which are available.

Period IV (The First Weeks Post-Trauma)

Period IV includes the first weeks after the trauma. During this period, interventions are proactive and their goal is to screen for cases of people with acute disorders. The objective for this period is to target people with acute stress, posttraumatic stress disorder and problems in functioning in order to increase empowerment and resilience in the community.

After the impact, coping strategies will be used with varying results. Some individuals will be overwhelmed by the magnitude of the event, and will be unable to find strategies that allow them to regain equilibrium. This can lead to acute stress or posttraumatic stress responses. When a state of equilibrium is upset, people are vulnerable and may unsuccessfully attempt to maintain a certain level of functioning by using compensation strategies. This can create additional problems in the medium- to long-term, such as dependency to drugs or alcohol. The exacerbation of anxiety and depressive disorders, as well as irritability and aggression may also be manifestations of difficulties in coping. This can turn into a state of crisis, or may manifest in the form of mental health disorders such as anxiety, mood and adjustment disorders, as well as substance abuse. For all these reasons, it is important to maintain support over the long-term. The presence of a medical and psychological team (elaborated below) can help the school community identify, over the long-term, specific risk factors and vulnerable subgroups. This must take into consideration the evolution of the difficulties and symptoms of mental health problems that develop over time.

During this period, it is essential to follow-up by developing outreach activities, especially for those people who did consult, but did not follow up; for victims who were hospitalized or who were recuperating at home and returned to school several weeks after the resumption of classes; individuals identified by teachers or peers as being potentially at risk; students who were absent or who may have dropped out of school; etc.

Psychosocial education, which gives better understanding of the various aspects of mental health, must be set up and maintained regularly. They should be planned by the school's Health and Safety committee, using the standards proposed by the BNQ (BNQ, 2008). These activities can be carried out in classes, allowing for small group discussions, and possibly helping individuals identify that they need help. Screening tools on the College's website can also prove to be effective not only with students, but also with employees. These electronic screening tools can be linked to a mental health professional who can then refer vulnerable people to the appropriate services.

Maintaining psychological services within the school is also important to allow easy and immediate access to support. Accessibility to specialized mental health services must also be planned for, in order to be able to refer people with more complex problems.

Period V (Period Of Long-Term Vigilance)

Period V refers to the long-term, which extends into the months and years following the event. It relies upon the community–at-large's capacity to accommodate the increased needs for people with mental disorders in schools and the workplace. Maintaining a healthy environment depends on a holistic approach to both physical and mental health, identification of risk factors in the workplace environment (Vézina *et al.,* 2004; BNQ, 2008) and the therapeutic management of common mental health disorders according to the chronic disease model (Institute of Health Economics & Mental Health Commission of Canada, 2008).

A balanced psychological intervention program promotes a feeling of empowerment and, although it relies on the resilience of students and employees, it does not assume that, in time, all members of the community will heal. It is necessary to maintain a positive outlook regarding resilience, but also to recognize that individual vulnerabilities may be present as well.

Online consultation tools will be crucial in providing information about symptoms people may potentially experience and the biopsychosocial services which are available.

A balanced psychological intervention program promotes a feeling of empowerment and, although it relies on the resilience of students and employees, it does not assume that, in time, all members of the community will heal.

Psychosocial education and a watchful attitude can foster ongoing screening activities and social networking initiatives, as well as the self-screening of vulnerable students. It will be necessary to adapt these interventions as different types of mental health problems appear. Appropriate training and the competencies of the mental health professionals will ensure their ability to screen, identify, evaluate and appropriately intervene with the groups at risk.

Psychosocial education, which gives better understanding of the various aspects of mental health, must be set up and maintained regularly.

III- Philosophy Of Action In The Case Of A Shooting In A School

An intervention plan developed by national or state/provincial departments that is integrated, promoted and practiced

Since the early 1990's, in Quebec, a psychosocial component has been part of the emergency services offered. This plan was introduced following the École Polytechnique massacre of 1989. At that time, the Ministère de la Santé et des Services sociaux du Québec was in the process of developing an organizational model of socio-medical actions in the context of civil security emergency measures (MSSS 1994a, b; Laurendeau, Labarre & Sénécal, 2007). The Loi sur la sécurité civile, adopted in 2001, gave the Ministère de la Sécurité publique du Québec a supervisory role, including a mandate to create and maintain the National Civil Protection Plan. It also gave the Ministry the power to declare a national state of emergency.

It is unrealistic to ask educational institutions to develop individual programs requiring frequent updating. With regard to jurisdiction, it is the responsibility of the Quebec Government to mandate the ministère de la Sécurité publique to develop a province-wide plan. This plan should be developed jointly with Quebec's ministère de l'Éducation, du Loisir et du Sport and the ministère de la Santé et des Services sociaux and the ministère de la Justice (in other jurisdictions, the equivalent bodies should participate).

A guide should be developed for educational institutions that would propose activities to help schools develop tools that they can then share, thus avoiding the duplication of effort. The adoption of the Workplace Health Standard (BNQ, 2008) by educational institutions would also improve the state of preparedness and resilience to support an eventual crisis, which may reduce some of the harmful psychological consequences. Public security must ensure that the psychological intervention plan is implemented over the long-term and that, in the first years after a critical incident, schools continue to carry out activities to increase psychosocial education as well as screening and outreach activities.

A guide should be developed for educational institutions that would propose activities to help schools develop tools that they can then share, thus avoiding the duplication of effort

During the crisis: development of a crisis management team and appointing a team leader who is an expert in short- and long-term crisis intervention

The *Evaluation of the emergency psychological intervention plan* (Roy *et al.,* 2010) discusses the creation of the Dawson College crisis management team. This team was composed of members of management as well as academic and communications professionals. The team was supported by psychiatrists from the local hospital who happened to have expertise in crisis intervention. This expertise has in fact been recognized by the Agence de la Santé et des Services sociaux de Montréal.

Adopting a strategy for action, with contingencies for the immediate, the short-term and the long-term phases

Some aspects must remain constant throughout the life of a program. The predetermined philosophy for intervention should be clearly stated and understood by the crisis management team in order for it to be successful as a shared belief in the development and implementation of the plan. This is particularly important, as the philosophy will guide the plan for intervention. This philosophy must be repeated frequently during the development of the program so that the crisis management team can base its decisions on it while making intervention choices in light of these values.

Coordinating and maintaining these activities will allow the crisis management team to have a clear vision of how mental health difficulties may develop over time. This vision will help to identify the subgroups of individuals at risk during certain periods, so that appropriate intervention choices may be made over the medium- and long-term. Therefore, both the activities and the teams responsible for them must be coordinated so that the necessary resources are available and adapted according as needed.

Cultural sensitivities are an important consideration, particularly in some communities, in recognition of mourning, rituals and certain commemorative activities. Interventions must constantly be evaluated and adjusted according to the community's needs.

No program can determine with certainty when specific interventions should occur. Despite preparation, psychological interventions will be determined by clinicians (psychologists, psychoeducators, social workers, doctors, etc.), who will use their skills and clinical judgment to choose the interventions best suited to the situation. It is essential to evaluate situations on a continuous basis before determining the interventions that should be offered. Those entrusted with this responsibility must assess the situation frequently and share the findings in order to coordinate activities.

While it is difficult to know in advance which individuals may be at greater risk of developing difficulties in coping after direct or indirect exposure to a tragic event, certain elements can allow the identification of groups at risk.

It is important to support all employees, regardless of their employment status (permanent or contractual). Every employee should be given the opportunity to participate in the recovery and re-appropriation process as an effective way to ensure sharing common values. The teaching staff, as well as other employees and management play a supportive, supervisory and protective roles towards the students for many months, despite also having been affected by the tragedy. An essential part of the plan should include activities that support them to create a healthy and positive atmosphere, underscoring the importance of shared values throughout the development and implementation of the psychological intervention program.

Finally, it is important that the program include an intervention plan for families and loved ones who have had to fulfill major caregiving roles. The support to these families can also prove to be an important asset in the quality of the social climate in the institution as well as in the recovery of the entire community. These families can also play a part in social advocacy for the prevention of violence.

IV- Reaching Out: Identification Of Subgroups At Risk

While it is difficult to know in advance which individuals may be at greater risk of developing difficulties in coping after direct or indirect exposure to a tragic event, certain elements can allow the identification of groups at risk. These can be, for example, people who were directly exposed to the tragic event, people with a history of psychosocial or mental health disorders (including substance use disorders as well as self-destructive and suicidal behaviour), and vulnerable individuals with limited coping strategies who would find it more difficult to deal with the additional stress brought on by a traumatic event.

In dealing with teenagers and young adults, it is important to recognize the feeling of invulnerability that characterizes this age group. Specific challenges will emerge, depending on the stage of development. Young adults, for example, often want to distance themselves from adults, particularly parental figures. Requests for help can therefore be very difficult to express and even more difficult to recognize during this stage of development.

When one is exposed to a traumatic event, the feeling of invulnerability can suddenly disintegrate, leaving people more fragile, without adequate coping skills for facing adversity. Being unaccustomed to facing adverse situations, along with immaturity, can make it difficult for a young person to distinguish between problems which will resolve themselves and problems which are becoming chronic, necessitating psychological consultation. This lack of understanding means that certain young people will underestimate their difficulties, wait too long or hesitate to ask for help, hoping that their difficulties will dissipate with time. A program based on the identification of groups who are potentially at risk would allow for the development of multiple screening strategies over a long period.

Mental disorders are prevalent among children and teenagers (Breton *et al.,* 1999; Santé-Québec, 1993): between 10 and 15% are affected with externalized disorders such as attention deficit and hyperactivity disorder, or conduct disorders, and internalized disorders such as phobias, anxiety and depressive disorders. A minority of this group will receive assistance, especially from the school community. As adolescence progresses, internalized disorders anxiety are more prevalent among girls, while substance abuse disorders surface in boys. Like adults, adolescents are not likely to consult with mental health professionals for these problems.

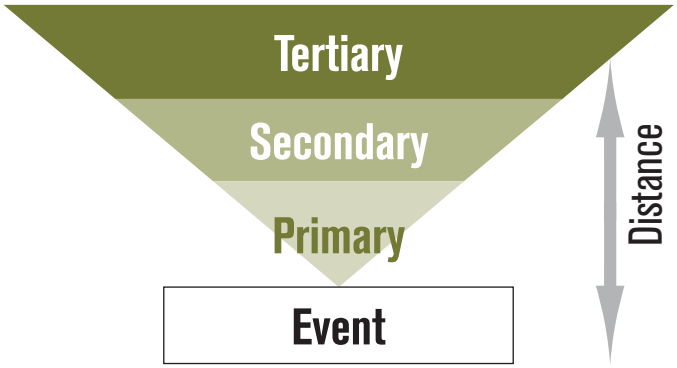
In adults, the prevalence of mental disorders and substance abuse is similar to that of adolescents, between 10 and 15%. The majority of adults do not seek help, and those who do often consult first-line services such as general practitioners and psychologists in private practice (Kairouz *et al.,* 2008).

In the study conducted at Dawson College, the prevalence of mental disorders and substance abuse prior to the shooting was similar to that of the general Quebec population, and the use of services, was comparable. After the shooting, mental disorders and substance abuse increased, as did manifestations of aggression among men and of victimization among women. The use of services was comparable, except for the use of the Internet as a source of information (Boyer *et al.,* 2010).

Different strategies can be used to target groups at risk. However, the level of exposure or proximity to the traumatic event is a good indication. Depending on the target group, different types of difficulties may emerge in the short- and medium-term. The subgroups of people identified can be at risk of developing mental disorders, taking into consideration:

- difficulties facing reactions to stress, which can lead to acute stress or posttraumatic stress problems;
- the lack of coping ability, meaning that some people are more vulnerable to personal crisis, suicidal crisis or aggressive behaviour;
- complex reactions to mourning, including the eventual development of a pathological mourning reaction;
- the exacerbation of pre-existing mental disorders or the development of mental disorders after exposure to the recent trauma;
- mental health difficulties such as forms of mood disorders, anxiety disorders, dependency, manifestations of aggression or vulnerability to victimization, possibly adding to the difficulties that can develop in the short- and medium-term.

Based on this categorization of subgroups and evidence gathered in the Dawson College study, the risk of psychological trauma increases with the proximity of the person to the violent event. It may therefore be necessary to develop interventions specifically for the following groups, identified as: the primary group, the secondary group and the tertiary group.



Primary:

I. People who were wounded physically, as well as the families, friends and loved ones of those who were wounded or killed;

II. People who were present at the College and directly exposed to the violence (direct witnesses).

Secondary

III. People with pre-existing mental health disorders as well as those at risk for suicidal or aggressive behaviours not included in the first two groups;

IV. People exposed by virtue of their positions at the College either through therapeutic relationships, or administrative or support roles (e.g. those who participated in the physical clean-up of the premises after the incident).

Tertiary

V. People on the premises, but not directly exposed (indirect witnesses).

A Heterogeneous Group Of People

In the tragic event that took place at Dawson College in 2006, one young woman was killed, the shooter died and several people were wounded. During similar events in the United States and around the world, the number of people killed and wounded has been higher. In some cases, members of the families of the deceased or injured had to continue to study in the same institution where the shooting occurred.

In some instances, the person who committed the murder(s) was an outsider, while in other cases, the person was known to the school, having studied there or having friends or siblings attending. Therefore, a heterogeneous group of people may continue to have a relationship with the institution. A psychological intervention program must take the needs of the families of the deceased, the physically and psychologically wounded, and even the people close to the killer into consideration. The desire to support all vulnerable people must be a shared value during the psychosocial and psychological interventions.

The Specific Context Of The Wounded And The Families Who Are In Mourning

People who have been wounded or who are mourning may have trouble functioning normally as a result of physical or cognitive impairment. They may have difficulty maintaining the levels of concentration necessary to continue their daily activities, such as attending classes or working. For the mental health professionals, a thorough understanding of the mourning process and the distinction between healthy adjustment and pathological mourning is necessary to help people going through bereavement. It is also essential that these professionals have the ability to recognize and evaluate all common mental health difficulties.

The support to the people who were wounded in what they believed to be a safe environment is an essential part of the intervention plan. In certain circumstances, injuries may force certain young people to completely alter the course of their lives. The clinical evaluations of people wounded during the Dawson College shooting show the presence of multiple and significant difficulties for these people and their families. Difficulties can be physical, psychological, social, academic, financial, etc. Siblings and friends must also be given specific, sustained attention. These considerations must be extended to all affected families.

During the interviews conducted for this study, researchers were keenly aware of the suffering of the families of the people who were killed or wounded. To lose a loved one suddenly under brutal and violent circumstances is an unfair and incomprehensible situation which can be difficult to overcome. During interviews, families acknowledged having experienced states of disorganization for many months following the event. They had to negotiate their own sorrow, that of their family and children, of the friends of the wounded or deceased child, of the extended family, of neighbours, etc. They must often face the intrusiveness of the media, the complexity of the legal system, a lack of financial resources, the disorganization of the family environment, etc.

Offers of support and services are numerous during the first days after the event, at a time when loved ones are often feeling numb and having trouble understanding the deluge of information. Unfortunately, support dwindles shortly after the event. In fact, few organizations have a mandate to maintain long-term contact with families, so after a few weeks, families find themselves alone and having to make numerous important decisions. Many families said they needed case management-type support, which would have allowed systemic intervention by mental health professionals.

The school community cannot – and should not – be responsible for all these interventions. The psychological intervention plan must include provisions for receiving services from local, regional and national organizations which must also support the school community and offer intervention outside the institution, both in the short- and long-term. It is therefore recommended to apply a hierarchical management approach in general, the same approach used in the first-line management of chronic diseases, and case management-type clinical services for direct witnesses of violence, including those wounded, and their loved ones. This combination of approaches allows mental health professionals to support the most vulnerable people proactively over the long-term.

V- The Crisis Management Team

The elaboration of a multimodal psychological intervention protocol must begin with the creation of the crisis management team. At its core are members of the administration of the school, supported by an external crisis intervention expert and team that includes regional and/or provincial health and education authorities. Members of the crisis management team will be designated to work with the leaders of the cells described below to develop and coordinate the emergency intervention plan.

This crisis management team is made up of the institution's director, selected managers who, according to their professional expertise, may be responsible for cells, the school's psychosocial professionals, the Health and Safety manager (if one existed prior to the incident). This team should also include external members, such as the designated expert in psychological intervention, managers of the local and/or regional health centres, liaison officers from the hospitals treating those injured in the shooting, and the staff responsible for logistics and security who have been in contact with the police or paramedic teams. This crisis management team will coordinate the activities and plan the long-term follow-up. This committee should meet regularly to debrief and plan the next steps.

Subsequently, it is necessary for the team to identify and define the roles that each team member will play during each phase of the multimodal intervention plan. These roles can be assigned according to the person's area of responsibility or logistical issues inherent to the particular community.

The elaboration of a multimodal psychological intervention protocol must begin with the creation of the crisis management team. At its core are members of the administration of the school, supported by an external crisis intervention expert and team (...)

The four areas covered are:

1. Medical and Psychological Support Cell;

2. Communications Cell

3. Cell In Charge Of Security / Restoration Of The Premises;

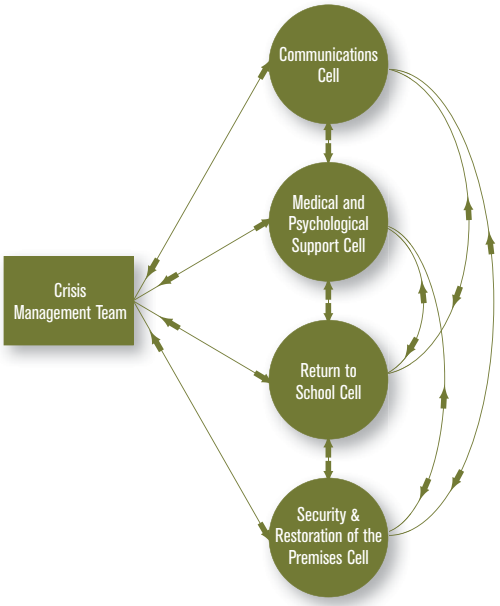
4. Cell In Charge Of Return To School And Psycho-Educational Activities.

Each of these cells within the institution has the responsibility of coordinating its activities with its external members.

While each cell has distinct responsibilities, the delineation of these responsibilities can be blurred. It is essential that these four cells interact closely during the crisis. For example, the logistics required to organize the return to school and the communications strategies will be greatly influenced by the psychological intervention plan.

Medical and Psychological Support Cell

This cell is identified first because it will be the first to collaborate with the emergency teams from the hospital(s) where the physically and psychologically wounded will be directed, along the surge of families and friends. The first actions will be emergency medical interventions, triaging the surge of people, following up with the wounded, setting up case management for the wounded and their families, etc. This team is made up of the school nurse, doctors, a psychiatrist from the hospital, the institution's Code Orange psychosocial intervention leader, and regional or local hospital psychosocial responders designated by the hospital's Code Orange psychosocial intervention plan.



This team must then organize psychological coordination for the following activities: employee training during the preparation phase, psychological support for the school community, diagnostic evaluations, clinical interventions, follow-ups, etc. This team is made up of psychologists from the school, the CSSS and the hospital, as well as a manager from the school who is familiar with the student body.

Communications Cell

This cell is responsible for media relations. The term "media" includes all forms of communication: public media, school media, public radio, student radio, all forms of Internet communications, etc. During the crisis at Dawson College, students and employees used electronic communications as soon as the shooting began to exchange information with those who were locked in offices and classrooms. This cell will therefore have responsibilities that will evolve over time.

Cell In Charge Of Security / Restoration Of The Premises

This cell is generally prepared in advance for crisis situations. They will be responsible for emergency interventions, activating evacuation plans, distributing a crisis intervention kit, organizing a location for triage, setting up accommodations and an area where students can receive support, planning the cleaning and the re-appropriation of the premises, etc. This is an emergency logistics intervention team, similar to the emergency medical intervention team. This team is made up of the institution's director of security, a police officer, school psychosocial responders, the manager of technical services of the institution, etc.

Cell In Charge Of Return To School And Psycho-Educational Activities

This cell is responsible for maintaining an atmosphere of safety, producing and providing general and academic information, and planning commemorative activities. It is important to maintain a direct link between the students and the institution so that questions and requests may be dealt with promptly. In the same vein, maintaining links between the administration and employees is equally important: the team must ensure that decisions made by the administration are communicated clearly to employees and that dialogue remains open throughout the recovery process. These interventions must be made over the long-term. This cell includes managers, teachers, students, etc. It must make judicious and constant use of the institution's website and other communications tools used or created by students, friends and family and employees.

This cell will ensure that relationships are maintained between the educational institution's administration and its employees, creating activities of psychoeducation, outreach, case management, etc. This team comprises the psychosocial professionals in the school, a manager responsible for students, a manager from the local CSSS, a physician from the outpatient clinic, etc.

Each person in the crisis management team and its cells must be familiar with his/her responsibilities, and prepare intervention plans and protocols that allow for efficient intervention. The people responsible for each subgroup will receive the theoretical knowledge necessary for the preparation of their roles, and must develop interventions consistent with the theoretical frameworks.

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