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The DMH Responder is a quarterly production of...

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Welcome

Welcome to the Winter 2018 issue of the **New York DMH Responder**, our quarterly newsletter for the Disaster Mental Health community. This issue summarizes key points from our 2018 training, which was webcast on February 9 to 22 Office of Mental Health sites and 21 Department of Health sites statewide, as well as three sites in South Carolina. The training focused on the mental health consequences of mass violence events including mass shootings, vehicular assaults, and other terrorist attacks. The timeliness of the topic was underscored when, less than a week later, 17 students and educators were shot and killed at a high school in Parkland, FL in an attack that shared many of the characteristics described in the training. While we hope readers never need to respond to one of these attacks in your community, it's clear that we all need to be prepared to do so and we hope the information in the webcast, summarized in this newsletter, will be helpful. The psychosocial response to mass violence is also the focus of the upcoming Institute for Disaster Mental Health conference on April 27, 2018. Thanks to sponsorship by the NYS Division of Homeland Security and Emergency Services, OMH and DOH personnel can attend at no cost, though the conference is now sold out. We'll summarize those presentations in the Spring 2018 Responder so those who can't attend can continue to build your knowledge about these terrible events.

As always, your feedback and suggestions for topics to cover in future issues are welcome; please email any comments to Tom Henery at DOH or Steve Moskowitz at OMH.



"Nothing good ever comes of violence."

— Martin Luther, ~1520

Managing the Mental Health Consequences of Mass Violence

This year's training was organized by the SUNY New Paltz Institute for Disaster Mental Health and broadcast from the Office of General Services Media Services Center in Albany. It was delivered by Steven M. Crimando, the Director of Training for the Disaster & Terrorism Branch of the New Jersey Department of Human Services, Division of Mental Health & Addiction Services. Mr. Crimando is an internationally recognized expert in the prevention, response, and recovery from active shooter incidents and other forms of mass violence. He has published widely on the topic, and he has developed violence prevention and response programs for government agencies, hospital and healthcare systems, and multinational corporations.

Mr. Crimando began by acknowledging how intense and difficult the topic of mass violence is to confront, and he put a human face on its impact by showing portraits of several of the young people who were severely wounded in the 2011 Utoya attacks in Norway that killed 77, and caused life-altering injuries including amputations and serious scarring for many of the 110 injured survivors. There's a tendency, he noted, to mourn those killed in these events but to overlook the lasting effects – physical as well as psychological – for survivors, and it is important to address the ongoing needs of all impacted.

In terms of event characteristics, while not all mass violence events should be classified

as acts of terrorism, most do share terrorism's core goal: the creation of extreme fear, destroying the individual and communal sense of safety and security. Regardless of the tactic used (bombing, shooting, other), terrorist attacks are intended to cause psychological, social, and economic disruption, not simply to hurt or kill those in close proximity to the attack. These assaults are often carefully planned in advance and are not conducted in response to a specific threat; they're predatory in nature rather than reactive. Perpetrators are often described by survivors as being calm and in control, not overwhelmed by emotion. They're often looking to inflict as many casualties as possible, and may select a "target-rich environment" where many potential victims are clustered, rather than a setting they have a personal connection to. For example, shooters

selected crowded sites full of unsuspecting potential victims in the movie theatre in Aurora, CO, and the music festival in Las Vegas, and they rehearsed their plans in order to maximize the victim count.

In addition to mass shootings, Mr. Crimando noted the need to prepare for evolving threats including "Hybrid Targeted Violence," meaning attacks targeting a specific population using multiple and multifaceted conventional and unconventional weapons. These perpetrators (often working in pairs or groups) often attack several locations simultaneously and may use a combination of tactics such as explosive devices and guns. Perpetrators may use fire or other preliminary tactics to complicate the response – and to lure first responders to an area where they can then be targeted. Examples include the Mumbai siege and the

The Facts on Mass Shootings

According to research by the New Jersey Office of Homeland Security and Preparedness, shootings conducted in the United States between January 1, 2015 and June 30, 2016 included the following characteristics:

- 7 were ideologically driven; 38 were non-ideological
- There was fairly even geographical distribution, with 19 in the East, 11 in the West, and 15 in the Central region
- 381 victims were killed or injured
- 98% of offenders were male

Shooting locations varied:

- 46% places of commerce (businesses, shopping malls)
- 25% educational institutes
- 10% government facilities
- 9% open spaces
- 4% residences
- 4% houses of worship
- 2% health care facilities

Managing the Mental Health Consequences of Mass Violence, *continued*

Paris nightclub attacks. Another evolving threat is “Vehicular Terrorist Attacks” where a vehicle is intentionally driven into a crowd, like the Halloween 2017 attack in lower Manhattan. Obviously access to vehicles is far easier for perpetrators than acquiring guns or explosive devices, and protecting pedestrians is virtually impossible in many areas, so preventing these acts is extremely difficult.

Mr. Crimando then showed an excerpt from the documentary “Terror at the Mall” which includes security camera footage of the 2013 attack on a shopping mall in Nairobi, Kenya, in order to demonstrate the confusion and chaos experienced by those present in an attack as they first begin to understand what is happening and must try to decide how to act to protect themselves and those around them, based on limited and confusing information. Participants then paused for an exercise at their sites which asked them to consider the immediate response needs following a vehicular and knife attack on a college campus, including the expected emotional and behavioral response of individuals and families who would come to a Family Assistance Center. Likely survivor reactions in this earliest phase include shock and anger, but Mr. Crimando also emphasized challenges related to not knowing many details in the early aftermath of an event, and the resulting frustration for responders of not being able to provide survivors



with answers to their questions. He also noted that “we are the very first generation of disaster behavioral health responders that has to contend with the effects of social media.” That means that people are getting immediate information from multiple sources – potentially including good information, bad information, misinformation, and rumor, and even fake news that may distort the picture at a time when people have a tremendous thirst for facts about what happened.

Emotions in this first phase are generally raw and intense as survivors begin to process their experience and family members confront their losses. Psychological First Aid is essential as part of the initial response, and its value shouldn’t be minimized: Mr. Crimando

noted his experience in multiple incidents where he questioned his team’s ability to help shocked or bereaved families, only to have those families later thank them for their support, reinforcing the value of disaster responders providing a compassionate presence even when there’s little direct action to take. That said, he acknowledged that mental health responders can also be perceived by families as part of a system that isn’t fully addressing survivor needs, so helpers may have anger misdirected at them or be accused of withholding information. It can be exhausting for responders to meet the rapidly changing needs during this immediate post-event phase, so team managers need to be very mindful of how team members are holding up through this particularly intense stage.

Acute Behavioral and Mental Health Reactions and Response Priorities

Mr. Crimando then turned to the psychosocial consequences of mass violence and how to develop effective strategies for managing those consequences. An important point is to remember that these reactions are phase-specific, shifting from hour one, to day one, to week one, to year one, so our response needs to adapt continually to the needs in each time period. Behavioral responses are also hazard-specific, with intentional acts like targeted mass violence producing specific emotional needs given their particularly distressing characteristics:

- Shattered sense of safety; “safe places” like schools, shopping malls, concert venues no longer feel safe.
- An identified responsible party, who often dies during the event so they can’t be brought to justice.
- Event is unexpected so there is a lack of preparation among victims; the shooter has the initial tactical advantage.
- Innocent victims, often randomly involved due to their presence in the targeted location.
- Children and adolescents may be primary actors.
- Loss of life is more substantial than loss of property.

These factors mean that acts of mass violence “cast a long shadow” into communities and are associated with far higher rates of Acute Stress Disorder and Posttraumatic Stress Disorder among survivors than



natural disasters, so it’s very important for responders to cast a wide net to be sure all impacted groups receive needed support, including:

- Survivors of and witnesses to the incident.
- Loved ones of victims and survivors.
- First responders, rescue and recovery workers, especially those involved in the on-scene response.
- Neighbors and community members surrounding the incident.
- Those in the area at the time the violence happened.

A key point in planning a response is to remember that “behavior is a function of person and environment” (known as Lewin’s Equation), and the environment during a violent attack may cause individuals to act very differently than they would under more normal circumstances. Mr. Crimando

outlined characteristics of the “hot zone” when an attack is underway. It’s a dynamic, chaotic, hostile environment that will thrust citizens and responders into a spontaneous deadly force encounter. Multiple weapons and ammunition are often involved, possibly including explosive devices. Responding officers may or may not be fully trained and equipped for this type of incident, while ordinary citizens are likely to have little or no mental or physical preparation for such a terrifying violent event. They may be exposed to physical carnage and multiple, graphic, and traumatic injuries. Overall, the level of stimulation, possibly including noise from screams and alarms, is overwhelming and makes it incredibly difficult for people on-site to figure out what to do. “Choke-points” like stairs, escalators, and doors that funnel people into confined areas may lead to crush or stampede injuries among those trying to escape.

Acute Behavioral and Mental Health Reactions and Response Priorities, *continued*

When law enforcement arrives, their tactical priority is to contain the threat rather than to assist survivors, which is difficult for both groups. Officers may need to treat everyone as a possible suspect, leading to aggressive treatment. Especially in a mass shooting event, uncontrolled blood loss from wounds is the main cause of death, so survival may depend on bystanders' ability to provide emergency first aid. (See the Resource box for details on a FEMA program, "Before Help Arrives," aimed at providing those skills.) Throughout the response cycle, mental health responders need to understand that these events are criminal acts so we may need to collaborate with and respect the priorities of law enforcement organizations as well as victim service groups.

Once the active event ends with the capture, escape, or death of the perpetrators, response attention immediately shifts to the survivors. Thanks to the omnipresence of cell phones, Mr. Crimando noted, most survivors' first act is to contact their loved ones, leading to an almost instantaneous surge to incident scenes, reception centers, and hospitals. Planners should expect to receive 8 to 10 loved ones for each direct survivor or victim at Family Assistance Centers (FACs) and other reception sites. There may also be an influx of spontaneous volunteers eager to help, but perhaps lacking the training to do so appropriately.

At this point, survivors begin transitioning from the powerful, instinctive fight, flight, or freeze

response, but Mr. Crimando emphasized that it takes some time for that gut reaction to wear off, so people may still be in the throes of an adrenaline rush for hours or days after the event is over. Responders will encounter people experiencing "Extreme Stress Reactions" including:

- Frantic, unfocused behavior
- Difficulty following directions
- Fine motor skills deteriorate
- Problem solving diminished
- Irrational fighting or fleeing; freezing
- "Autopilot" behaviors

Over time, as we know, these reactions generally evolve into recognized post-traumatic stress reactions (though these do not equal PTSD!). Everyone who experiences a disaster is affected by it in some way, though most will recover fully over time. People pull together during and after a disaster, and their natural resilience supports individual and collective recovery. Few will develop diagnosable conditions, though stress and grief are common reactions to uncommon situations. While some percentage will have severe reactions that would benefit from professional mental health support, most do not seek treatment, and survivors often reject help when it's offered. Most people are not seeking counseling or even PFA shortly after an event, so Mr. Crimando suggests mental health helpers can use an "active lurking" approach to identify and reach out to distressed individuals.

That outreach should not be limited to FACs, nor to the

immediate post-attack phase. Mr. Crimando suggested incorporating mental health support at diverse locations including:

- On-scene
- Hospitals/field hospitals
- Family Assistance Centers
- Community vigils
- Memorials (both planned and spontaneous)
- Transitioning from hospital to home
- First responder organizations
- Affected schools and businesses

FACs do play a critical support role following mass violence events and should be opened as quickly as possible, Mr. Crimando noted. In the immediate aftermath of a violent event, families and friends will frantically seek assistance and will gravitate to where they believe they will find their loved one or where they believe they will find information – usually the incident site and local hospitals for those thinking their loved ones are injured and have been transported to the nearest hospital. A FAC will provide a private place for families to grieve, and protect them from the media and curiosity seekers. Those managing the FAC can help to facilitate the information exchange between the Medical Examiner/Coroner's Office and families, both so that families are kept informed and so the office can obtain information needed to assist in identifying the victims in order to provide death notifications and facilitate the processing of death certificates

Acute Behavioral and Mental Health Reactions and Response Priorities, *continued*

and the release of remains. In general, the FAC provides a safe place to address family needs and to respond quickly and accurately to questions and concerns, as well as psychological, spiritual, medical, and logistical needs. Meeting all of these needs, perhaps initially on a 24-hour basis, is essential but extremely demanding, so Mr. Crimando strongly recommended actively practicing the process of establishing and operating a FAC.

At this point in the training, participants broke into groups again to discuss what mental health needs and activities would be relevant three days after the attack in the original scenario. One of the challenges during this early phase, Mr. Crimando pointed out, is to determine who are the diverse groups who may need support, and

then determining how to reach those various populations. In this particular case, there is also the possibility that students at the targeted college may go home so they're not present to participate

in university-based activities, and the families of victims also may live far from the college and require outreach. At this stage PFA would still be a relevant intervention for many impacted.

Family Assistance Centers: Guiding Principals

- Maintain a single focus: supporting the families.
- Convey this single focus in all communications and actions, both internally and externally.
- Deliver only unequivocal, accurate information to families with honesty and empathy – although painful, the truth is always most supportive to the families.
- Guide family member expectations from the beginning of the operation.
- Accommodate families' requests to the maximum extent possible and recognize that some requests cannot be met.
- Remain flexible, allowing room to adapt and evolve to meet new requirements and family needs.
- Provide every opportunity for family members to make decisions to regain control of their lives.

Acute Behavioral and Mental Health Reactions and Response Priorities, *continued***Mid- and Long-Term Reactions**

In the final section of the training, Mr. Crimando turned to addressing the potential lasting effects some survivors experience emotionally, in addition to sometimes permanent physical effects from life-changing injuries.

As time passes the settings where support is provided will shift – for example, FACs will close and funerals and vigils will end at some point, so providing mental health support may require outreach to wounded victims transitioning from hospital to home, or to collaborations with affected schools and businesses. If a perpetrator has been apprehended, law enforcement's focus shifts from investigation to litigation. Trials usually receive extensive media coverage and often trigger traumatic memories for survivors.

Anniversaries, particularly the first year after the attack, are extremely significant for impacted communities, and planning for marking this milestone needs to begin well in advance. It's essential, Mr. Crimando said, that this planning be done "with the community, not to the community." For example, residents of Newtown, CT, managed to hold their first anniversary commemorations without media coverage, but that took a tremendous amount of planning and effort to accomplish. Anniversaries allow individuals and communities to mourn losses associated with the violent event,

and to reflect on resilience and healing. They're a time to:

- Take stock of the accomplishments of both individuals and the community.
- Reassess the needs of the community.
- Enhance and strengthen connections with community stakeholders.
- Continue creating educational materials and community partnerships that promote resilience and create a legacy.

These anniversaries tend to reawaken strong emotions, so mental health support resources should be incorporated in commemorative events, perhaps including written psychoeducational materials and connections to hotlines like the Disaster Distress Helpline (see the Resources box for details). Administrators of crisis counseling programs or other community resources should be prepared for a temporary surge in demand for services around anniversaries.

To conclude the training, Mr. Crimando described four potential long-term outcomes:

- The individual moves into a dysfunctional state.
- The individual experiences recovery with loss, establishing a lower level of homeostasis.
- The individual returns to baseline homeostasis.
- The disruption represents an opportunity for growth and increased resilience, leading to a new, higher level of homeostasis.



That final, most positive outcome isn't guaranteed, but as disaster mental health helpers, we need to take care not to get in its way by creating an expectation of pathology. As he described it, "some people will come out of this not with the idea that they were the victim, not the idea they're a survivor, but the idea that they're a thriver – they're more robust and more resilient because they survived this." Resilience, he said, doesn't mean the absence of any psychological symptoms, but the ability to bounce back despite experiencing distress. For responders, resilience requires an awareness of the signs of Operational Stress and the practice of good self-care, including knowing our own limits.

You can view the entire webcast at: <https://tinyurl.com/2018MassViolenceWebcast>

Media's Complex Role in Response

Disaster responders and journalists are often uneasy allies in times of disaster, reliant on but sometimes mistrustful of each other. While disaster mental health responders should

perpetrators' desire for public attention in order to maximize the psychological trauma of the event, so posting in real-time plays into the terrorist's narrative. He acknowledged that it's hard

to suppress the instinct to share and seek out information, but this risks not only glorifying the perpetrator but also traumatizing those exposed to graphic images and first-person accounts.



be receiving official updates through the Incident Command System, Mr. Crimando noted the importance of also paying attention to how mass media and social media is reporting on events since that is how members of the public will be receiving their information, so it will shape their perceptions of the event and the response.

We also now must factor in the role of the “citizen journalist,” with those present at an event immediately posting images and videos – which occurred to an unprecedented degree during the recent Parkland, FL high school attack. Unfortunately, Mr. Crimando noted, this feeds

VIP Visits

Shortly after major attacks, politicians, celebrities, and other VIPs often want to visit impacted communities, which can have both pros and cons for survivors. These visitors are likely to attend memorials and funerals, and to meet with family members, local officials, and first responders. Mr. Crimando described these visits as double-edged swords: Some community members express appreciation for the attention and concern, while others find it offensive to shift the focus off of the survivors to the VIP, who may try to politicize the event.

These visits also require intensive logistical planning that redirects resources from the response efforts, requiring a high degree of collaboration with state and federal agencies. They're often high-profile media events that may attract worldwide coverage – which itself can be seen as either invasive or validating. In general, authorities should be prepared for the fact that these VIP visits tend to be disruptive and often receive a mixed reception from the community.

Helping the Helpers

Throughout the training, Mr. Crimando emphasized the need to support first responders in every phase. Police officers and other first responders to an event likely faced a high level

that the first responders (EMS as well as police) arriving on the scene are often members of the impacted community, so they may personally know victims, and in the case of school shootings,

To address these professional populations' needs, Mr. Crimando endorsed the appointment of a "Psychological Incident Commander" who would be responsible for sharing information about available mental health services with first responders, connecting with and answering questions for first responders' family members if needed, and coordinating with the employee assistance provider and other agency mental health service providers to organize follow-up services. Other recommendations for supporting responders (including mental health helpers) during and after particularly stressful events include:

- Screening before deployment.
- Shorter shifts than usual.
- Rotation of difficult assignments.
- Emotional support available before, during and after.
- Protection from media.
- Respite from the community.
- Responders brought in from out of the area.

of personal threat, including the risk of line of duty death; a recent FBI report found that one out of every three police officers entering an active shooter event alone was shot during the response. Police may have had prolonged exposure during the incident, particularly if it involved a barricade or hostage situation, and they may have been involved in wounding or killing an innocent person during the course of the response. Encountering child victims is also recognized as an extreme stressor for law enforcement, as are events of prolonged duration and high intensity. He also noted

may even have children in the school. This also applies to healthcare and mental health workers who treat victims of violence in their communities.

So, while we generally recognize professional first responders as very strong and resilient, we also must recognize that anyone's coping and problem-solving abilities can be overwhelmed by certain traumatic experiences. This can also lead to "trickle-down trauma" that causes secondhand effects in responders' family members who must confront what their loved one experienced and risked on the job.

Peer support from colleagues with similar experiences has long been recognized as beneficial for responders and Mr. Crimando endorsed the creation of an officer peer support program following a major incident, but he also suggested that peer support officers should work with mental health professionals in order to help them identify and refer officers who need more intensive services.



Research Brief: What Really Helped Survivors of Mass Violence?

Responding to Disaster Mental Health Needs

Note: The lead author of this study, Erika D. Felix, will present a keynote address on this topic at the April 27, 2018 Institute for Disaster Mental Health conference on the Psychosocial Response to Mass Violence.

While the incidence of mass shootings and other violent attacks continues to grow, and the responder community's commitment to providing mental health support to survivors is genuine, one element that is often missing in our efforts to help is the voices of survivors themselves. A newly published study attempts to rectify that by surveying students at the University of California at Santa Barbara (UCSB) following a 2014 violence spree committed by a young man who murdered six students and wounded over a dozen others before killing himself. This was a "Hybrid Targeted Violence" event where the perpetrator stabbed and shot some victims, and struck pedestrians and cyclists with his car.

This study is particularly interesting because the researchers, two of whom are professors in the UCSB Department of Counseling, Clinical, and School Psychology, had collected data from 593 students who participated in a study of college adjustment during the year prior to the attack. Those students were contacted after the attack and invited to participate in a follow-up study, which 141 completed. That longitudinal structure allows a rare comparison of pre- and post-disaster functioning, rather than the more common post-event-only study that limits our understanding of specifically how the experience changed participants' functioning. At both time points (as well as during a second pre-disaster point) participants were asked about a variety of topics including their sense of school membership, general self-efficacy, perceived social support, depression, and anxiety. After the attack, they were also asked about their level exposure to the event, fear for friends, and loss of resources following the tragedy. They were also asked whether they attended various UCSB- or community-organized memorial events, whether they found them helpful, and in an open-ended question, "Do you have any comments or suggestions about events to help universities respond to student needs in the aftermath of tragedies?"



Exposure levels were high overall: 37% of respondents said they were in the neighborhood at the time of the attack, and 29% personally knew someone who was killed. Data analysis revealed a significant increase in both depression and anxiety symptoms following the attack, as well as increases in social support and school membership. While depression and anxiety symptoms increased at the group level, it's important to note that most students did not reach the clinical cutoff deemed to merit a referral for possible mental health services, which was reached by 17.9% (n=24) of the students on either the depression or anxiety scale, while 9.7% (n=13) reached clinical criteria on both scales. Students who had reported higher depression symptomology or more childhood trauma in the pre-attack survey were significantly more likely to reach the clinical cutoff after the attack, indicating that those with a history of trauma or depression may be more vulnerable to a worse post-disaster reaction.

Looking at the helpfulness of different memorial activities, students said the most helpful events in the immediate aftermath of the tragedy included a student-organized candlelight vigil, religious or spiritually oriented memorial events, a memorial "paddle out" into the ocean, and supportive and relaxing activities organized by the university or community volunteers, including therapy dogs and

Research Brief: What Really Helped Survivors of Mass Violence? *continued*

yoga. While write-in comments about the helpfulness of memorial activities were generally positive, some participants criticized the official campus memorial service, as in this response:

“The memorial itself was a disservice to those who were lost . . . I never felt as if anyone was remembered. It was a statistic . . . devoid of any significant meaning. The only true consolation came from one on one interactions with professors, discussions among close friends, and hearing the names of those who were lost and what lives they lived.”

Others praised the same event:

“I think it was great to emphasize the sense of community. Not only did friends and people I did not know come together, but there was the support of faculty... It was nice to have the memorial service.”

This seems to exemplify the challenges Steve Crimando discussed regarding planning anniversary ceremonies and other memorials – events which need to somehow create one ceremony that will meet the emotional needs of hundreds or thousands of distressed and bereaved survivors. It’s an important lesson for any readers who will become involved in planning rituals following mass violence incidents, as is the evidence that those with pre-existing challenges are at risk for worse psychological responses to a disaster. The authors also emphasized the importance of training as many faculty and staff members as possible in Psychological First Aid in order to provide responsive support after a tragedy – a suggestion DOH, OMH, and IDMH strongly endorse.

Source: Felix, E.D.; Dowdy, E.; & Green, J.G. (2018). University student voices on healing and recovery following tragedy. Psychological Trauma: Theory, Research, Practice, and Policy, 10, 76-86.

Additional Resources

The following are sources of information Steven M. Crimando suggested in his training.

The Anatomy of Violence: The Biological Roots of Crime, by Adrian Raine, 2013. New York: Random House.

An examination of the physiological correlates of antisocial and violent behavior, for those interested in why perpetrators commit acts of mass violence.

The Unthinkable: Who Survives When Disaster Strikes – and Why, by Amanda Ripley, 2008. New York: Random House.

A journalistic exploration of how humans react to danger, and what made the difference between life and death in eight historic disasters.

Terror at the Mall

Mr. Crimando showed excerpts of this HBO documentary on the 2013 terrorist siege of the Westgate shopping mall in Nairobi, Kenya to depict the chaos of an unfolding event as captured on security camera footage, as well as the longer-term effects on survivors. The documentary is available

to stream for a small fee through multiple services – search “Terror at the Mall watch online” to find current options.

Until Help Arrives

<https://community.fema.gov/until-help-arrives>

FEMA-created training program intended to give citizens emergency first aid skills to sustain life until professional help is available.

Disaster Distress Helpline

This 24/7, 365-day-a-year, national hotline dedicated to providing immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster is a useful resource to refer survivors or colleagues to. The toll-free, multilingual, and confidential crisis support service is available to all residents in the United States and its territories. Anyone experiencing stress, anxiety, and other depression-like symptoms after a disaster can call 1-800-985-5990 or text TalkWithUs to 66746 to connect with a trained crisis counselor.

Register Now for the 15th Annual IDMH Conference: Psychosocial Response to Mass Violence

Building on lessons from the recent webcast, the upcoming Institute for Disaster Mental Health annual conference on April 27, 2018, will devote an entire day to this difficult but essential topic. Presenters will include Dr. Patricia Watson from the National Center for PTSD, and Dr. Erika Felix, whose work responding to the Isla Vista college shooting is highlighted in this issue's Research Brief. A panel discussion, moderated by IDMH Founding Director James Halpern, will feature Disaster Mental Health responders discussing their experiences responding to mass violence

events including the Las Vegas shooting (2017), Sutherland Springs, TX church shooting (2017) and the NYC truck attack (2017) as well as the historical Oklahoma City bombing (1995). Workshops are targeted to different professional groups, with topics including Stress First Aid for first responders, a session on supporting children following mass violence, an overview of the American Red Cross model of multidisciplinary teams using the Integrated Care Team Approach to support survivors, and a session on sensitively delivering death notifications.

Thanks to generous sponsorship, provided by the NYS Division of Homeland Security and Emergency Services, there are no fees for this conference for personnel connected with DOH, OMH, or other relevant response organizations.

For program and registration details, please go to:
<http://www.newpaltz.edu/idmh/>
and click the conference image.



SOLD OUT
See the Spring Issue for Presentation Summaries

15TH ANNUAL CONFERENCE

**PSYCHOSOCIAL
RESPONSE TO
MASS VIOLENCE**

APRIL 27, 2018

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State University of New York at New Paltz, New Paltz, New York