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(EFFORTS TO PROVIDE SUPPORT AND PREVENT STRESS-RELATED PROBLEMS IN POLICE OFFICERS POST-PARKLAND, 10/20/18)

(The following may contain unintelligible or misunderstood words due to the recording quality.)

STEVEN GELLER: Good afternoon. Thank you all that came back. We appreciate it. We weren't sure how much of an audience we were gonna have. So the fact that you're here, we are grateful. You got to see Corporal Gist this morning and she was absolutely wonderful. We got to see how she went through it just a year and a half ago, and it was her own trials and tribulations. This is gonna turn into an infomercial. I get it. But it's very important. One of the things that she said was, took a doctor giving her an examination to say, "Hey, have you seen anybody? Have you gone to a mental health professional? And if you haven't, you need to." And she didn't want to go.

The sell here today -- and I emphasize it's a sell, because it works -- it has to do with peer resources, knowing that you have fellow officers out there who've been through trauma. That trauma, it goes from generation to generation, agency to agency. And we have a history of it. So if we start off talking about the history, we know that it started off in the Civil War. Guys that were fighting would come back and they were acting strange. So they called it soldier's heart. They thought that it was a

disorder, that if these guys got some rest, we could sent 'em right back in.

Then in World War I, they called it shell shock. Shell shock, which is what they thought was standing too close to a bomb when it went off, you got shocked from it. These guys were coming back. It wasn't until they realized that guys weren't around shock, they're coming back from war, they're coming back from battle and they're not the same. Something's not right with them.

So finally we move on to World War II and we call it battle fatigue. We're getting closer. The fatigue part starts to become the mental part of it, the fatigue. Then we move on to the Vietnam War. The Vietnam War, soldiers are coming back and they're not adjusting well. And that's when we start to realize as a nation something's deeply wrong and we need to classify it differently. It's not just the body, it's a physiological -- it's the mind. Something's not right with the mind. So with that being said, I'd like to present to you a short video. Some of you are gonna know it. Most of you go, "Oh, I know this song, but I didn't know what it was about."

Kevin Wells and Andre Pessis wrote a song, and it was actually handed over to Huey Lewis and the News. And I present to you this song because I think that it kind of explains what post traumatic stress disorder is like for those who are living

it.

[Video played]

Quick show of hands. How many have heard this song before? Keep your hands up if you knew what this song was about. There you go. Gonna have to move on to the next. Okay. Okay. Kendra, there we go. Okay. So looking statistically, there were 2.7 million people who fought in the Vietnam War. Fifty-eight thousand, two hundred and twenty perished. The average age was 22 years of age. And there were 150 to 200,000 suicides since that time. It means that we weren't getting it right. When our soldiers came back -- there we go. We realized that it was a shameful history that we went through.

There were three main reasons doctors, psychologists, psychiatrists attribute to soldiers not doing well. One was gorilla style fighting, the second was witnessing a trauma, and the third was just a lack of support. That lack of support came from the community, it came from their own regiments, the VA. It just wasn't progressing well for soldiers as they were returning home. And we know what the results are from these soldiers. It's now called Post Traumatic Stress Disorder. And we know that as defined trauma, which is a deeply distressing or disturbing event, is what these men and women saw.

The VA is trying to do a better job. And I think they have, but they're not where they need to be. On any given

night, 830,000 returning veterans are now homeless, living in the streets. And it's estimated that over 90 percent to -- I would venture to guess 99.9 percent have some form of mental disorder.

So how does that equate? Now we gotta bring it over to our industry. If we want to professionalize our profession, we have to address it, we have to have a system in place. And that brings us to an agency that got it right. That agency was Coral Springs. On February 14th, they had the Parkland incident. And I'm not gonna rehash that whole incident, but I do wanna give out proper props to the Chief, Tony Pustizzi, now Chief Clyde Parry, Shawn Backer, Brad McKeon, Captain George Soberon, Brad Mock, and Ryan Gallagher, and finally, Jerry Irwin.

The night of that incident, they went down a checklist of things that they had to do. And they got down to contacting another agency that can bring in peer related officers that can assist and debrief and get these officers to understand what they've just been through, and that's trauma. The things that they saw can never be unseen. The things that they heard can never be unheard. That night, it was complete chaos as it was described to us when we went the following day.

I'm gonna turn the microphone over to Dr. Van Hasselt, who is integral in the critical incident stress management for Broward County. He's trained many of the officers there. And

Coral Springs was aware that you can use your own people. A lot of them went through the trauma. But you can reach out to other agencies, and that's what they did. They reached out to Plantation and Pembroke Pines. And I'll let Dr. Van Hassel explain how that phone call came in and then what transpired over the next week.

VINCENT VAN HASSELT: Thanks, Steve. Good afternoon, everyone. Can you hear me okay?

AUDIENCE: Yes.

VINCENT VAN HASSELT: All right. Thank you very much. I have to move around, so I have a lapel mike. First, I wanna thank you very much. It's an honor to be here with you this afternoon. I'd also like to thank Kendra and Sierra for setting this up as well. They've done a wonderful job helping us get this together. So I'm a clinical psychologist. I'll give you a little bit more of my background a little bit later, but I've also been a reserve officer. I've been a clinical psychologist for about 35 years. I've been a reserve officer with Plantation PD for about 22 of those years. And much of what I do know with Plantation involves our Crisis Response Team. So that includes hostage negotiations, deal with barricaded suicidal subjects.

But I always half jokingly say that over the course of my career with law enforcement, I've spent half my times dealing with problems related to the job and those problems related to

those, you know, working on the job. So the big focus of what we're gonna talk about today will be the problem of PTSD and related issues. However, what we're also gonna present to you is a model -- I call it a four-legged chair 'cause there are four components to it -- that really are ideal in terms of best practices model, to be able to prevent these sorts of problems.

But I do wanna say a few words first, specifically about our response, as Captain Geller mentioned. I got a phone call from one of our local police agencies, it turns out, in our county, which is Broward County, Florida. There are three police crisis response teams that are also trained in critical incidence rescue management. Has everybody -- raise your hand if you've heard of CISM. Okay, great. Raise your hand if your agency has people trained to do CISM. All right. Well, that's very good too. Okay. That's one leg of that four-legged chair. And we'll see why that's the case later. It's really important to have these types of teams in place.

Plantation had one, another department -- Pembroke Pines Police Department had their crisis response team people cross trained in negotiations and crisis response, and Coral Springs itself had a team in place. They couldn't really work with their own people. If you know something about the model, you know that ideally, you don't work with your own agency with your own people if you've experienced a critical incident.

So what we were able to do is mobilize quite quickly. And I believe we were there probably the next morning for the first briefing at 5:00, meeting with officers as they were coming in. And we did so, I think, just about every hour for at least three or four hours. But we also set up other meetings. We had group meetings. In fact, some of the groups were quite big. I think we had between 40 to 50 of the officers in one meeting, who had gone into that school immediately upon arrival to the school. We also had a group where we met with those officers who had set up the perimeter, but were also directly involved in the incident.

So what we did in a sense was a modified critical incident debriefing. Now, if you're familiar with these, you know ideally you don't want the groups to be more than 20 or 25 people. Can't always do that, you know? What really works -- what you're able to do in the real world isn't always the ideal. But we wanted to make sure we had the opportunity to speak with each and every officer. Some we met with individually, some we met with in small groups, some we met with in larger groups, as I mentioned. Captain Geller also met with communications, with dispatchers.

By the way, you think that's a high risk group for trauma? Do you think they get much attention? No. Let me throw out another group I'll talk about later if we have time -- crime

scene investigators. Do you think that's a high risk group for trauma and the effects of trauma? Do you think they get much attention? Not really. I got a call very recently from a South Florida group of crisis crime scene investigators asking if I would talk to them to talk about how to prevent PTSD and related problems, which I'm gonna do.

Any group that's exposed to trauma repeatedly is at risk for stress related problems. It's not always PTSD, but in many cases there are other problems related to that or else it's misdiagnosed, which I'll talk about in a minute. But what is our goal working with Coral Springs? We were trying to get in quickly, meet with people quickly, see how they're doing, go through a debriefing process. Because essentially, if you're familiar with CISM, you know that it's a small amount of time and effort invested in a very big payoff. And the payoff is to prevent problems later. Okay?

And often, you know, many chiefs and deputy chiefs will say to me, "Well, do we really need this?" And I'll say, "Yes, you do. It's one piece of the puzzle. You need more. You can't just do CISM and you can't just do debriefings." And we'll talk about what all goes into the CISM model in a few minutes as well. But it's a critical element and thank goodness I got Coral Springs administrative staff, the chief, assistant chiefs and everybody in the department were very supportive. 'Cause if

you don't support this, it's just not gonna go. Okay? So we had the opportunity to do that.

A couple of other things we did, we had a family support night where we met with families of officers who wanted to attend. I was asked to come -- I guess it was two days later -- to do a family support night with firefighters who also responded to that. Now, if you know something about firefighters, they're a pretty organized group and they had the briefing teams coming from all over the state and up north in Georgia, so they were pretty well accounted for. The problem was though, then these teams leave. Then they leave. All right? Who's there to follow up.

So that's why we'll talk about a couple of other pieces to that are also very important because you need to follow up, you need the continuity of care, need a comprehensive approach if you're gonna prevent the kinds of problems we're gonna talk to you about today. And part of my job is to tell you about the problems. The other part of what my job is today, to tell you about some of the possible solutions. Okay? Steve, you wanna continue?

Okay. Just very quickly, about my background, I mentioned I'm a psychologist. I'm with Plantation Police Department at Nova Southeastern University. Couple of things that aren't on there though, I've been a lecturer and consultant to the NA --

particularly their stress course for probably about 20 plus years now. And I'm sure -- how many of you guys have been to the NA? All right. Good number of you. And as you know, there you really get an opportunity to meet with other police professionals around the country and around the world. And one thing I did learn is that gee, the problems are more similar than different. 'Cause you also get international people at those, and when I've had an opportunity to speak with them, what a great learning experience 'cause you see that they've already shared problems. They have the exact same issues that they deal with if they're in Germany, France, or in this country. So that was very enlightening years ago. The other thing that's not up here is I was in private practice probably for about 25 years. I'm not now, but most of my practice specialized in the problems of police officers, firefighters, and dispatchers. All right?

And I can tell you some funny stories about, you know, how people come in for help. 'Cause, you know, if a cop is coming in on his or her own for help, man, there's a story there, isn't there? All right? So put your seatbelt on. So it's always been very interesting. I'll talk some more about that in a little while. All right. So let me give you some bad news. And you guys are probably familiar with the statistics.

And I can tell you in a nutshell, you name a mental health problem outside of schizophrenia and bipolar disorder -- throw

those out for a moment -- but most other mental health problems like substance abuse, sleep problems, depression, and PTSD -- they occur almost at two to three times the rate of civilians. Does that surprise you? All right. Let me take the first one, substance abuse. Do you think that substance abuse, historically speaking, has been a problem in law enforcement? Yes. All right?

Now, let me tell you why though, 'cause this is part of what the feedback is, the information we give to officers when we're doing debriefings. And this is usually part of what I do. All right. Look -- and this -- I'm gonna tell you like I tell them. Substance abuse by itself is not the issue. Hey, I like a Mojito. I live close to Miami, I lived in Pittsburgh for 12 years, I learned about a Boilermaker, if you guys are familiar with what a Boilermaker is. How many of you know what that is? Yeah, good. Shot and a beer -- any kind of beer, any kind of shot. All right?

The issue is not the drinking, it's the timing. All right? And if somebody's pattern is to drink or drink heavily after a critical incident occurs, that's doing something to you physiologically. And what it's doing -- you guys know if you're sleeping next to your husband, wife, boyfriend, girlfriend, whatever your partner may be, and there's a little movement under their eyelid where's it's bouncing around. Have you ever

noticed that? And whoever's sleeping next to ya -- that's called REM sleep. I'm sure you've heard of rapid eye movement sleep.

Well, the more you drink, the more it screws up your REM sleep. And the problem with that is REM sleep is what processes or gets rid of the stress you had from the day before. Very important for that. Okay? How you get rid of stress has a lot to do with how you sleep. And the more you drink, the less the REM sleep, the less you're able to get rid of that stress. So if somebody's chronic pattern is to, "Hey, when I have a bad day, I go drink and I drink heavily," what's happening to that stress that they had if they had a particularly bad day? Not getting rid of it. It's still there. Okay? So it becomes a chronic sense of stress or condition of stress.

So that's the big issue of substance abuse, right? I tell the guys, "Look, it's not I'm not telling -- I'm not gonna talk about the evils of alcohol, watch the timing." All right? But we know substance abuse occurs -- alcohol abuse at two or three times the average of civilians in law enforcement.

How about this little matter, sleep disturbance, 40 percent. Now, when I'm talking about sleep disturbance, that means difficulty falling asleep -- it takes you an hour or two or a long time to get to sleep -- sleep continuity disturbance, which means you wake up repeatedly during the night -- does this

sound familiar -- or early morning awakening. All right? You wake up too soon or some combination. I'll tell you about a case I had of a federal level agent who was up at ground zero, immediately was deployed right after the attack. Hadn't slept for more than about two hours for three weeks.

At the point in which I saw him, he looked schizophrenic, all right? He looked psychotic. He hadn't slept. He was starting to hear voices, he was starting to see things. He wasn't schizophrenic, he hadn't slept. All right? So that symptom by itself is a problem. And if you have 40 percent of police officers characterized by some level of that, that's a problem. All right.

How 'bout depression, anxiety, anger management, and all these sorts of things? Two to three times the level of civilians. Hey, I don't have it up there. How about divorce rates? Higher or lower than civilians? It's higher. All right? But let me play devil's advocate with you for a second. All right? Let's say I have that first one behind me. All right? I'm not gonna make the same mistake the second time around? I'm a little older, I'm a little wiser. All right? Not gonna do the same stupid thing. What do you think the divorce rate is for that second time around?

AUDIENCE: Seventy percent.

VINCENT VAN HASSELT: I hear the number. What is it?

AUDIENCE: Seventy percent.

VINCENT VAN HASSELT: Seventy percent for second marriages. All right? Now, we know that when we have these sorts of difficulties, they put a strain on the relationship. And one of the hallmarks of what we're gonna see on our next slide -- oh, okay. It's coming up after this. In fact, do we have the video to show first? All right. This is a video I think you might find interesting on post traumatic stress disorder in a police officer who was interviewed about it.

[Video played]

VINCENT VAN HASSELT: All right. The best estimate that we have now is that roughly 25 percent of police officers have PTSD. Now, the last number that I heard in terms of the number of local police officers in this country is about 800,000. Does that sound right to you? Is it close? All right. Now if that's the case, that means that close to 200,000 police officers are running around with post traumatic stress disorder. All right?

So is that good news or bad news? That means that 75 percent are fine. They're doing quite well, as far as we know. Twenty-five percent, they're not doing so hot. To me, I've always been a glass half empty type of guy. I think that's way too many, especially in a problem that's preventable and treatable if you do the right things. All right?

Now, what I'd like to do is take you through something. As a clinical psychologist, if somebody walks into my office, I'm gonna go through how I determine if they have this disorder or not. And at the same time, I'm gonna make sure that the criteria for this are very clear. 'Cause typically, when we think of post traumatic stress disorder, we think of a couple of key symptoms. Anybody yell out -- when you think PTSD, what comes to mind? What's that?

AUDIENCE: War.

VINCENT VAN HASSELT: A war. But what symptom might come out of that? Ah, good. I heard flashback. What's another one. Oh, alcoholism. Okay. Hang onto that. We'll come back to that in a minute. All right? Flashbacks, nightmares usually a response to war or some kind of combat condition. Somebody has or is diagnosed with PTSD, at first a couple of criteria are met. They've been exposed directly to some violent or aggressive act that's beyond their threshold for acceptance. But it doesn't have to be just that. Somebody could've witnessed this happening to another person, and not be directly, physically affected by it themselves, but they just witnessed. Somebody else was a victim of a violent or aggressive act of some sort. Now, it's not just those two. You can be ware that a loved one or friend was a victim of a violent or aggressive act. You didn't see it, you didn't hear it, but you

heard about it. That can lead to PTSD. Fourth, you can have somebody who's dealing with the aftermath of a violent or aggressive act. And I think the easiest example of that, crime scene investigators. All right? They go in after the fact. So just keep in mind it's a fallacy if you think somebody has to be directly involved in an incident to have the impact of post traumatic stress disorder. So keep that in mind first.

And now let me go through the symptoms with you. Intrusion symptom: so that's where we do have the nightmares, the distressing memories, the heightened reactivity and the flashbacks. So this is kinda what most people think about with post traumatic stress disorder. Now, when I'm giving a diagnosis, it's very much like a Chinese menu. And it goes usually like, well, if you have one from A, two for B, you know, and one from C, you might have whatever the disorder is. So far, let me just say with intrusive symptoms, if you have one of them, you're on your way. You can have more, but you need at least one of those symptoms for me to think, "Oh, I'm gonna diagnose somebody with post traumatic stress disorder."

Avoidance symptoms -- thoughts, feelings, people, activity -- you're avoiding all those sorts of things that may in some way remind you or have some kind of -- give you some sense of a bad feeling connected with the experience that you went through or somebody else went through that's causing you the problems.

The isolation is particularly difficulty. When somebody is isolated, they're not making use of their peer support system or family support system, which is crucial to try to prevent this.

So again, looking at a Chinese menu, you just need one of those. All right? So, so far, if you have one from A and one from B, we're sort of on our way. Alterations in cognition and mood, all right -- memory loss, short term, long term -- it's usually short term for the event itself -- blame. Who are they blaming? Themselves. What did I do? I must've done something. How did I get in this situation? How'd I put myself in this? Why didn't I handle this better? Why didn't I do something different? All right? Self blame, and related to that guilt.

A negative state means basically depressed, a negative view of themselves, the future, the world, some combination of those things -- which is part of depression, by the way -- diminished interest, withdrawal, not doing things they used to like to do. They used to like to fish, you don't care about fishing. You used to like go hunting or motorcycle riding with your buddies, you don't wanna do that anymore. Okay? Also a symptom of depression, by the way. An inability to experience positive emotions -- you need two from that one. All right? You need two.

Alterations in arousal in reactivity -- this is another big one -- anger, recklessness, self destructive behavior, hyper

vigilance, exaggerated startle response, concentration difficulty, sleep disturbance. Let me just talk about hyper vigilance for a second. There's a very good book that was written almost 20 years ago by a Dr. Kevin Gilmartin. Many of you may have read the book, "Emotional Survival for Law Enforcement." If you've read it, he spends a lot of time talking about the hypervigilance rollercoaster. All right? Which means when you're working, when you're on road patrol, all the different physiological and psychological indices are kind of up.

When you're responding to something that, you know, is particularly exiting or requires your attention and really revs up the vigilance, what's going on with your blood pressure? Up. What's going on with your heart rate? It's going up. What's going on with your -- what's called galvanic skin response? You're sweating more. All right? But just keep in mind the heart rate and the blood pressure 'cause those are particularly important.

So what Gilmartin said was well, when a police officer is working, all these things are up. When you're on a call, all right, then they come down. In between, they go up. If you have something else you have to do, then you're at home and everything is kinda depleted. All right? It's like the adrenaline is gone. And in some cases, people get isolated or

less interested in things that are going on at home over time, and it presents a problem in families.

There's a piece he was missing though, I tell ya, and that has to do with this. If a police officer is not working -- and let's say shopping out around town doing something -- do you think you guys are more vigilant than civilians about what's going on around you? You think you're paying more attention to that suspicious vehicle or person -- there's something going on somewhere -- than the civilian? Sure, you are. Now, when you're doing that, what's happening to your blood pressure? All right? Yeah. Well, all the time. What's going on with your respiration? All right? What's going on with your heart rate. All right?

So in a sense, there's not a switch that turns this off for a lot of people, and you have the vigilance on throughout the course of a career or a lifetime. So I think what Gilmartin missed was that piece to it. It's not just when working, because as we know, a lot of police officers -- I mean, most of 'em are very vigilant when you're on your own time. Okay?

Sleep disturbance. Oh, and the gentlemen mentioned it's not a part of the -- and by the way, you need two of these. You need one from A, one from B, two from C, two from D. It can be any one or any of the two when you have post traumatic stress disorder. And the symptoms have to be with you from like, about

five or six weeks. All right? Up to that point, we don't call it PTSD, we call it acute stress disorder. All the same symptoms, but you haven't had it long enough to get the diagnosis.

Now the good news is, most people after four to six weeks, they're pretty good shape. All right? They get through it. They might still be a little rattled, but they don't have enough of the symptoms to be diagnosed, but some do. And when it goes past that four to six-week mark, then we're talking about post traumatic stress disorder, which is why we try to catch these things early, all right, before they come what we call consolidated. The earlier the better. The smarter up front you are about these sorts of problems and focus on prevention, the less trouble you're gonna have later. Okay?

All right. Let's see. Oh, so what the gentleman was saying, substance abuse. Why would someone with PTSD drink heavily? What's that?

AUDIENCE: (Unintelligible).

VINCENT VAN HASSELT: Yeah. Basically, self medication, trying to mask the issues. All right? That's not unusual at all. That happens quite a bit. When you also see though high levels -- particular high levels of anger and irritability. And what happens is this, if you don't have mental health people -- which is what I tell law enforcement administration all the time

-- be careful who you have providing services for your department. Do you trust the EAP to be properly trained to deal with police officers and problems like PTSD? Maybe they are, but my experience is that most aren't.

'Cause when we have an officer coming into an EAP saying, "Well, I'm drinking too much," they start treating the drinking. "I'm not sleeping well." They start treating the sleep problem. When in fact, those are symptoms of the bigger problem, Post Traumatic Stress Disorder that provider's missing, providing incomplete treatment, and that guy or woman is not gonna get better. Okay? So you need people who know what they're doing and you have to be careful who you select to do these things.

All right. Now, I'm not gonna spend a lot of time on this. You guys know this as well. You know the estimate for suicides in law enforcement -- and a lot of departments have 'em. We certainly have had 'em in Broward County, I think, half if not more of the departments in our county have had at least suicide since I'd been there a little over 20 years. The estimate has always been that twice as many officers kill themselves as are killed in the line of duty on average per year. Okay? Interesting fact also, most of these suicides are proceeded by serious relationship conflict. All right. So, if you have marital relationship problems, that's a very strong predictor for self harm. Like, that's just how it is.

All right. Let me just run through this quickly. There are a bunch of risk factors. And this comes right off Hostage Negotiations 101 because we always train our negotiators. And you guys probably do this as well in your agencies. What to look for? You have somebody in crisis. Let's say they're barricaded, they're suicidal. What are you listening for? Now, what are the keys that tell you or what do you -- what helps you to be aware that somebody's a greater risk for suicide. And this comes up later in a few minutes when we're talking about peer support training. 'Cause if we try to train here, it could be a support people to other officers, they need to know these as well.

So, let me just hit a few of the highlights. Hopelessness is one of the big ones. It's enough to be depressed. Depressed people certainly are at risk for suicide. But if they give you statements of hopelessness, such as, "My life will never get better. Everything's a mess. I'm such a loser. I'll never get better," you know, those sorts of hopeless statements, great predictors of suicide. So, we always tell our negotiation team, if you hear those kinds of statements, put that on your situation board because you know that this guy's a risk or woman.

Prior attempts, always a big predictor. If he tried it before, maybe he'll do it next time. The best predictor of

future behavior is -- past behavior. All right? So past attempts, very big. If you have schizophrenia, bipolar disorder and serious depression, examples of major dental disorders that are higher risk -- especially schizophrenia and bipolar disorder and polysubstance abuse -- we don't have time to get into all that -- but certainly, alcohol and substance use distorters mixed with some of these other things that are a risk.

How about this. Does suicide run in families?

AUDIENCE: Yes.

VINCENT VAN HASSELT: Yes. Yes and no. What runs in families is depression. All right? Depression runs in families, which can lead to suicide, so it makes it a greater risk. What we say about all these mental health problems. This is a little on the side. I don't know how interested you are in this, but almost every serious mental health problem has a genetic piece to it. We now know that from research. So that means that if mom or dad was schizophrenic or bipolar or a substance abuser, is there a greater risk for that kid to have something? Sure, for PTSD.

So, what we -- the phrase is, there's a genetic vulnerability. All right? That means there is a risk because of the gene pool. Does that mean that that child has to have the problems? No. If you have a parent with diabetes, are you at greater risk to be diabetic? Sure. If you have a parent who

has cardiac problems, are you at greater risk for that? Sure you are. All right? So, what has to happen is, if one knows they have that vulnerability, you have to do smart things to try to protect yourself and be as healthy and all these things as best you can. 'Cause just because you have the genetic vulnerability does not mean that somebody has to have the problem. It's not automatic. All right? So, we always try to, you know, teach our negotiators about that a bit.

So, family -- but we know that suicide does run in families, but mainly based on the depression, it's very significant. Giving away items, that's a sign. Impulsive tendencies, physical illness, availability of weapons -- ooh, that's a big one -- unwillingness to seek help. That's a big one. We'll talk about it in a few minutes. 'Cause we know that first responders are a group that tend historically to be very reluctant to seek help. We'll talk about it. I think most of you know why. We'll review that just briefly in a little while.

Hey, how about this thing called contagen effect. Years ago, in a place called Plano, Texas, there was a high school. And in this high school, they had had no suicides ever until one day one student killed himself. Now, within three or four weeks after that happened, three more students killed themselves. All right? Do you see that violent acts often happen in clusters? All right? So you know if there's a school shooting or

something particularly bad, we're really vigilant. Everybody's very concerned because something might happen again. So the real term for that is contagen effect. We know in some cases suicides, especially in adolescents, are pushed by this contagen effect. They hear about others doing it. Okay?

By the way, just a little aside, depression presents differently in different people. Everybody thinks well, if you're very depressed, you have to be the couch potato, right, where you're not doing anything, you're sleeping 18 hours a day, you don't feel like doing anything. No, no, no. The ones that you guys have to deal with regularly are that subgroup of depressed people who are irritable and angry, and they carry out some crazy stuff. And I'll tell you, most of these school shooter situations, I'm sure if you do a serious psychological evaluation, you'll almost always see that a severe depression is part of it, but it was missed because it was the irritable, angry type, not the couch potato type. All right?

All right. So let me talk about a few components that we've -- I said there are four things basically that I suggest and other psychologists have talked about doing. And this follows the best practices model. All right? This is the ideal. But we've started doing this over the last couple of years down in our county with a few different agencies. We started, of course, with my own, which is Plantation. And

that's where we started developing mental health training.

How 'bout this? Do you think it might be a smart thing to start talking to recruits or cadets at the academy level about possible mental health risks and things that could happen in the course of a career, and things that would be smart to do to prevent those kinds of problems. You know, it's kinda like D.A.R.E. What's the whole point of D.A.R.E., Drug Abuse Resistance Education? Everybody hears about, you know, the problems with substance use and ideas to try to prevent these things. Well, with behavioral health training, we're trying to do the same type of thing with recruits in an academy class, as well as part of a mandatory retraining on a regular basis, so that everybody hears about this stuff from time to time.

Now, of course, at the academy level, everybody's sitting there thinking, "This can't happen to me. This will be somebody else." And that's great. In most cases, it probably will. In some cases, it won't, or they'll know other people are having problems. So we developed what we call a behavioral health training program, which is preventive. There's a two-hour, there's a four-hour version of this. And let me just go through the components with you.

This was a collaboration, basically, with the psychology department -- that was me -- with Plantation Department, who started this a couple of years ago, actually. A series of

presentations developed specifically for police officers and it really highlights, underscores the importance of identify tell signs. That means antithesis. What are the precursors? What do we look for early on that might suggest to us there could be problems later, all right, the risk factors? So we have a two hour version, a four-hour block of instruction composed of five modules.

Now, just about every training program that I put together with my colleagues has focused on these five elements: stress -- and under stress we have traumatic stress, post-traumatic stress disorder, stress related problems, depression -- different types of depression -- clinical depression, bipolar disorder -- sleep difficulties, substance use, and suicide. All right? So it's like an instructional program. By the way, I taught at the police academy down in our county for many years. And I'll tell you, unless it's changed a lot, there wasn't much on these topics specifically geared toward recruits or academy people themselves. Has that changed? I don't think so. Okay.

And I think what we got at the time was probably about four or five hours just basically stress management. All right? Then, you know, "Oh, this won't happen to me." So that -- it really amounted to very little. The behavioral health training, again, should be initially people just getting into law enforcement, then presented on a regular basis as part of an

overall prevention program. So if somebody starts to see something or feel something that's not quite right, they have a sense of what that is, they can identify it and ideally seek help. But we know that's not easy.

So why don't officers seek help? All right. Well, we know this, stigma. If I go for help, what might that show to my fellow officers? Weak, all right? There's a reluctance to do that. Is there still a culture against going to seek help? Yeah. How 'bout distrust of mental health workers? Yes. All right. That's part of it. I'll tell you an example. In our county, we had a psychologist who did a stress interview for new recruits. All right? New recruits, these are people who wanna be police officers.

So when they go to see this particular psychologist, he basically let them wait for two hours, he'd tell 'em they did something stupid, they did something incorrect on one of the measures they filled out, made 'em feel bad. Why is he doing it? Well, it's a stress interview, and he's trying to see how they respond to stress. Now, I kinda see what he's doing. But at the same time, what is that person who went through that process -- what's their view on that psychologist or psychologists in general? Asshole. I won't go to see a psychologist again. Look at that experience that I had with this guy. All right? So that's unfortunate. If that's your

first experience with a mental health person, oh, crap. All right?

So part of it has to do with well, we need to do a better job as mental health people to make sure we don't do things like that, 'cause that's just plain stupid. But, you know, when I was in private practice, here's how it went. It probably won't surprise ya. I get a phone call from a police officer and he says, "My buddy has a problem." I need to tell you what my -- see what you think about my buddy." Now, was it about his buddy? Wasn't about his buddy. All right? Now, on other occasions, it was about his buddy. All right? And his buddy didn't wanna come in to see anybody.

So I had one of two possible tacks that I would take. One is bring your buddy in. If two guys have to carry him, you bring him in. Because if he really needs help and you're that concerned about him, let's head something off before it turns into something. Get him in the door to see me for at least that one session. If he doesn't like it, he never has to see me again, but get him in for that first time.

The other choice was I'll meet him at a diner. We have a couple of 24-hour diners. If you or your buddy is uncomfortable coming to see a psychologist in an office, let's meet for coffee, at least that first time. If that person doesn't wanna see me or anybody else after that, fine. But just agree to go

for coffee. Lester's Diner, right Chief? We have diners that are 24-hours that are helpful. All right? So that was what I call the foot in the door.

But we know that historically this has been a problem getting people to admit or come forward, unless they're mandated for treatment, and then it's gonna be a tough sell in law enforcement generally. And another problem, lack of resources. You have to have people out there you can send people to, all right, if you have a problem.

All right. So here's another piece of what we did. I wanna thank Chief Dunn, who's here from Davie PD. His program we piloted out with Davie Police Department almost two years ago now. We call it Peer Resource and Support Training. The idea with this is we train peers who've been around. And there are a number of ways to select people to do this. But the trained peers usually are people who've been with the Department, they're well respected. They really are concerned about the troops. They're very into the mental health. Sometimes they're members of a crisis response team, but they don't have to be. But in a sense, they're the first line of defense. All right?

Do you think a cop is more likely to tell another cop about a concern that he or she may have than to run the mental health professional, at least in the beginning. Well, that's our assumption. And I think most of you will say that I'll be the

case. All right? They'll talk to the buddy, even if it's over a beer, rather than go and see somebody, at least in the beginning. And better they do that than not say anything.

'Cause by the way, you know, part of the treatment -- and we won't have too much time to get into what this is -- of PTSD is getting people to talk about what's bothering them. That's putting it pretty simply. The ones who run into difficulties are the ones who bottle these things up. And I think you guys know this. So if your tendency is, when something bad happens, you don't talk about it with anybody -- maybe a buddy, but you certainly don't bring it home, you don't say much about it, and that's your way of doing things over time -- you don't gotta share or talk or, you know, have a chance to vent about what happened -- these things tend to blow up on you later on. All right? Now, so with peers, if they're available, if they're trained and they know what to look for, how to identify problems, that can be very valuable.

All right. So what are the goals of peer support, peer training? Provide assistance in times of crisis when somebody's aware that another officer is having serious problems or not -- they don't have to be serious, but some distress or some difficulties about what's going on in their lives. Foster social, physical, emotional health, recognize and evaluate conflicts. This one's a big one, utilize active listening

skills. You know, when we're looking to get new hostage negotiators on a team, we always ask this question of the person who's interested, what is the most critical skill for a crisis or hostage negotiator to have? What's the most important skill? Good listener. All right?

If they say good talker, we have a problem, all right? 'Cause it's not about talking, it's about listening. And the same goes for this. If you're trying to find a peer to help another peer, the one that's the peer support person needs to be a good listener. And part of the program that we do for them is to train what are called active listening skills, almost identical to what are used in hostage crisis negotiation training schools and programs. Identifying emotions, identifying feelings, reflecting, paraphrasing, summarizing, IA statements, open ended questions, all this kind of stuff.

If anybody who's been in DB, you've probably went through similar things because they're about building rapport, building relationships. All right? And that's very important. You do that from listening. Okay? And the thing, you know -- in law enforcement, there's always such a premium on problem solving, especially on the road where you have to solve a problem, get to another problem, fix that one and get to something else. Which is why often it's hard to train crisis negotiators, 'cause that's just the opposite. They were trying to slow things down

and buy time and extend these interactions so that the emotions calm down. All right? So active listening skills are very important.

Promote communication, trust fidelity, serve as a liaison between peers to be helped and resources to provide help. All right? And the resources we'll talk about last because that's the fourth leg of the chair. All right? These are just the modules. This is a 16-hour program. So we do it over two days. I do part of it. I have doctoral students in psychology who help. We have officers who've been trained before who help. So it's kind of a group effort over the course, typically, of a two-day program. And part of it -- a big part of it involves role playing. Role playing interactions -- how are they gonna deal with one of their buddies who's depressed or anxious or having marital problems, how to listen and what to say.

What if they're concerned about someone who's at risk for suicide? What do they say to them? All right? How do they listen to them? What are they looking for? All right. So a lot of role playing goes into this. You have to do that. You can't just sit there in a classroom and listen to facts and information, you have to practice doing this kind of stuff. Any of you who've been on a crisis response team hostage negotiations unit, you know that that's how you have to do that. And this is very similar. All right? So we talk about marriage

and family relationships and health and wellness. Very big.

All right. So let me talk about -- we talked a bit about this already, so I'll go through it rather quickly. We throw around the term critical incident. And early on, Steve and I were talking about critical incident stress management. A critical incident is the term in law enforcement, traumatic event is the term in psychology. They mean the same thing. Basically, it's the same thing, all right, just different terms. So a critical incident, anything that's really above and beyond what you normally experience in this business, all right, is not the usual. And you know, the threshold for something above and beyond in law enforcement is much different than civilians, of course, because of the exposure to different types of things.

So here's an example of types of critical incidents. You guys recognize them. In no particular order, but these would fit. Now, what we've done in our agency and many other agencies is write this in as part of SOPs that, if a critical incident occurs and you have a CIS, CISM trained team, or you have another agency that works with you, that these -- if it's mandated, that a critical incident debriefing take place. All right?

What happens if you don't mandate? What if you say, "Well, anybody who's involved in this particular --" in our case, we deal with a lot of child drowning -- I'm sure most of you do as

well -- anybody who's in this particular incident can go to a debriefing. It's gonna be held at such and such place and time. Who's gonna show? Nobody. All right. And not that they're not -- they don't all feel that maybe this would be helpful, but it goes back to that issue of who's the weak one? All right? It's that stigma. So what we've done and what you really have to do if you're gonna do these, is have part of your SOP that anybody directly involved in this critical incident will go to a critical incident stress debriefing. All right?

Now, they may be kicking and screaming about it. And, you know, I've led a number of these over the years, and invariably, you get the question, "I don't have to be here. I don't need this." Okay. You may be right. You may not need this. But maybe your buddy does. Maybe your partner would benefit from your being with him or her. Okay. All right? So they can be very helpful and they're very important. You can't just do these though, you have to have these other pieces in place as well. But critical incident debriefings are part of a bigger list of activities that are part of the CISM model that we don't have time to get into, but there should be a family support piece to it.

There should be a pre-crisis preparation for these. There should be a mobilization plan. These things should be ready to be rolled out, ready to go. When something happens, it's too

late. After Parkland, I guess you could say the fortunate thing was we had three trained teams in the county. Well, that's not a lot. I think we did a lot for what we had. It would be nice to had more teams be trained. And hopefully, in the future now, we will get more. But we didn't have that much at that point.

I always like to throw this out here, this is something -- you guys follow the thing, you know, with football like concussions and CTE. I think everybody's pretty familiar with that. The person who's had one concussion is six times more likely to have a second concussion than the person who's never had a concussion before. All right? Which is why, when you see these players who have had -- they had one, two, three, you know -- they've had, you know, up to a dozen concussions in some cases, maybe more, if you consider their college and pre-college careers especially. Troy Aikman, how many concussions has that guy had? And how many did he have in his career? Ben Rothlesberger is another one. He's still playing. So once you've had that first concussion you're more likely or greater at risk for subsequent concussions.

It's the same thing with traumas. The old school thinking was that well, when something awful happens to me in terms of a critical incident or traumatic event, I get over it, and over time, these are less impactful. You get desensitized. The word's always been desensitized to these things. And if, to

some extent, that didn't happen, how can you do a 20 or 25 career repeatedly being exposed to different types of traumatic events. But here's usually what happens, you -- the desensitization process really is what's going on at all, it's a compartmentalization process, the model -- it's almost like well, something bad happens, you tuck it away in a little box and you put the lid on. That's called compartmentalization. And it works up to a point.

But on another level, psychologically, unconsciously, if your response to stress -- and everybody's different with how they handle stress -- if your response to stress if you get stress headaches, it's not uncommon. But if that's a common reaction, what could those stress headaches become eventually? Migraines. If you're response to stress is gastrointestinal, you get stomach problems. All right? Some people have it, it's very common. When you're under a lot of stress of something unusual happens and you have a strong stress response, stomach problems. What might that turn into? Ulcers, exactly. If when you're stressed or exposed to a traumatic event or critical incident, your blood pressure goes up, what are you at risk for? Cardiac problems. Okay? All right? So that's how these things come up.

And I think you're all familiar with the fact that well, you know, the lifespan of a lot of police officers isn't that

great after retirement. All right? And the main killer is what? Cardiac events. Okay. And that's related to the hypervigilance and what Kevin Gilmartin talked about and what I've been talking about today, if you don't do things that are smart. All right? So that's why critical incidents are the traumas. Once you've had that first critical incident exposure, it actually sensitizes you to the next ones over the course of a career, rather than you thinking you're getting desensitized, unless you do smart things. All right. So this is part of several steps to the CISM model.

The goal of the debriefings -- and I gotta tell you the training to do these is very simple. There's a three-day school that tends to be offered by the International Critical Incident Stress Foundation. It's based in Baltimore. You don't have to go there. They have certified trainers around the state. Our team was just trained a year a half ago, I think, by a group in Fort Myers that came down to train us. Very inexpensive and sometimes it's free. You just have to pay the expenses for the trainers to come down three days. It's three days to go through this. All right? So it's really a very low expenditure for a high yield payoff later in terms of preventing problems. And the goal has always been to minimize the impact of the incident, accelerate recovery of the response, facilitate return to previous level of functioning. All right?

So I get a battle about this from, you know, law enforcement administration, "Well, why do we have to do this or pay for this?" I always throw out the question I can't answer. You guys can and the chiefs. When you've had an officer, let's say, for 10 years -- let's just say 10, how much have you invested in them in terms of training and time and equipment and all this? It's a lot. I know it's a lot. All right? Wouldn't it make sense to spend a much smaller percentage of that amount on things up front that make sense to try to prevent problems so you don't lose those officers. All right?

All right. So structure -- by the way, these are the group -- the critical incident meeting is a group meeting, facilitating -- I can give you an example of what we did up in Coral Springs. We had several trained people who were leading the groups. We had a group of police officers who were involved in the incident, and we go through a several step procedure. I'll show you that in a second. Take an hour, hour and a half. It depends on how many people are there. These aren't lengthy, they're not time intensive, they're not expensive, but they make a lot of sense to do. All right?

And as a psychologist involved with these, I can identify and meet with people later I might be most concerned about for follow up. All right. These are the seven stages. We don't go into those, but again, it's not a whole lot to learn the seven

stages. You know, the training part is easy. It's very, very easy, if you have the interest and inclination. You earn the benefits, the cost saving, maintain your employee, long-term follow up support, overall standard of care if improved.

You can identify immediate intervention in some cases when necessary. If I see somebody in a debriefing who's not doing well, I can follow up with that person and make a referral. It reduces the stigma. If everybody goes to this involved in the incident, there's no stigma 'cause oh, we all have to go. All right. After Parkland and after -- as part of any of the critical incidents that I've responded to over the past many years, I always like to cover what I call the six S's. And I'll do that with you very briefly and I'll do it ya as if we're doing a debriefing. All right.

There's -- there's six things that begin with S that I think you have to keep in mind over the next few weeks after what you just went through. And some of them might seem kinda silly, but let me explain them nonetheless. The first one is sharing. And I know you guys are uncomfortable with the S word. That's one of those sensitive kind of words that always makes people uncomfortable in law enforcement. I don't like it either. Forget sharing for a second. Talking, all right? The idea is to be able to talk with other people to some extent, share the experiences to the extent that you can. And that

includes family. And I know the -- you know, the response is always, "Well, I don't wanna take things hope and upset my -- my wife or kids or husband," whatever you have.

And I said well don't get into the details, but mom or dad -- kids know if something's not quite right. And if they don't know what it is, they're guessing and playing the telepathy game, which causes more problems in a relationship. The more you talk, share, vent, emote -- I don't care what in the hell you call it -- the less of a problem this ends up being later. And the treatment for PTSD in the VA system now -- the best practice in the veterans system is something called exposure. Now it sounds weird, but it's basically getting that person to talk about, vent somehow about what happened, what that trauma was like for them.

It's not that confession is good for the soul, it's that the more someone has an opportunity to talk about things that have affected 'em, over time the emotions dampen the more you talk about this. They don't go away, you don't forget, but they don't have the impact physiologically that they did in the beginning. So this sharing business, very important.

Sleep problems -- all right. I talked about that with you before. If you have any of these -- difficulty falling asleep, sleep continuity, early morning awakening -- you have one of 'em, after a few days, it's gonna cause you a problem. If you

have two of 'em, if you have three of 'em, it's even worse. All right? And you all know people who have all three. All right? From time to time, it's normal, it's not a big deal. But if it becomes a chronic problem, meaning after a month, these things are still going on, that's not easy to -- something has to be done.

Substance abuse, we talked about. And I will tell 'em about the timing of using alcohol 'cause we're gonna assume that's the -- that's the drug of choice 'cause that's legal. All right? But if they're pounding 'em down after a critical incident, that's not gonna allow that person to get rid of that stress from that day and that chronic pattern is gonna cause a chronic problem.

General media and social media -- don't keep watching the news about a bad event that took place, 'cause as I just said -- well, you can watch these things and see them happening to other people, and in some cases, that's enough to cause a traumatic response by itself. You know, after the planes crashed into the towers in 911, you'll remember mental health people were saying, "Don't keep watching this. Don't keep watching this. Don't have your kids keep watching the planes hitting the towers." And the reason for that was we don't wanna create traumatic responses. All right? But that's -- that does happen.

Stress management 101, we talk about what are the smart

things to do. And one of the real smart things is well, there has to be physical activity involved. And often when somebody has a traumatic event occur, they stop doing that. "I can't possibly keep my routine of running or yoga or whatever it is until kinda the dust settles and I feel better." Well, that's not the case. I suggest strongly to keep doing those positive things that you've done. You don't have to do 'em at your best, but keep doing 'em. All right? You have to keep the good habits going. You need the exercise, you need the good nutrition, you need all those positive stress management 101 kind of things that you guys know about. But a lot of people stop doing 'em along with something bad happening, particularly bad.

And then support, this is a huge one. Those people, whether they're police officers, firefighters, combat infantry, who do not have a good support system in place are at higher risk for trouble. All right? We just know that and we try to encourage people to make use of the support system that they have. And that's where peer support can come in very handy if that person is not having a good time in a relationship or is in the process of a divorce or separation. You need some peer support network there to help. All right? And the more you have, the better.

So we have friends, we have peers, we have family. I could

add to that the agency. If you have the supportive agency (unintelligible) peer support group that's there helping to support that person, all right, as a supplement. So I call these the six S's. I did these -- it's really interesting -- I guess it was two or three days after the Parkland shooting, I was doing the family support night for firefighters. And I thought well there won't be many of them showing up, you know, plus they know I'm a police officer. Hundred of 'em showed up. All right?

I went through this with 'em, I said are there any questions. I expected to be out of there really quickly. It took me an hour and a half to get out of there 'cause they had a lot of questions. The families were there for the most part. All right? So the support people were there in place, which was very good. They had a lot of concerns, which was reasonable, and they asked about it. And that's what part of what my job was, to answer them as best I could. And it wasn't easy. All right?

Now in the last piece of this four-legged chair are resources. And this is gonna vary. You need to identify -- and probably most of you have done this -- what are the resources in your community if, in the event that one of your people needs some help. Now, there are different levels of this. And we just -- we met very recently with one of our local hospitals

that takes law enforcement professionals and, if they have a substance abuse problem or a serious mental health issue, we can take 'em there, an inpatient setting, and they won't be Baker Acted, but they will get help and they'll be on a special unit in place identified in a hospital just for first responders.

That's great. I mean, we didn't know that this existed 'til, you know, we had some training with Miami Dade Police Department and we found out that's what they were doing. I can't guarantee everybody has something like that. But boy, in a last ditch effort, if you have somebody you're worried about hurting themselves or drinking themselves into oblivion, you need a place to take that person. All right? You need mental health providers. You don't need just psychologists, you also need psychiatrists that you can trust and knows something about this, which means you have to vet them. Somebody has to sit down with them and find out what their interest is, why they wanna work with you, and what they know about law enforcement.

Don't just think because somebody has a degree, they know what they're doing. And I always like to say the example is dentists. Every dentist has their degree from dental school. You go to some dentists, it's very painful when you get a tooth filled. You go to others, it's almost painless. Yet they have the same degree. So that tells you, they're not all the same. All right? You have to make some determinations, set up a

committee or group to vet people who you think seem to be interested in providing services for you. You have to make sure they know how to do that. Like, that's very important.

And then again, your peer support people should be then able to refer where necessary to some of these outside resources. You can't count on being able to do everything in house. You cannot do that in serious cases with mental health problems. All right? That's more than you can handle. What else do we have? Any questions? Any questions? This is the time. Can I be of any help? If there are any questions that I can answer. Yes, Chief.

AUDIENCE: I think one of the (unintelligible) 25 years of being a cop and --

VINCENT VAN HASSELT: Yeah.

AUDIENCE: -- (unintelligible) with problems on them starting to increase, but they do not have medical coverage or the resources available.

VINCENT VAN HASSELT: I don't know about the medical coverage part. I know that's very important. And we're working with your agency, as you know, to try to develop a special program, a support program for retired police officers. We don't -- we did have psychological resources, but not on retirees. Both police and firefighters retired, not a lot of 'em are doing well post retirement in terms of mental health

issues. So they have to be addressed and they really aren't, you know, they really aren't. It seems once they leave the agency, they're on their own. All right? And that's not a good thing.

But I think what we're gonna try to do with you guys -- you know, we're in the early stage of this, but Davie Police Department -- is really trying to build something that's available to them. You know, we -- I know we did have a meeting with them recently when they came to get certified, but that's just a start. That's a big problem. What else, what else? Anything else? I'm here for you. And if there aren't questions now, I encourage you, call me, let me know, send me an email, contact me. I'm always glad to talk to talk.

Captain Geller and I are always glad to respond to any questions that you have, any materials we have or programs we've developed. Send, you know -- they're there for everybody. All right? Be glad to share any of these things. I'll send you the PowerPoints if you'd like to see 'em. Just contact me and let me know if any of this sounds of interest to you. If you're doing everything already, great. I'd like to hear what you're doing. But if you think there's some missing pieces that maybe we could put together and I could be of some help and Captain Geller can be of some help, that's what we're here to do. Okay? So thank you very much. You've been a great group. Glad to see

a lot of you here. So again, any questions, let us know. Thank you.

STEVEN GELLER: Thanks.

VINCENT VAN HASSELT: Sure. You're welcome.

STEVEN GELLER: Okay, everyone. Thank you. That will conclude our day's worth of training today. But I did wanna talk real quick about tonight before we depart. A brief announcement to make sure everyone understands our festivities. As you know, tonight's main event is our host chief's night which is being held at Dave & Buster's. Buses to Dave & Buster's will begin departing from the hotel lobby at 5:30 p.m. Buses will depart and return throughout the night, and the last bus returning to the hotel this evening at 9:30 p.m. from Dave & Buster's.

Please ensure you wear your credentials. You will not be able to attend the event without them, so it is imperative that they be worn. Again, please meet in the hotel lobby for departure, and we look forward to seeing everyone. And tomorrow morning is our sponsor appreciation breakfast beginning promptly at 8 a.m. Directly after, we will have Governor Scott joining us. We want to give the governor a grand welcome, so please ensure that you are here tomorrow at 8 a.m. for both breakfast and his arrival.

Now, do we have anyone here from the host chief's committee

that can answer a question? So the -- the buses depart beginning at 5:30, and the last one from there to here is at 9:30. What kind of interval are we talking about here leaving from the hotel.

AUDIENCE: I'll have to find that out.

STEVEN GELL: Okay.

AUDIENCE: (unintelligible).

STEVEN GELLER: About every 30 minutes.

AUDIENCE: (unintelligible).

STEVEN GELLER: What's that?

AUDIENCE: (unintelligible).

STEVEN GELLER: You wanna come on up and talk? Get it directly from the horse's mouth.

AUDIENCE: Also, don't forget, you got your flyer (unintelligible). We had hoped to have the Panama City Sky Wheel opened. It didn't open up. They also have beer available on the back deck for ya as well. So if it gets a little too noisy in Dave & Buster's, wanna hop next door, they have beer on the back deck. Still gotta have your credentials. If you want something different, maybe don't like the fare we have, they'll also offer a discount for food over there. So --

STEVEN GELLER: All right. Anything from Kendra in the back? Staff? Okay. We're running ahead of schedule, so we'll see everybody hopefully tonight at Dave & Buster's. Have a good

night.

(CONCLUSION OF SESSION)

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