



NY DMH Responder

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Welcome

Welcome to the Summer 2016 issue of the New York DMH Responder, our quarterly newsletter for the Disaster Mental Health community. For this issue the NYS Department of Health, Office of Mental Health and the Institute for Disaster Mental Health at SUNY New Paltz decided to create a new summer issue tradition: We're reprinting some of the most useful and relevant articles we've published since our first edition was produced in Winter 2011. The pieces we've selected describe mental health reactions to mass casualty events, infectious disease outbreaks, traumatic loss and other topics that demonstrate how timeless the human response to disaster and tragedy is. We hope you'll find it useful to revisit these articles. We also describe the new training curriculum, Fundamentals of Disaster Mental Health Practice, which we're starting to roll out statewide to train the next cadre of OMH and DOH disaster mental health responders. The program was years in the making and we're excited to start implementing it across the state.

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

In Appreciation of Dr. James Halpern

This summer will mark a significant milestone for the Institute for Disaster Mental Health as it says farewell to its retiring founder and director, Dr. James Halpern. James has been a leader in the field of Disaster Mental Health since its infancy, not only as an academician and author but also as a practitioner and responder. To each of his many efforts, be it the writing of curriculum for OMH and DOH, the creation of a highly respected annual conference, or teaching many of you in the field, James brought considerable practice wisdom, meaningful personal experience, and above all a level of humanity that represents this field at its best. We wish James all the best in his retirement and offer our sincerest appreciation for all he's given us over the years.

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Fighting Fear with Facts: *Lessons for Helpers in Infectious Disease Outbreaks*

Note: This article was first published in Fall 2014 at the height of the Ebola outbreak. While it focuses on Ebola many of the same communication challenges and principles apply to the current spread of Zika – and they will apply to whatever the next public health emergency turns out to be. If this topic interests you please note that the mental health consequences of infectious disease outbreaks will be the topic of the annual DOH-OMH webcast in early Winter 2017.

As a healthcare or mental health professional in New York State, there's little doubt you've got Ebola on your mind at the moment. DOH and OMH personnel have dedicated countless hours to planning efforts to prevent the spread of the disease, and to training for and responding to the one case that had occurred in the state at the time this was written.

Rising to that challenge in order to protect our community is the essence of why people gravitate to the helping professions. However, compounding the medical and logistical demands that are shared by all infectious disease outbreaks, the extreme fear and misunderstanding around this particular virus are clearly complicating the role of responders. Of course, fear and misunderstanding are common reactions to any new type of public health threat. Readers will probably remember the storm of rumors and mistrust that surrounded the 2009 H1N1 influenza outbreak. These ranged from the absurd (for example, because it was referred to as a swine flu, rumors spread that it could be acquired by eating pork) to the actively harmful, as claims that the vaccine was dangerous spread through social and mass media. As a result many people did not get vaccinated, leaving them subject to an entirely preventable risk.



When misperceptions like that can spread around something as relatively familiar as a strain of seasonal flu, it's little wonder that the reaction to Ebola has been so strong. Popular but pseudoscientific books and movies like the *Hot Zone* and *Outbreak* have trained the public to view Ebola as inevitably lethal – which is not true – and highly contagious, which is only true at certain times. Horrifying images and reports from Western Africa, where social practices and inadequate access to medical care have resulted in a true crisis, certainly reinforced those beliefs, priming people to overreact when the first case was diagnosed in the US.

Despite constant efforts by health organizations like NYSDOH as well as government agencies like WHO and SAMHSA to educate the public, correct these misperceptions, and calm exaggerated fears, they remain in place for many

citizens – and in some cases, healthcare professionals are paying the price. Staff at New York City's Bellevue Hospital, where an infected physician was being treated, reported being stigmatized by neighbors and even by their own family members. The *New York Times* quoted one Bellevue staff member whose hairdresser refused to provide services after learning where she worked, though she'd had absolutely no contact with the patient. And that patient himself was widely criticized for actions people inaccurately feared might have exposed others in the city, rather than being commended for his work in Western Africa for Doctors Without Borders. In fact, the only people who contracted Ebola within the US were healthcare workers who overcame fears for their personal safety to treat a symptomatic and therefore contagious patient, while another returning Doctors Without Borders volunteer was

forcibly isolated for several days despite being asymptomatic.

One can hope the fact that Ebola so far has not spread further within the US will begin to allay public fears and reduce the stigmatization of responders, but until the international outbreak is fully contained, healthcare and mental health providers need to be prepared to deal with psychological reactions to the disease as well as medical consequences among those they serve. We can draw on lessons learned in previous infectious disease outbreaks, and certainly will be able to apply current experiences to future situations. Some of those lessons include the following.

1. Extreme fear can prevent accurate information processing.

While the usual guidance on rumor control is to disseminate factual information that directly counters the false belief, that's only an effective corrective measure if people are willing to listen and are receptive to changing their views. However, Dual Process Models of communication suggest that people consider new information simultaneously at two levels, an affective level driven by emotions and a cognitive level driven by rational thought. When fear is intense, the affective level can essentially hijack the entire process, making people unable to absorb new information sufficiently to change their opinion about the threat. Unfortunately this means that it's very difficult for official communications to reduce

some people's fear enough to then open their minds to a more realistic understanding of the danger, which is extremely frustrating for those who are working hard to correct these misperceptions. Understanding the source of that resistance to change can perhaps help reduce frustration, though it doesn't correct the underlying disregard of scientific appeals.

2. Most people are terrible at accurately assessing risk. That's a strong statement, but there are countless examples of the public's skewed beliefs about relative dangers. The classic illustration is comparing the risks of driving versus flying, and of course the current example is the risk of dying from flu versus Ebola. Providing simple statistics and framing an unfamiliar threat like Ebola relative to a familiar one may help to give a more realistic perception – though flu may not be the best comparison point as many people vastly underestimate its annual mortality rates. Rather than repeating that example, officials should provide multiple different types of comparisons in hopes that at least one will resonate with the individual listener.

3. Any inconsistency in official responses will heighten uncertainty and anxiety.

Unfortunately, in a new and rapidly changing situation it's inevitable that messaging to the public will change, as will guidance to responders. However, that can be interpreted by the public not as a sign that officials and responders are adapting appropriately to the

evolving picture, but that they don't know what they're doing. Transparency in the rationale for any changes may reduce this by minimizing perceptions that changes are arbitrary, or that officials are concealing dire new information.

4. Professionals responding to serious outbreaks face significant role strain resulting from balancing professional obligations with personal and family concern for their safety.

This has been evident in previous outbreaks including Ebola epidemics in Central Africa and the global response to Severe Acute Respiratory Syndrome in 2002-2003. In addition to potentially being stigmatized in their communities, workers may face family resistance to continuing to report for work. And personal fears are not limited to worries about acquiring the disease but extend to practical concerns, such as who will care for their family if it's determined they need to be isolated for weeks.

Clearly there are no easy solutions to these issues. Fears among some subset of the population are likely to remain disproportionately high; stigmatization of healthcare workers may continue, and responders will need to manage fears about their own safety while performing professional obligations. So far the extraordinary measures taken by healthcare professionals have succeeded at preventing any further spread of Ebola within the US, but public fears may be even more difficult to contain.

Crisis Counseling after the Sandy Hook School Shooting

By James Halpern, Ph.D., Director, Institute for Disaster Mental Health

Note: This article, describing a disaster mental health responder's experience providing support after this horrific event, first ran in Summer 2013. It remains timely given the ongoing series of mass shootings nationwide, though the targeting of child victims made this response particularly grueling for all involved. We also include this article to honor Dr. James Halpern's lifetime of service and leadership in the field of disaster mental health as he retires this summer from SUNY New Paltz and from the organization he founded, the Institute for Disaster Mental Health.

On December 14, 2012, Adam Lanza killed his mother, drove to the Sandy Hook elementary school, killed 20 children, ages 5 to 7, and six adult educators, and then took his own life. Like most of us, I was shocked and horrified and soon agreed to be one of a small group of national Red Cross workers, mobilized immediately, to provide assistance to family members, first responders, and the community. While packing and driving to Connecticut I felt considerable trepidation about how I might help parents and immediate family members. While I've responded to many natural disasters and to the attacks of 9/11, it was clear that the nature of this crime and the age of its victims would make supporting survivors uniquely difficult. My self-care plan included evening calls home, regular talks with an experienced colleague, music, magazines, and absolutely no exposure to television or radio coverage of the event.

Once on the scene, coworkers and I worked alongside state troopers who were assigned to each family. Our first priority was to protect families from exposure to unwelcome sights and sounds and an extremely intrusive press. Parents were concerned for their own safety as well as the safety of their surviving children. There were bomb scares, extremists who



threatened to protest at funerals, rumors of more shootings, spontaneous memorials, and vans moving furniture in and out of the school, funerals, police processions, officials, celebrities, and the world media with lights, cameras, satellite trucks and dishes. We provided as much calm and safety as possible. We advised families on how to deal with the media. We encouraged thoughtful conversation about what families hoped to gain by telling their stories to the media and the public. We provided support when authorities (state crime victims and FBI counselors) informed families about benefits. We reminded survivors to connect with trusted friends, family, and clergy – but it was

far more necessary to support family members who did not want to connect with peripheral friends and family members who had not been heard from in years. Counselors gave permission to family members to keep unwelcome family, friends, and clergy at a distance. Not every phone call needed to be answered. We supported a strategy to place trusted friends between themselves and what was at times an unintentionally unhelpful and intrusive community.

Parents asked very difficult and challenging questions. Some were versions of the heartbreaking “how could this happen to my 6-year-old child,”

which were really not questions but expressions of shock and grief. However, often parents sought advice and counsel, asking questions such as how should the events be explained to a surviving brother or sister, and is it okay for children to watch the description of events on television, be interviewed by the press, or attend funerals or see an open casket. We emphasized the importance of caregivers providing reassurance, safety, routine, and honesty.

We shifted back and forth between offering a compassionate presence – simply bearing witness to intense grief and suffering – and providing more direct advice, counsel, and psychoeducation. I found that there is considerable misinformation about grief and bereavement. For example, one parent was disturbed to be told that seeing the open casket would be helpful to her young surviving child in order to experience “closure.” She did not feel comfortable allowing the child to witness this sight but was afraid she might be thwarting a healthy grieving process. I was able to reassure her that such exposure was not a necessary part of the healing process. We informed survivors about the significant individual, gender, and cultural differences in length and expressiveness of mourning that could cause friction. We encouraged them to tolerate each other’s patterns and styles of mourning and also to ritualize the loss within the context of the family and the culture. We also reminded parents that grief can have a ripple effect: Surviving

children have not only lost a sibling, but their parents and grandparents are grieving and are less available. We therefore encouraged them to expand their support system of trusted friends, family, and clergy.

Like most counselors, my training and academic culture falls within the scientific, secular humanist tradition, but mass casualty disasters, such as the one at Sandy Hook, make it impossible for us to avoid discussions with clients about meaning, faith, spirituality, and religion. Parents and members of the community needed to talk about death, meaning, and the afterlife and we needed to be culturally competent to have these conversations at the same time that we helped family members access spiritual/religious clergy.

I am a seasoned clinician and disaster worker and did not go into this assignment naively. Although I knew that nothing I had done previously would prepare me for a tragedy with children who had been executed, I followed my self-care plan. It was not enough. Unexpectedly, interfaith memorials intended for families, the community, and first responders, along with the presence of disaster spiritual care workers, were profoundly helpful for me. However, what was most sustaining was the constant awareness of why I was there. The dignity of the families touched by this tragedy and their sincere expressions of appreciation affirmed my belief that I was fortunate to have the privilege and honor to be of assistance.

Twice
and thrice over,
as they say,
good is it
to repeat
and review
what is good.

– Plato

Talking to Survivors after Traumatic Loss

Note: Whether deaths are due to a mass shooting like the Sandy Hook massacre and so many subsequent attacks, a transportation accident, or any other disaster that causes many fatalities, it's important for disaster mental health responders to be prepared – as much as is possible – to support survivors with traumatic losses. This article, which was first published in Fall 2012, provides guidance on how to help and what to avoid doing.

Since the defining characteristic of mass casualty incidents (MCIs) is the presence of multiple fatalities or injuries, responders to these events are likely to find themselves talking to people in the raw state of early bereavement. This state is usually intensely painful for survivors, even after expected deaths due to serious illness or those of elderly people whose passing is seen as following the natural course of life. Not surprisingly, these emotions are heightened when the loss is due to an MCI or other unexpected event.

MCIs make it hard for everyone to distance themselves from thoughts about mortality due to the presence of mass casualties – and MCI deaths are traumatic by definition. These fatalities are perceived as untimely and unfair, and often intensify feelings of disbelief, shock, and anger. The risk of complicated grief and bereavement are increased. The need for funerals and memorials is magnified, but holding them may not be possible due to the physical state of remains or the general conditions in the community. The inability to follow traditional mourning rituals adds another level of despair for survivors who may feel distressed at not being able to provide this final service for the deceased, and who are deprived of the social support these rituals normally provide.

Regardless of your professional role in the response to an MCI, you may be able to provide a degree of comfort to the newly bereaved, compensating at least partially for their inability to turn to natural support systems in the disrupted post-disaster environment. Many people will simply want someone to talk to about the deceased person, so being a willing listener can provide a more valuable service than you might imagine. However, the act of listening to highly distressed people who are just beginning to confront their grief can be disturbing and may place you at risk for burnout or vicarious traumatization. It's important to prepare yourself to take on this role, and to pay attention to your own functioning and take a break or seek out someone to talk to yourself when needed.



Some points to keep in mind when talking with loved ones about a death in the family:

- The emotional phases in an MCI may be very different from other disasters: Don't expect to see a "honeymoon phase." Depending on when you speak with family members you'll see very different kinds of emotions. Early on you're more likely to see shock and disbelief, followed later by sadness and grief. Anger may also be present at any point, and may occasionally be misdirected at helpers simply because they're there and the truly responsible party isn't.
- Although feelings change over time, everyone copes and grieves differently. There are enormous cultural and gender differences, particularly in terms of expressiveness. Some responders react to extreme emotionality with fear and can wrongly assume that the individual is more disturbed than he or she is. Others believe that people must experience and express intense emotionality or they're not processing the death properly. Don't judge survivors if they show significantly more or less emotionality than you think is appropriate.
- The notion of "grief work," meaning that people need to go through a series of stages of mourning in order to successfully adjust to loss, is now generally dismissed by bereavement experts, yet people sometimes feel they're not mourning correctly if they don't pass through a culturally imposed series of stages.

The following are some questions concerning culture and ritual that you might consider asking when speaking with survivors. The nature of these questions will change depending on how long after the death you meet with family members, and the attitudes and culture of the survivors:

- According to your culture/religion, what happens after death?
- What are your religious or cultural beliefs about how to best mourn a death? Have you been able to fulfill these expectations?
- Are family members in agreement about handling the funeral or mourning rituals?
- Are there funeral or memorial rituals you'd like to perform but have not been able to accomplish?

Answers to these questions may point to tasks you can assist with or resources you can connect the survivor with, and talking through them can also help survivors structure their thoughts and begin to take planning into their own hands.

Finally, the following are some statements people often default to when they don't know what else to say after a death. Though well-meant, these platitudes provide little real comfort and should be avoided:

“You'll be alright.”

“You must be strong for your children / parent.”

“This too shall pass.”

“I know how you feel.”

“It could have been worse.”

“At least he's no longer suffering / you had X time together,” or anything else beginning with “at least.”

Also avoid religious statements like “It was God's will” or “She's in Heaven / in a better place / with God now” unless you know for sure that this is in keeping with the person's values or beliefs – and be cautious even then. Someone who usually takes comfort in their faith may currently be feeling betrayed or abandoned by it. Instead, consider offering these statements of condolence and support:

“I'm so sorry for your loss.”

“I can't imagine what you're feeling right now, but I will be here to help you however I can.”



Children and Media: *The Hidden Stressor*

Note: This piece, first published in Summer 2014, provides advice on limiting children's media exposure post-disaster – advice that applies to adults as well, including responders.

In times of disaster or crisis, many people's immediate reaction is to turn on the television or other mass media outlet to find out what's going. That's a natural and often productive action when there really is a potential threat looming: We need to know what's happening, if we're in danger, if we need to take protective measures, and so on. However, in that quest for information it's easy to become so transfixed by sensationalized media coverage that we can't tear ourselves away despite the often repetitive nature of programming as reporters attempt to fill the void of actual news (we're looking at you, CNN, after Malaysia Airlines Flight 370 disappeared, though other networks are equally guilty).

It's also easy to overlook who else may be exposed to that media – specifically, any children in the home. This combination of factors means that children may absorb hours of dramatic coverage without their parents realizing it, or recognizing the potential impact of that exposure. Perhaps the best known example of this is the numerous anecdotes and research studies (i.e., Otto et al., 2007) that reported elevated rates of PTSD symptoms in children who experienced extensive television exposure of the 9/11 attacks. Younger children in particular were often described as being unable to recognize that the constantly repeated images of the planes hitting the buildings were not actually new incidents. This misperception created an ongoing sense of threat that

kept physiological arousal high rather than allowing children to regain the sense of safety that's an essential first step toward recovering from a traumatic event.

Another issue parents may not consider is the potential impact on very young, even pre-verbal children: Caregivers may think their kids are too young to grasp what's happening on TV, but even if they don't understand the words, they may pick up on presenters' intense negative emotions, creating a sense of uncertainty or anxiety that compounds perceptions about a parent's distress.

Media exposure can influence older and children and adolescents as well. For a study that was published in the journal *Pediatrics*, Comer et al. surveyed 460 Boston-area parents/caretakers who reported on their child's (ages 4 to 19, mean age 11.8 years) experiences during the week of the Marathon attack, which included extensive media coverage of the pursuit of the two suspects in addition to the bombing itself. Caregivers also reported on children's psychosocial functioning in the first six months after the attack. Not surprisingly, children who were present at the marathon when the attack occurred, who knew someone who was injured or killed, or who were directly exposed to elements of the manhunt (such as seeing armed police in their neighborhoods) experienced PTSD symptoms at significantly higher rates than those who did not. Looking



at the role of media, these parents reported that children had extensive exposure to television coverage of the attack day, averaging 1.54 hours that day – and only about one-third of parents reported that they attempted to restrict exposure to coverage of the attack or subsequent manhunt. Controlling for demographic characteristics like age and family structure, regression analysis found that longer television exposure was significantly associated with PTSD symptoms, conduct problems, and total difficulties over the next six months. As the authors conclude, “Despite needs for live information during disasters, increasing evidence suggests parents should minimize children's media-based exposure to whatever extent possible” (Comer et al., 2014, p. 6).

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Maintaining Responder Resilience through Extreme Disasters: Self-Care Beyond Lip Service

Note: This article, printed in Fall 2013, summarizes points provided in a training that had recently been held by the Institute for Disaster Mental Health at SUNY New Paltz and webcast to more than 30 DOH and OMH facilities statewide. We revisit it here because self-care remains just as important and just as neglected by most responders.

How many times have you attended a professional training that concluded with a brief reminder about the need to practice self-care? It seems like it's become standard procedure to include some token acknowledgment of the need to get enough sleep, eat well, exercise, and so on. Too many of us in the helping professions are quick to offer the same guidance to others, but slow to follow it ourselves.

Yet it's become increasingly clear that the changing face of disasters means we need to stop paying lip service to self-care and start actually practicing what we preach. Probably everyone who plays any role in disaster preparation and response in New York State recognizes a number of recent trends: Disasters and crises seem to be happening more frequently overall; some events, like Hurricanes Irene, Lee, and Sandy, are enormous in scope and long-lasting in their impact; and other events, like the shootings in Webster, NY, and Newtown, CT, are notably intense in the anguish they expose us to. And for many people these acute incidents are occurring amid more chronic stressors like economic struggles and job insecurity, as well as the usual demands around family, work, and so on. To put it simply, most of us are stressed, and we need to learn to address that stress in order to stay personally and professionally resilient.

That was the focus of a NYS DOH-sponsored training that was delivered by Dr. Mary Tramontin, clinical psychologist and experienced American Red Cross Disaster Mental Health Volunteer, and Dr. Karla Vermeulen, SUNY New Paltz Assistant Professor of Psychology and IDMH Deputy Director. Their goal was to give participants specific skills to develop plans for improving their self-care habits.

Key points from the training:

Not all stress is bad! In fact, many people who are attracted to challenging professions like ours thrive on "eustress," the positive demands that keep us engaged and performing at optimal levels, and we're often able to bounce back quickly from acute stressors. However, forms of stress that are chronic or traumatic can affect our physical and mental wellbeing if we're unable to cope with them effectively.

The concept of resilience is receiving a lot of attention these days, but people are often using the same label for very different processes including:

- Resistance - apparent immunity to typical impairment of functioning in response to stress or trauma
- Recovery – the ability to rebound, to regain equilibrium, to return to a state of health
- Sustainability – continuation of recovery, possibly even resulting in growth and enhancement (e.g., post-traumatic growth)
- Resilience is a result of wellness, which is a result of self-care.
- Wellness involves multiple domains: Physical, Emotional, Intellectual, Occupational, Spiritual,

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and Social/Relational. Different domains may be more important for different people, and even for the same person at different times, so developing self-care practices in multiple domains is kind of like cross-training in physical fitness: It gives you more tools to draw on in times when your usual habits may not be possible or sufficient.

- Self-care begins with self-awareness, or being mindful of what you're experiencing physically, emotionally, and cognitively rather than focusing entirely on action and ignoring how stress is impacting you.
- Self-talk is also a key element of self-care. For example, when you're heading into a disaster response or other stressful activity, what do you tell yourself about your training and abilities? Do you have automatic thoughts or beliefs (i.e., "I can't handle this") that undermine your confidence and increase your stress? Or thoughts that keep you functioning but prevent you from paying attention to your wellness needs (i.e., "I'm the only one who can handle this so I'm not going to take a break")? If so, you can learn to recognize these thoughts and replace them with more productive internal messages.

Training participants were encouraged to establish two types of self-care plans:

- 1. A growth goal for everyday life.** This involves identifying an area you want to improve, where you will commit to establishing a new practice to bolster wellness and resilience. Essentially this goal is to build up your strengths in advance, so positive practices are easier to call on times of high stress.
- 2. A maintenance goal for disaster response work.** This means committing to consistent use of established and effective self-care practices during a deployment. You're far more likely to practice at least basic self-care during a response if you have a specific plan in place for how to do so.

We hope you'll try this planning for yourself. As a minimally stressful starting point, try this simple step: What is one self-care practice you will commit to doing daily for the next 30 days? Make it an achievable goal – it may seem small, like singing again while in the shower or eating more vegetables.

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That said, it's important to distinguish between PTSD symptoms that may be related to media exposure and full-blown clinical PTSD, a point made by the diagnostic criteria for PTSD in the fifth edition of the Diagnostic and Statistical Manual, which specifically states that for adults and children age 6 and over, "exposure through electronic media, television, movies, or pictures" does not qualify as a triggering experience "unless this exposure is work related." The newly added PTSD criteria for children 6 and under note that

witnessing an event "does not include events that were seen on the television, in movies, or some other form of media."

Therefore, parents should be encouraged to limit children's exposure to dramatic television coverage and other disaster-related media in order to prevent adding to their distress, but they should also be reassured that inadvertently allowing a child to overhear news in the first quest for information is not likely to cause lasting serious harm. Still, anything that can be done to shelter children from unnecessary

distress is certainly worth recommending. Really, the best advice of all may be to encourage adults as well as children to step away from the screen and to avoid the compulsion to constantly monitor breaking news when none is really occurring, but to check television or websites every hour or so when there may actually be new information worth paying attention to. Doing so is likely to interrupt the constant stream of stimulus that increases hyperarousal for adults as well as children and prevents us all from regaining a sense of safety.

Introducing the *New Fundamentals of Disaster Mental Health Practice Training*

After years in development, the NYS Office of Mental Health and Department of Health are delighted to be rolling out a new curriculum and training program for disaster mental health responders statewide. Fundamentals of Disaster Mental Health Practice was developed by the Institute for Disaster Mental Health at SUNY New Paltz to replace the decade-old Disaster Mental Health: A Critical Response (DMH:ACR) curriculum previously in use throughout New York State.

The devastation caused by Hurricanes Irene and Lee in 2011 and Sandy in 2012, as well as numerous other weather-related events, transportation incidents, and other disasters, have demonstrated the need to maintain a well-trained corps of responders. However, changes in the field since DMH:ACR's creation resulted in at least two limitations regarding its continued use. First, research in the field of disaster mental health has evolved dramatically since the original curriculum was produced in 2006 so there is now much greater understanding of essential issues like risk factors, typical and extreme reactions, and evidence-based interventions. Second, that course took two full days, making it a prohibitive commitment for many facilities and individuals with limited training time available.

It's clear that the response environment has changed as we move into an era of mega-disasters resulting in protracted mental health support needs. It's equally clear that trainings now need to emphasize efficiency and to focus on practical interventions, while being grounded in current research. Therefore, the Bureau of Emergency Preparedness and Response at the NYS Office of Mental Health, in close collaboration with their counterparts at the NYS Department of Health, Office of Health Emergency Preparedness, commissioned the development of this new training program.

Materials were produced by Dr. James Halpern and Dr. Karla Vermeulen from the Institute for Disaster Mental Health at SUNY New Paltz (IDMH). Since IDMH began working closely with OMH and DOH in 2008, its staff members have delivered the existing DMH:ACR and Psychological First Aid (PFA) modules and developed multiple supplemental modules on specific audiences and event types. For the current project, a series of discussions and pilot tests with experienced trainers and other OMH and DOH personnel led to the design of this one-day training that is intended to:

- Update all content to reflect current research and best practices
- Emphasize interventions, with opportunities to practice PFA and other skills

- Provide additional resources for participants who would like to delve more deeply into background information

To launch the new program, Drs. Halpern and Vermeulen delivered train-the-trainer sessions in New Paltz and Syracuse in early Summer 2016, presenting the curriculum to a total of about 40 OMH and DOH personnel from regions ranging from Buffalo to Staten Island. These trainers are now beginning to deliver the curriculum in facilities statewide, with administrative and organizational support provided by OMH and DOH.

If you're interested in organizing a training delivery in your facility or region, contact either OMH at: dmhomh@omh.ny.gov or DOH by contacting your Regional Training Center (RTC). Note that this curriculum is intended for mental health counselors, social workers, psychologists, psychiatric nurses, and others with graduate-level mental health education or the equivalent. Other people without that background should be encouraged to train in PFA, which includes guidance on knowing when to make a referral to a trained DMH helper. Social Work Continuing Education credits will be available for participants provided certain conditions are met regarding the trainer and class composition.

We plan to hold two more train-the-trainer sessions in the future targeting the Western NY and NYC/ Long Island regions of the state. If you have been a trainer using the DMH:ACR curriculum and would like to learn to deliver the new program, let OMH know at dmhomh@omh.ny.gov. In order to maintain the highest possible level of quality as the curriculum is rolled out statewide, trainers are expected to have been previously trained in DMH:ACR or Fundamentals of Disaster Mental Health Practice and to have direct disaster mental health response experience. Masters-level mental health training in counseling, social work, or related fields is generally expected, though exceptions can be made at the discretion of the OMH and DOH program managers, e.g., psychiatric nursing or Credentialed Alcoholism and Substance Abuse Counselor.