National Advisory Committee on Children and Terrorism
Department of Health and Human Services
Centers for Disease Control and Prevention
April 30, 2003
Emory Conference Center – The Abbott-Turner Center
Atlanta, Georgia

Dr. Angela Diaz, Committee Chair, called the meeting to order at 8:05 am.

Committee Members present
Dr. Angela Diaz, Committee Chair, Director, Mount Sinai Adolescent Health Center, Mount Sinai Medical Center
Joseph Henderson, Executive Secretary
Mr. Kevin Dinnin, President and Chief Executive Officer, Baptist Child and Family Services, San Antonio, Texas
Ms. Brenda Greene, Director, School Health Programs, National Schools Boards Association
Dr. Alexander Kelter, Chief, Epidemiology and Prevention for Injury Control Branch, California Department of Health Services
Dr. Bobbie Maniece-Harrison, Adjunct Associate Professor, Department of Health Studies, New York University
Dr. Angela Mickalide, Program Director, National SAFE KIDS Campaign
Dr. Richard Mollica, Director and Associate Professor of Psychiatry, Harvard Program in Refugee Trauma, Massachusetts General Hospital
Mr. Richard Ricciardi, Chief, Primary Care Nursing, Department of Ambulatory Care Center, Fort Meade, Maryland
Dr. Peter Rumm, Chief Medical Officer, Division of Public Health, Wisconsin Department of Health and Family Services
Dr. Jean Wright, Executive Director, Backus Children's Hospital

Dr. Steven Marans was not present.

Federal Advisors present
Dr. Robert Amler, ATSDR
Dr. Joanne Cono, CDC
Dr. Loyd Kolbe, CDC
Dr. Larry Pickering, CDC
Ms. Cyndi Shaffer, CDC
Dr. Wanda Jones, DHHS
Dr. Woodie Kessel, DHHS
Ms. Liza Veto, U.S. Department of Education
Dr. Rosemary Roberts, FDA
Mr. Rick Smith, HRSA
Dr. Margaret Feerick, NIH
Dr. Farris Tuma, NIH

Consultants present
Dr. Claude Chemtob, Mount Sinai School of Medicine
Dr. Louis Cooper, American Association of Pediatrics
Dr. Peter Holbrook, Children's National Medical Center
Dr. David Markenson, Mailman School of Public Health, Columbia University
Dr. Betty Pfefferbaum, University of Oklahoma Health Sciences Center

Committee Staff
Victor Balaban
Amy Loy

Others
Jeni Schmitt, American Institutes for Research
Heidi Taylor, American Red Cross
Beth Blair
Lisa Barrios
Sonya Hubel…..
Don Dornberg
Paul Simac
Angela Fuzah (contractor)

Dr. Diaz reminded everyone that the next meeting will be May 21st in Washington, DC, and that the final report is due on June 6.

The minutes had been sent to all committee members, but not everyone had received or reviewed them. Therefore it was decided to delay approval of the minutes until everyone could review them.

The agenda for this meeting included presentations of all the committee members, with discussion of particular issues and specific recommendations for the Secretary. Presentations covered the following areas: Schools; Risk Communication and Public Education; Primary Care Pediatricians, Office-based Practice and Urgent Care Centers; Community Involvement; Training; Mental Health Response Phase; Mental Health Recovery and Mitigation Phase; Public Health Departments, Government Agencies/Government Role; Surveillance and Assessment Mechanisms; and Pre-Hospital and Critical Care and Hospital Preparedness. The goal was to reach consensus on ten to twenty recommendations. The report submitted to the Secretary will be a short document, with clear recommendations and actions. There will also be a larger document with all the details and rationales supporting the recommendations. This larger document will be part of the public record, together with the short document.

Dr. Diaz asked whether there was any new business and there was none.

Before the individual committee member presentations, there were two other presentations.

Overview of Strategic National Stockpile Program
Dr. Nicki Pesik, The Strategic National Stockpile Program, Centers for Disease Control and Prevention

The mission of the Strategic National Stockpile is to delivery medical materiel to the site of a national emergency. The program components include logistics, operations (planning, coordination and security), science (medical, clinical and pharmaceutical oversight of formularies), program preparedness (state planning for receipt, delivery and distribution), knowledge management, and program integration.

Emergency response has three components:

- Provide rapid delivery of a broad spectrum of support for an ill-defined threat in the early hours of an event, including the 12-hour Push Package.
- Provide large shipments of specific materiel when a threat is known.
- Provide technical assistance to receive and distribute Program materiel during an event.

The 12-hour Push Packages are scattered through out the United States. Each is identical and contains a broad range of materiel, including bandages, IV supplies, burn treatment, antidotes, antibiotics, and much more. They are guaranteed to arrive within 12 hours of request, by air or by land. For specific items, the CDC maintains a Vendor Managed Inventory (VMI), which sits in manufacturers' warehouses even though owned by the NPS (National Pharmaceutical Stockpile Program). Manufacturers rotate inventory constantly so that there is also fresh product on the shelves. There are also repositories of vaccines throughout the U.S. The Veterans Administration Acquisition Center partners with the CDC for rapid purchase of items, such as respiratory masks, at the lowest possible prices.

Rapid deployment is possible because the material is pre-packed and configured in color-coded transport-ready containers, which are stored in secure facilities near major transportation hubs. They are delivered by world-class transporters, such as UPS and FedEx.

The formulary has evolved over the years in response to new treatments and threats. Based on recommendations from experts regarding Category A threat agents, it contains treatment for smallpox, anthrax, botulism, viral hermorrhagic fevers, plague and tularemia, as well as chemical nerve agents. It also contains medical supplies and equipment and vaccines. Each Push Package can provide 34,400 children under the age of five with post-exposure prophylaxis, 4000 5-day doses of ciprofloxacin suspension, 4000 7-day doses of doxycycline syrup, and 25,400 10-day doses of chewable amoxicillin tablets. It also has equipment in pediatric sizes, such as ventilators, emergency airway equipment, IV equipment and supplies, antibiotic formulations, and medication delivery systems.

General Recommendations

The SNS committee met on April 29th and came up with 18 recommendations for the Advisory Committee on Children and Terrorism. Those can be summarized as follows:

- The Committee recommends that a regular review process by subject matter experts of the SNS program be established to ensure continued and enhanced pediatric capability and capacity.
- The Committee recommends that a formal process be established to determine prioritization of recommended formulary additions and modifications to maintain and enhance pediatric capability and capacity.

The Committee recommends:

- That the SNS program increase the public visibility of the pediatric capabilities of the program.
- Evaluating purchasing mechanisms for pediatric-specific equipment
- That state and local communities evaluate their pediatric equipment and medical inventories and capacities to treat pediatric patients and coordinate this assessment with neighboring states
- That state and local communities review the distribution plans for pediatric-specific equipment
- That state and local communities [allocate] time and staff for distribution and administration of pediatric resources
- That a working group be created to develop a list of emergency use INDs needed for treatment of the pediatric population for events involving biological, chemical or radiological agents.
- That a working group be created to review pediatric treatment protocols for events involving biological, chemical or radiological agents. The primary goal is achievement of a national standard for treatment protocols.
- That specific data for the pediatric population be obtained through future research on the impact of disasters on the pediatric population and more specific population demographics of communities (currently 2000 U.S. census data is used)
- An annual review of the SNS formulary content for pediatric capability by subject matter experts
- That tetanus toxoid for emergency use is included in the strategic planning of the NPS.

Formulary Specific Recommendations

The Committee recommends:

- That the SNS program use 9 years of age as the cutoff age for determining the requirements for antibiotic suspensions. The committee favors antibiotic suspension formulations over chewable tablets.
- That the 12-hour Push Package be designed to have pediatric-specific containers, to assist in distribution
- Review of Epogen for treatment of anemia secondary to trauma to reduce the need for blood transfusions.
- Inclusion of cytokines for treatment of radiation-induced neutropenia

- That sufficient qualtities of thiosulfate for the treatment of 1000 pediatric patients be added to the formulary
- That emergency-use IND be developed for Mark 1 Jr Kits
- That future SNS formulary additions include assets to treat burn/blast and radiation injuries. At a minimum these additions should be sufficient to treat 2500 pediatric patients.

The Committee strongly supports the addition of the following pharmaceuticals and medical supplies as identified by SNS pediatric gap analysis, and SNS burn/blast and radiation review:

- Additional airway management equipment
- Medication Delivery Systems such as spacers and masks
- Additional ancillary supplies for IM administration of medications
- Alternative sedatives and analgesics
- Additional IV antibiotics
- Alternative concentrations of intravenous antibiotic solutions.

Questions and comments:
Dr. Diaz noted that these recommendations would need to be prioritized, depending on the specific threat/response.
Dr. Pickering asked whether these products were all in storage and Dr. Pesik explained that some were for emergency use only, while others are used constantly and can be rotated out by vendors, sold, and replaced with fresh stock. The NPS Program participates in the FDA shelflife extension program. Some drugs are stable past manufacturer expiration dates, so the military developed ways to test drugs for continuing potency. If they meet standards, the expiration is date extended.

Dr. Pickering asked whether this program was just for civilians, or included the military. Dr. Pesik explained that the DOD has its own stockpile, but there is a great deal of coordination.

Emergency Medical Service Systems and Protocols
Dr. David Markenson, Director, The Program for Pediatric Preparedness, Mailman School of Public Health, Columbia University

EMS training occurs at the following levels:

- Certified first responders get CPR training only, with limited concentration on how to treat children
- EMT Basic is a 110-hour training program, with six hours of pediatrics.
- EMT Intermediate includes limited pediatric training, which may include airway levels and intravenous access. Some medications are also discussed.
- EMT Paramedic training has one whole module devoted to pediatrics, but the time spent on this module is variable. Most states use existing coursework and add pediatric component/topics.

The first priority is to make sure there are resources for general care of children, then focus on terrorism-specific care.

The EMSC program was created in 1984. Its mission is "to reduce child and youth mortality and morbidity sustained due to severe illness or trauma. It aims to ensure state-of-the-art emergency medical care for the ill or injured child and adolescent; to ensure that pediatric service is well integrated into an emergency medical services system backed by optimal resources; and to ensure that the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation, is provided to children and adolescents as well as adults."

The ultimate goal of EMSC is to save the lives of children and adolescents. Several secondary goals relate specifically to disaster and terrorism preparedness for children:

- Goal F: Ensure that integration of health services meets children's needs.
- Goal H: Include pediatric protocols in medical direction for all EMS agencies
- Goal K: Improve pediatric emergency medical services through public education

EMSC has been developing model pediatric protocols. A review of the literature on pediatric EMS found that existing protocols were extremely limited, mostly epidemiological and with no outcome data. There was some data on cardiac arrest and recent data on fibrillation in children. The National Consensus Conference of Stakeholders included professional medical organizations, firefighters and EMT organizations, national registries, and other national programs. General issues addressed included medical control, regional variation and BLS vs. ALS. Model protocols developed will now be reviewed and distributed. Revision will be ongoing, based on new technologies and literature, and new protocols will be developed around new topics.

Recommendations:

1. The Secretary should support and enhance the existing HHS programs which assure that the needs of children and met in the EMS system through:
    - Increased funding to the EMSC Program to allow for enhanced activities related to Emergency and Terrorism Preparedness via:
        - Creation and distribution of educational program and resources for EMS providers related to pediatric emergency and terrorism preparedness
        - Revision of the Model Pediatric Protocols to include protocols for Emergency and Terrorism Response based on the National Consensus Conference
        - Targeted issues grants focused on emergency and terrorism preparedness
        - Development of mental health resources for EMS providers including triage tools and information regarding the importance of mental health in emergency and terrorism preparedness and response
        - Increased program staff to provide support and consultation to state, territorial and tribal EMS offices, professional organizations and EMS providers

- Integration of the EMSC program in all HHS emergency and terrorism preparedness cctivities
- Assurance that all HHS emergency and terrorism preparedness activities that involve EMS require that pediatric considerations be included in these efforts.

2. The Secretary should increase funding for research on EMS pediatric emergency and terrorism preparedness and response via:
   - Establishing as an MCHB research priority EMS pediatric emergency and terrorism preparedness and response
   - Establishing, in the form of RFP and RFA from NIH and its institutes, research funding for studies related to EMS and pediatric emergency and terrorism preparedness including triage, assessment, and treatment, including mental health
   - Creating mechanisms for pediatric emergency and terrorism preparedness research gaps identified by the EMSC program to be funded.

Discussion
Dr. Rumm commented that it is hard to get money from state legislatures for EMS. An important question involves the legal authority of non-physicians to give medications, which is often a county decision.

Dr. Markenson said that PALS was originally designed as a hospital-specific intervention, and it was modified for the EMS community. The PALS program has now been supplanted by other programs. More federal direction would be useful, but still maintain state physician-licensing. He would prefer that the emphasis be on pediatric capability first, with EMS capability second.

Dr. Mollica noted out that many people see EMS workers as invaders coming into complex communities with complex social norms. He asked whether EMS workers should try to be mini-pychiatrists, especially when responding to situations where families are in acute distress. Dr. Markenson replied that studies show pediatric emergencies exceed adults emergencies in stress levels, however EMS providers' first priority is to stabilize the situation, assess, treat and transport the patient.

Dr. Mollica asked whether EMS workers ever do any follow up. Dr. Markenson replied that in cases where child abuse is suspected, EMS workers should at least have the ability to assess risk levels so that appropriate information is transmitted to ER staff. Mr. Ricciardi added that EMS personnel are trained to ensure safety (including their own) rather than sorting out mental health issues.

Schools
Brenda Greene, Director, School Health Programs, National Schools Boards Association

Overarching recommendation

It is incumbent on the U.S. Secretary of HHS to ensure that each major content area in DHHS-funded terrorism initiatives, and in federal initiatives in which DHHS in a partner, addressed the role of schools. These programs should require through regulatory and fiscal oversight that states and local health departments, and other agencies involved in this work, truly build partnerships with state and local education agencies and schools in order to meet standards.

Supporting Recommendations

- Revise the **Federal Response Plan**, indicating the need for schools to be an integral part of preparedness, response, recovery, and mitigation efforts.
- Site visits by CDC to states to provide technical assistance in implementing Cooperative Agreement Awards for **Public Health Preparedness and Response for Bioterrorism**, specifically to review efforts to include educational agencies in the planning process and to meet the needs of schools. Funding should also be provided to bring educational agencies into the planning process.
- As the *Model Public Health Act* is currently being revised, add language indicating the need for schools to be an integral part of bioterrorism planning.
- Recommend to states and territories funded through the HRSA Bioterrorism Hospital Preparedness Program that state and local education agencies be invited to participate in Terrorism Preparedness Planning Committees.
- Assure that all funding for disaster mental health services allow for funding of school mental health and counseling.
- Ensure that HHS research agencies conduct and support new research on post-disaster children's mental health that study the effectiveness of school-based interventions.
- Integrate schools with public health surveillance programs that allow for trends in increased disease incidence and early detection of possible chemical, biological, or radiological terrorism.
- Revise state & local Plans to include surveillance methods for schools, day care facilities and other venues for child care.
- All DHHS agencies which develop materials on the handling, identification, response, and decontamination for acts of chemical, biological, and radiological terrorism must include consideration for children in schools and, when appropriate, provide any educational materials in a format directed toward schools.
- Develop school-specific information related to preparedness for biological, chemical, radiological, and mass trauma terrorist events, place this information on the CDC bioterrorism and mass trauma websites, and make it available to schools using their preferred delivery methods.
- Assure that school-based mental health services are part of a network that provides not only outreach but also triage and referral to those with specialized training and expertise who can offer more comprehensive and intensive treatment. These linkages can and should be established pre event.

Discussion

Dr. Rumm endorsed the idea of linking schools with public health, but cautioned that without funding there can be no coordination. Ms. Greene agreed that there is never sufficient funding, but that this is a significant recommendation and there are models in other states. Dr. Kolbe informed the group that DASH has been trying to build the capacity of state health and education agencies to work on health problems together. They have funded 20 states over the years and are working to get funding in 2004 budget. Dr. Rumm recommending encouraging the DHHS to support a position in each state to work with the Department of Public Instruction.

Dr. Modzeleski noted that the recommendations should be written in plainer English, with more specificity and fewer vague terms and platitudes. The recommendations should be presented in terms of actions. He also suggested making sure schools are specifically linked into the recommendations. In other words, they need to be involved in developing training modules. Finally, he pointed out that there is a role for students in terrorism, and a role for parents in health and bioterrorism. This should be clearly articulated.

Dr. Rumm wondered whether there were legal issues around quarantining a pediatric population. Dr. Mollica noted other issues related to the post-terrorist period, e.g., assistance for families damaged by terrorism, disruption of schools, and children infected by disease who would need home care and education. Dr. Modzeleski pointed out that there is never enough money in education budgets for major catastrophes, including alternate sites for education or home education. Ms. Greene commented that although one can never anticipate the details, planning and relationships can be set up in advance.

Dr. Mollica brought up the issue of resiliency and that keeping children in school is therapeutic. He also underscored the role of parents and children as ombudsmen and the importance of asking children about their feelings and needs.

Dr. Modzeleski felt that there was nothing wrong with recommending that the Secretary of HHS work with the Secretary for Education. All federal agencies have a responsibility to expand their roles around children in recovery, preparation, mitigation issues.

Dr. Kessel commented that since history classes teach about world conflict, preparedness could be incorporated into the education domain, in terms of understanding violence and conflict in the world. Long-term preparedness and prevention is about education.

Dr. Holbrook was concerned there were too many micro recommendations. A recommendation that one of best things for the mental health of children is to get them back in school as quickly as possible seems to be a macro recommendation and a principle around which state and local communities could frame their actions. Dr. Kolbe thought this was an excellent idea, but it was not a recommendation that could be acted on by the Secretary of HHS. Dr. Modzeleski stated that the issue was how to get children back into a routine. Schools may not be able to open, but that's where faith-based

communities, youth services can play a role. Ms. Greene asked the group to think about having an overarching vision for the Committee's work, which might include getting children back into routine.

Dr. Chemtob pointed out that in a disaster teachers often become non-traditional first responders and then have to come back to work, even though their own families are often affected. Teachers need instruction in emergency management. There needs to be a more rapid funding mechanism to support recovery, and a mechanism to support schools in how to deal with mental health issues.

Dr. Malkenson noted that the Office of Emergency Management never considers schools as an integral part of the emergency planning process. School issues around transportation and sheltering considerations all require integration with other emergency planning and management.

Risk Communication
Angela Mickalide, PhD, Program Director, National SAFE KIDS Campaign

Remarks
There are many consistent themes in materials on risk communication to parents, including: maintain the daily routine, avoid exposure to the media, and anticipate children's questions. But other content varies, such as how much information to give children and how that relates to age level and maturity. None of the materials seem to be research/evidence based, and there is no guidance on how to disseminate information to parents or which messages have most relevance and clarity.

Recommendations

- Encourage federal agencies and national organizations to develop clear, concise and consistent and situation-specific guidance for parents concerning helping children to cope with terrorism
- Encourage all stakeholders to disseminate the same information to parents via websites, print materials, public service announcements and other communication channels.

Discussion:

Mr. Henderson noted that there are 31 centers of public health preparedness funded by CDC at universities, and that it would be important to assure that those institutions are deriving communication messages.

Dr. Tuma pointed out the importance of concrete, scenario-specific messages and guidance. The risks are different for every event and messages about self-care are different from those about information shared with children. NIMH and SAMSA are looking at different scenarios and developing messages based on what is known about

decision-making behavior. He recommended building in additional detail that is situation specific.

Dr. Kolbe said that communication should allay parents' concerns regarding systems being put into place. Parents need to know what will happen at schools in the event of an emergency, whether children be locked in or sent home, cell phones may not work, etc.

Dr. Kessell noted that in addition to message and content, it is important to determine who is best positioned to deliver and reinforce messages. Individuals like the late Fred Rogers are can be very important. There are multiple issues about style, sensitivity, and credibility of communicators. When television is interrupted with breaking news, who is the voice?

Ms. Schmitt gave some information about a course that has been developed by the American Institutes for Research on writing and communicating messages. It addresses the issue of the best voice to communicate public health messages during a crisis.

Dr. Kelter stressed that messages need to be prepared in advance because emergency response is always local.

Dr. Modzeleski felt that the conflict between closing schools or using them as shelters was a primary issue to be addressed. What is the message to the schools? How will parents react to keeping children in schools? Messages from public health, law enforcement and schools have to be consistent.

Primary Care Pediatricians, Office-Based Practice and Urgent Care Centers
Dr Angela Diaz, Director, Mount Sinai Adolescent Health Center, Mount Sinai Medical Center

Remarks
Many providers take care of children, and all have to be involved in preparedness. Children have different needs--developmental, psychological, emotional and social. Adolescents have very different needs from smaller children in reacting to trauma, but teenagers are often left out of discussions about pediatric needs. The special needs of children have not been addressed in preparedness in the past. Children have fears and parents have fears for their children. The commitment to children's safety is universal. Finally, it is important to remember that first responders have children and emotions too.

Recommendations:

- Ensure that there is universal insurance coverage for all children and that every child has a medical home with a primary care pediatric provider who provides services in a bio/psycho/social manner to assess the needs of children and ensures that all these needs are addressed in a holistic manner, with an emphasis on primary prevention.

- Ensure and make provisions for the primary care pediatric provider to be involved in all stages: planning and preparation; first response to identify, triage, and treat the special needs of children in the acute phase; providing ongoing care in a holistic manner; and participating in the healing process of the community after the event, capitalizing on the strengths and resiliency of all those involved.

Discussion

Dr. Rumm noted that the AMA's call for universal medical access relates to this recommendation. He suggested there could be a mandate that in an emergency situation, all children/families are covered by some kind of funding.

Dr. Diaz elaborated on the recommendations, saying that when a child has a medical home, it is an easy place to go with questions. Emergency rooms are overwhelmed in a crisis and have to provide medical, social and psychological services. Pediatric providers have to be able to assess all needs and provide holistic care. Providers should be involved in all phases, from planning to first response to ongoing services to helping community health, taking into account resiliency of community.

Mr. Ricciardi worried that spending so much time on disaster preparedness without universal health care coverage seemed to be a disconnect.

Dr. Jones noted that a major focus of this administration is expanding community health centers and wondered whether they were captured in this recommendation or somewhere else. Dr. Diaz replied that the recommendation is to link all providers and centers because the pre–event status of the child determines his or her outcome after the event.

Dr. Mollica wondered how the first recommendation would deal with the fact that many adolescents don't see pediatricians. Dr. Diaz replied that the wording needs to be "children and adolescents" and this must be consistent. Mr. Ricciardi added that it would be even more accurate to say "children, adolescents and young adults."

Dr. Diaz pointed out that adolescent health care goes up to age 21, but there are legal differences between those under age 18 and those over 18. Dr. Cooper added that there were other statutes to consider as well, such as Medicaid.

Dr. Amler told the group about a network of specialists (general pediatricians, toxicologists, environmental health and medicine) formed at ATSDR to discuss clinical problems of children living around waste sites. After 9/11, they fielded phone calls regarding exposures around the WTC, such as asbestos. It would be useful to have such units placed around the country.

Dr. Kessel noted that when children that are healthy, fully immunized, and screened, they are more resilient and able to deal with threats. Prevention is the best means of preparedness.

Dr. Roberts pointed out that one goal is to have approved products in a stockpile for children, but the issue of getting permission from parents has to be considered. Dr. Cono added that this is a problem whenever children are separated from their parents, so part of preparation is amassing information to facilitate contact with parents. This includes first responders during disaster events. Standards and procedures must be in place for their own families so they can pay attention to their activities. Dr. Diaz suggested expanding the recommendations to include all providers of services for children.

Community Involvement
Kevin Dinnin, President and Chief Executive Officer, Baptist Child and Family Services, San Antonio, Texas

Remarks
There should be a national spokesperson to reassure families the way the First Lady did after 9/11. She encouraged families not to let children watch all the media coverage. The majority of families have little understanding of the difference between real vs. perceived threats.
Even with separation of church and state, faith-based organizations want and expect to be involved, and are often first responders themselves, but coordination can be a challenge. The majority of clergy not prepared to respond. However they can offer mental health advice, and have as much information in this area as EMTs.
Volunteer organizations need to be inventoried regarding their capacities and resources. Government social service agencies have legal responsibility for children, in such areas as emergency shelter and guardianship issues. Childcare facilities not equipped to shelter and place children; childcare workers will want to go home to their own families, but they often have inadequate contact information about alternate guardians if parents are unable to pick their children up.

Recommendations
- Develop support and training for pastoral and volunteer counseling
- Provide small grants to facilitate meetings among faith-based and volunteer organizations and other community agencies.

Discussion
Dr. Makilide said that training protocols for faith-based organizations should be developed first, and that they should be ecumenical in nature.

Dr. Rumm pointed out that there is never enough funding at the state level when children and ethnic issues are involved. It would be better to have small grants to bring organizations together at the local level.

Dr. Feerick outlined some training issues, such as mental health, trauma, response to disaster, and coping activities, such as vigils. Churches play a huge role in public information/communications. People go to church even when they can't afford doctors.

Dr. Cooper noted that the CATCH program gives small grants to pediatricians and communities to do outreach. They have been successful in mobilizing beyond the pediatric community, including the faith-based community. The emphasis should be on local organizations, ministers and interdenominational organizations, together with hospitals.

Mr. Henderson commented that community preparedness is about bringing people to the table and deciding who has the responsibility and authority to fill in gaps in the plan. The Secretary could help to enable those linkages at community level as related to special needs for children.

Dr. Amler emphasized that people want to know who to call in a disaster. That contact is different in every community, and depends on the scenario. However there are always commonalities and table-top exercises are useful to determine some of the responses needed in any scenario.

Dr. Mollica referred to the refugee community, which has been traumatized and does not always see health as a social good. It can be difficult to link primary care providers with refugee communities. Health promotion is a community responsibility, but it would help to fund the refugee communities themselves to promote health. Those people with less access to mental health care are more apt to use the clergy, however, the clergy often have no financial support or training. They are often pushed aside by professional mental health people, even though over 90 percent of the population turns to the clergy during a crisis.

Dr. Kessel reflected that in times of crisis communities summon strength and eliminate barriers and wondered how those strengths could be fostered prior to a crisis. In CT and NC, small seed grants enable communities to come together to think about prevention. This leverages and links talent, expertise and resources, adding to community resilience and support before rather than after a crisis.

Dr. Harrison suggested looking at community health centers, which are already forming response teams trained by experts, and training community people in how to respond to emergencies. A pediatric component could be added.

Dr. Malkenson pointed out that the real first responders are people in the community. If given the tools, funding and resources to respond, they can take care of themselves, their relatives, neighbors and friends.

Dr. Chemtab informed the group that FEMA has established 10 demonstration projects for disaster assistance. He proposed similar demonstration projects for building psycho-social and terrorism preparedness in communities.

Dr. Kolbe wondered to what degree communities' formal government structures and the current preparedness infrastructure could be involved. It would be useful to develop

templates for bringing the public sector response together with the private sector, volunteers, and faith-based organizations.

Dr. Cooper said that the best way to prepare for terrorism was to build on fundamental health infrastructure. The process may be more important than the structures themselves. CATCH showed how to empower AAP physicians to go out and talk to the community.

Mr. Henderson reminded the group that 120 cities in the U.S. received Metropolitan Medical Reponse funds, which is now part of Homeland Security. He suggested that MMRS funding contracts could include empowering local communities to respond to the special needs of children.

Dr. Roberts asked whether the committee was addressing children in juvenile detention system. Dr. Diaz responded that there was a session on children with special needs, but Dr. Chemtab explained that this was about special-needs children in schools.

Training
Dr. Bobbie Maniece-Harrison, Adjunct Associate Professor, Department of Health Studies, New York University

Remarks:
Training must be addressed at every level of bioterrorism planning. Content has to be specific for different professionals. Training should include: protection of oneself, protection of the hospital environment, resources (equipment and human), and when to request defense medical assistance teams and national strategic stockpiles. Content should be organized so there is coordination among entities responding to a bioterrorist attack (who is in charge, channels of communication, roles and responsibilities, training for first responders--school personnel or parents and people in the community). Training should be consistent, up to date, and organized so it can be accessed from a number of sources and on trainees' own time.

Recommendations:
- Incorporate training into all disaster planning, at different levels of providers and responders, with accurate, appropriate, up-to-date information.
- Review training already going on and add or enhance the pediatric component in existing training programs.

Discussion:
Ms. Schmitt informed the group that American Institutes for Research and CDC have developed training curricula on communications, which is offered free to state and local health departments, and other organizations. AIR can go out and conduct training. They have added a scenario where children are quarantined, with information on how to communicate that to children and parents.

Dr. Amler suggested that training is much more effective when accompanied by drills. There is no way to write down what everyone has to do in a complicated scenario. Drills gives people confidence. Second, he noted that there are vehicles already in place to reach certain groups, such as the American Academy of Pediatrics. Third, specialty units have trained pediatricians in environmental topics such as lead poisoning, pesticides, etc.

Dr. Maniece-Harrison commented that didactic and simulated drills are needed, in the medical community as well as in communities and schools. Some schools are already doing evacuation drills with children. A long-term goal is to incorporate bioterrorism training related to children into the medical school curriculum. Dr. Amler added there is already an effort to get terrorism training into medical schools, so we just need to ensure that pediatrics is included.

Dr. Rumm pointed out that no one has assessed pediatric preparedness. The first step is assessment of communities, local health, and states to see what people are not being trained in. Ms. Shaffer added that training must be offered to everyone involved in pediatric response, emphasizing how they are an integrated team.

Mr. Ricciardi noted that training has to include academics as well as those with on-the-ground experience. The military has extensive training courses in disaster preparedness, including field exercises. The American Academy of Pediatrics has a humanitarian assistance course, which could be modified. Vanderbilt University has an international nursing coalition for disaster preparedness, with a set of core competencies.

Dr. Kessell emphasized that special needs of pregnant and post partum women must be included.

Ms. Taylor informed the group about some Red Cross resources that are specific to schools. The Facing Fear curriculum specifically deals with terrorism. Information could be folded into existing CPR and First Aid Training. The Red Cross can provide training programs and help develop materials. Dr. Maniece-Harrison added that the Red Cross has people trained to educate communities about disaster preparedness.

Mr. Henderson asked whether training was a separate issue or part of all components. He cautioned the committee to be clear about who needs to be trained and what competencies are required. Some people in the community have received no training in terrorism response, such as community health centers, which makes assessment very important.

Dr. Maniece-Harrison wondered how much training children should receive as victims.

Mr. Smith explained that HRSA's training priorities include education and preparedness training for adult and pediatric hospitals, out-patient clinics, and pre-hospital health care professionals responding to terrorist events. Pediatric needs are included throughout. Part of the task is needs assessment, and part is estimating numbers of pediatric patients to prepare for. These training needs can be met through partnerships.

Mr. Riaccardi commented that children and adolescents can be first responders among themselves too. How can we train adolescents in schools to care for their peers and teachers?

Dr. Reissman commented that children might go to primary care providers with increased symptoms and risk behaviors, but the office might not know what the stimulus was. Clinicians need a set of questions to ask. Dr. Diaz added that having a psycho/social history is key.

Dr Kolbe said that pre-service training was another issue, as applied to each profession. It is difficult to fit disaster preparedness into pre-service training because of competing curricula, but it should become imbedded in nurses or physicians or teacher education and be viewed as an integral part of their profession, rather than an add-on. Dr. Malkerson responded that one of his recommendations was to make disaster response a priority and a core competency in pediatric training.

Dr. Amler noted that training is fundamentally very empowering for adolescents, like CPR training or boy scouts. Let them become part of the solution, not just victims. Also, sometimes the best training is that which piggybacks on existing knowledge.

Dr. Chemtob tried to summarize the discussion, saying that parents, providers, first responders, and non-traditional first responders all have general everyday roles, so we're talking about expanding their roles focused on specific emergency response in disasters. One way to do this is through existing organizations and core competencies. A second focus should be on collaborative skills, working with people brought together into *ad hoc* teams by necessity. The third task is dissemination, using existing groups. However he cautioned that research shows training has little effect, so a recommendation is to do research to evaluate training effectiveness. The role of HHS is to provide infrastructure to develop, disseminate and evaluate these role extensions. We are talking about training system enhancement to support existing structures.

Dr. Kolbe asked what the likelihood of pre-service training would be if the likelihood of terrorism was small. Training should perhaps be for emergency preparedness, not just terrorism. Dr. Chemtob added that most people in the civilian sector don't want to think of themselves as needing competencies in terrorism.

Mental Health Response Phase
Dr. Steven Marans, Harris Associate Professor of Child Psychoanalysis, Yale University School of Medicine, presented by Victor Balaban.

Remarks
Mental health must be represented in pre-event planning and preparation. Interagency agreements should be formalized as part of the planning process. A primary aim of instituting new partnerships is to determine in advance, capacities and deficits of each provider/responder group prior to the advent of critical, potentially traumatic events.

Training in mental health disaster management and treatment is needed by many professionals in many disciplines who will respond to children post event. These include emergency management first responders, primary care mental health, schools, clergy, and the media. In order to maximize their acute response effectiveness, acute response providers will need cross-training and familiarization with principles of child, family and community responses to trauma. The best response to trauma is a local response and cross disciplinary. Disaster mental health should be incorporated into clinical training of all mental health disciplines.

Training content should include disaster mental health organization, management and coordination; response issues and considerations (safety and security, meeting basic needs, obtaining disaster assistance, evacuation, reuniting families, quarantine, and public education); physical reactions and safety, distinguishing symptoms from a biological or chemical agent from those associated with mental conditions; the range of acute trauma reactions; ability of parents and other adults to assess response of children; mental health interventions; and others.

A mechanism for establishing credentialing should be built into the recruitment and training of mental health first responders and implemented well before any critical event. National qualifying standards would be useful in identifying and registering mental health professionals who have had significant experience and training in responding acutely to events involving violence, terror, disaster and mass casualties.

School-based interventions must not supplant efforts to identify, refer and treat children in need of more traditional and intensive treatment. School-based services should be part of a network that provides not only outreach, but also triage and referral to those with specialized training and expertise who can offer more comprehensive and intensive treatment. These linkages can and should be established pre event.

Federal guidelines and regulations regarding use of funding should be examined and modified to increase flexibility with respect to services. A longer period of service with specialized treatment services may be needed to address terrorist victims.

Existing programs potentially provide a needed source of clinicians to assist in the planning process pre event, in disaster mental health training, and in service delivery and supervision post event.

Recommendations

- Determine the role of mental health providers in the immediate aftermath of disasters
- There is a tremendous need for basic knowledge about appropriate treatments and interventions that support resilience. Mental health outreach and triage should be connected to surveillance, so information can be translated into program development.

A third commendation is using a standard of passive parental consent in the limited circumstance of federal or state disaster to facilitate screening and identification of children in need, however the committee recommends retaining the requirement for active consent prior to referral for actual service provision.

Discussion

Dr. Chemtob provided information about a recent study of downtown middle school children in downtown NYC (Ground Zero area). Researchers had to use active consent with incentives just get parents to return forms. Still they were able to screen only 10% of children and of those, 20% met the criteria for post traumatic stress. Of those, only one in three received any services. So of 9000 children who were never screened, a minimum of 10% needed but never received services. Schools are afraid of being sued, but they are freer to do screening than mental health providers.

Dr. Rumm turned the discussion to trying to pull out action steps. He liked the idea of registries and credentialing. This is related to response, it is dramatic, on site, and gets teams on the ground.

Dr. Reissman cautioned that when talking about outreach, triage and referral, there should be a connection with surveillance. When there is a disconnect between screening and surveillance, it's hard to transfer information to drive program development.

Dr. Tuma noted that even if all the human and material resources are in place, there still may be questions about effectiveness. More needs to be known about how to promote resilience and what treatment and services to being to bear and when, in order to prevent severe psychological reactions. He recommended trying to close the knowledge gap by identifying what resilience is and how it can be bolstered at different levels, and also to close the gaps between primary, secondary and other interventions.

Dr. Jones felt there was a need to include developmental aspects in the recommendations.

Dr. Mollica pointed out that mental health always seems to support other responders, as opposed to interventions that will help prevent post traumatic stress down the road. He wondered about the role of formal psychiatric providers' assistance at the moment of a disaster. Theirs is mostly a support and training role; they don't rush in and provide assistance.

Dr. Tuma wanted to include recommendations about the right time to get out of the way and when to have screening processes in place.

Dr. Pfefferbaum pointed out that different people play different roles at different times and there needs to be acknowledgment of special expertise.

Ms. Greene brought the discussion back to the issue of needs assessments, to determine what problems children have and what issues they present. What does mental wellness in children mean? Let needs assessments drive the funding and prioritization.

Dr. Dinnen felt that the discussion was too focused on the locale of the event, whereas it might be important to equip local communities in how to communicate better. He also wondered if the committee should be looking at global action as well as local.

Dr. Chemtab noted there had been no discussion of the role of the media, which is a major instrument of psychological recovery. Dr. Pfefferbaum acknowledged that the media can be used for the benefit of public as well as its detriment. Many opportunists appear on the scene of a disaster, which creates the need for credentialing and weeding out those who could be detrimental.

Dr. Kolbe offered some YRBS data about whether kids feel safe at school; before Columbine 4% felt unsafe, after Columbine the percentage rose to 10%. He thought there should be a recommendation for surveillance systems for mental health of children, primarily for pathologies such as post traumatic stress disorder, anxiety, and depression, but also how kids feel generally about living in this society.

Dr. Reissmen added that surveillance and communication should be connected, in order to understand people's beliefs going into the response. Any surveillance of developing symptoms has to be connected back to resilience and mental health. Mental health is hard for people to get their hands around, but there are concrete things that can be done around mental health and keeping children well.

Dr. Kessell suggested that the Department of HHS have a working group on mental health issues. This area needs very careful language specificity re mental health, behavior, care, and how do to intervene on the continuum of mental health. It can be complicated talking to children because we don't know enough about normal behavior. They might only need a hug when we are concerned with post-traumatic stress and illness. Children's responses may be appropriate for their age.

Dr. Holbrook asked whether there were enough providers to provide the care we decide children need. Dr. Tuma replied that there was currently an IOM study asking these questions about capacity and the work force.

Mental Health Recovery and Mitigation
Dr. Richard Mollica, Director and Associate Professor of Psychiatry, Harvard Program in Refugee Trauma, Massachusetts General Hospital

Remarks:
The Surgeon General is asking whether the mental health system is weak for children and adolescents. In many communities children don't have access to mental health services and many children don't have health insurance.
There is an important distinction between mental health in the seriously mental ill population and mental health in general public. These are two different policy discussions.

The indigenous healing system includes primary health care, clergy, schools and local volunteer agencies and families. Many of these don't always realize their importance as healers.
An enormous number of children have already experienced violence in their communities—which is much more serious and real than the threat of terrorism.
Mexican children think about violence in different way than Chinese—so we need to recognize cultural diversity and context.
Primary care physicians are stressed out, afraid of anthrax and SARS, and flooded with people drinking and smoking more, having unsafe sex. Their issues are much more complex than 9/11 and terrorism.
Studies should focus on symptoms, behavior personality, school performance, and resilience. We can't go to policy makers and say 80% children have PTSD, we have to talk about numbers of children flunking out of school.
Children look different in the psychiatrist's office than they do at school. We need spiritual and psychological ethnographies on children, their physical, spiritual, and psychological symptoms, behaviors, and attitudes.
Even before doing evidence-based research, we have to determine best practices and deliver action plans to different groups, including teachers, school counselors and nurses, primary care physician and pediatricians, families, and clergy.
Training doesn't necessarily lead to improved health care and performance. Primary health care providers need on-site supervision. Training is an on-going process. How would we train parents; do they need hot-lines, ongoing support?
Do we have culturally valid and reliable screening instruments for identification of problems by teachers, clergy, etc. Many people don't like screening for mental health. If the best instruments don't fit the culture, they won't work.
Are there simple basic things kids need to know to protect themselves in extreme situations?
The issue of needs assessments keeps coming up. However, just polling teachers, clergy, pediatricians and asking them what they need to deal with terrorism is too negative. Also, you need data to get money for interventions.
There are no national guidelines for use of psychotrophic drugs for children in emergency situations. Are there any national studies on antidepressents for kids? Perhaps we should look at fear and anxiety instead of depression
Pediatricians know practically nothing about ethno-psycho-pharmacology—i.e., practices in African-American, Cambodian populations. Most psychotrophic drugs are given to children by pediatricians.
What about the media's role in giving prevention messages to children (Sesame Street)?
Someone should pay for children's health care in an emergency even if they have no insurance coverage.

Recommendations:

- There is a need for a financial mechanism to provide post-disaster mental health care to all children, regardless of insurance coverage or presence of pre-existing conditions.
- Surveillance of the range of post-disaster mental health outcomes must be developed.

Discussion
Dr. Roberts informed the group that the FDA is studying several antidepressants for children ages 7-17. Prozac is the only one proven efficacious, for conditions like obsessive-compulsive disorder, but other studies are underway for other mental health conditions.

Dr. Kessell commented that Hollywood scriptwriters and other media have indicated they would welcome exchange and dialogue about getting prevention and other public health messages across, but they are not sure what boundaries are. There is a precedent for the Secretary to meet directly with the news media, but no one is sure how to do that.

Mr. Dinnin asked if there was any merit to having a national mental health communications system. This would be proactive, not just a website and there would be someone with real knowledge and expertise, similar to Homeland Security, not just talking heads.

Dr. Rumm recommended finding ways to make studies easier. There will be other events in the future and we need the power to do these studies. Mr. Henderson said his experience was that mental health issues are the first on the table and the first off. There need to be very clear and specific recommendations around mental health. This can't just be academic exercise. It would include special needs of children with pre-existing mental health problems, during the event and post event, as well as resiliency.

Mr. Henderson recommended combining the two mental health sections into one, especially because of the need to streamline the recommendations. Dr. Mollica added that the issue was priority setting. How do we boil all these recommendations down and prioritize them?

Dr. Rumm commented that it was hard to access all the studies that have been done and recommended a clearinghouse of federal information and published studies. There is a committed workforce of psychologists, social workers, and others who will do the work anyway and we need to partner with and support them.

Dr. Jones asked whether there was enough data from Oklahoma City and New York City to understand what the gaps in immediate and longer-term response were there. Grief counseling is not the same as mental health counseling. What can we learn from the past? Dr. Pfeffermaum replied that there was plenty of research that identified the gaps and Dr. Reissman added that an IOM report on the consequences of terrorism was coming out soon.

Dr. Chemtob said he felt that the infrastructure was missing to address and act on these questions. He would recommend to the Secretary that a network of regional terrorism and disaster-related centers be established (similar to those established by the American Public Health Association). Together the two networks could provide research, training and action foresight.

Dr. Wright pointed out that there were no children at the meeting today, and recommended going to focus groups with kids, or getting data from Columbine. Children are often able to recognize symptoms and indicators in their friends and classmates. Also how can we use children to mitigate during the response, and as a screening tool? Dr. Kessel noted that the Sesame Workshop interviewed children before and after 9/11. This methodology is not as scientific as we are used to—they used open questionnaires, drawings, etc. But it is very interesting information and they would welcome collaboration.

Public Health Departments, Government Agencies/Government Role
Dr. Peter Rumm, Chief Medical Officer, Division of Public Health, Wisconsin Department of Health and Family Services

Remarks:
Public health has three core functions: assessment, assurance, and policy development.

Recommendations

HHS as the leading health agency should work with other federal agencies to assure that preparedness at state and local levels, particularly in the upcoming HRSA and CDC grants and funding, assures action on the following items:

1. Comprehensive assessment: Work with ASTA and NAACHO to help state and local health departments assess preparedness and at least have state results
2. Commit to schools of public health to focus on physical and mental health preparedness for terrorism.
3. Work with DHS to dramatically increase the number of pediatric DMAT teams.
4. Work on CDC's website to set up separate page on pediatric preparedness linked to all other federal and other sites, with a 24/7 operator available.
5. Fund in all states a school health officer, who would work with the State Department of Education on terrorism preparedness initiatives. Part of the funding would support a course on bioterrorism preparedness and risk communication.
6. Develop a web-based network linking all hospitals and laboratories so that real time information can be disseminated in an emergency.
7. HRSA should assess their funding to hospitals in states, regarding children's equipment and special needs.
8. Set up Emergency Medicaid, special needs, quarantine issues.
9. Strive to find a medical home for all children, possibly using the NYC model in the aftermath of 9/11.
10. Reconvene an annual meeting of this Committee for up to three years, to follow up on recommendations.

Discussion
Dr. Holbrook commented that one reason DMAT teams haven't taken off is that people can't see how they are in their best interests. As hospitals begin thinking more about

evaluation and other issues, the teams will become more central to their thinking. He recommended emphasizing the creation of pediatric DMAT teams, rather than giving specific numbers.

Mr. Henderson noted that in order to have this Committee reconvene regularly, it would have to be engrained in an existing institution at HHS or attached to an official body looking at emergency pediatric preparedness. There should also be changes in charter, so that children and bioterrorism is always discussed in the context of other emergency PH issues.

Surveillance and Assessment Mechanisms
Dr. Alexander Kelter, Chief, Epidemiology and Prevention for Injury Control Branch, California Department of Health Services

Remarks:
This whole subject should be called health intelligence, based on CDC's old Epidemic Intelligence Service. In the 1950s CDC stationed epidemiologists all over the country to detect diseases in case Russians put E-coli or some other infectious agent into the water system. We have been assuming the capacity to monitor conditions and diseases that might be associated with terrorism still exists, but it does not.

The Secretary should commit resources to establish and sustain PH infrastructure for surveillance, which includes all public and private health institutions that serve the mental and physical health needs of the population, including emergency and pre-hospital care, trauma systems and children's hospitals, and venues where substantial numbers of people might shelter during an event (schools, nursing homes, major employers, etc.). The system should be capable of real-time reporting to state centralized surveillance systems for policy development and decision making.

Another recommendation is related to research to understand whether the interventions effective, and what needs to be done to prepare communities for future events. The recommendation is to embed epidemiological capacity into all surveillance and response systems, to document the response and create the scientific basis for conducting outcome studies

We assume the need for surveillance speaks for itself. We know how to count cases of E-coli, anthrax or smallpox, but our ability to do surveillance for mental health outcomes is not well developed. States do not know how to report on mental health symptoms and conditions, so we need to recommend to the Secretary that definitions for mental health conditions and disorders be created.

Recommendations

- Commit resources to the establishment of a public health intelligence infrastructure specifically to support health needs of children, with data made available to policy and decision makers.

- Emergency planning and response must include the epidemiological and analytical capacity necessary to establish the scientific basis for outcome studies, direct researchers so hospitals are not overwhelmed, document surveillance methods, and recommend mitigation methods.

Discussion

Dr. Jones shared her experience in determining the set of common definitions recently released around domestic violence and categories of sexual assault. It was very difficult to get all communities to agree.

Dr. Mollica wondered if it would be possible to work backwards, from surveillance to defining mental health phenomena--see what the children are presenting with in the ER and then work backwards. Dr. Kelter thought this was research rather than surveillance. It would have to be planned in advance, so a sufficient number of people with research capacity would be deployed.

Dr. Rumm pointed out that children are more likely to show up at the ER with diarrhea or vomiting. Having robust surveillance for typical childhood diseases still is important to keep in mind. Dr. Kelter added that it was important to have this surveillance as a day-to-day system. It doesn't work in an emergency if not used, sustained and improved on a day-to-day basis.

Dr. Kessel was concerned about how to present these recommendations. There is plenty of data and no information. It is better to start with applications and what the information will enable us to do, as opposed to just constantly recommending more surveillance and research. What are the product, the benefit, the consequence and the outcome? He was concerned that people at the community level don't know enough about the conditions, needs and vulnerabilities of children in their own communities. Public health tends not to know where schools are, schools don't know where the fire departments are, and we have never integrated information on resources, assets and vulnerabilities. He cautioned against using the words "surveillance and assessment" without knowing how they will make people at the state and community level more knowledgeable and able to respond. Dr. Rumm responded that they don't have that kind of data at the local level, which is why assessments are needed.

Dr. Kelter pointed out that in 1997 people had to be evacuated in northern California during floods. There was no inventory of where people with special needs (such as dialysis patients who are cared for at home) were and what their needs were. Dr. Kessel suggested looking at other data and information systems and integrating them. Even police reports can be useful. All data is local and has to be collected at that level.

Ms Cono mentioned a set of tools called MAPP that has been pilot tested in several communities. There are instruments for mapping community assets, survey forms for assessing health status and outcome. These could be shared and modified.

Another person suggested that a recommendation might be to assure that children's hospitals and health care centers are incorporated into the surveillance system. It's also important to know the baseline for cases being seen. A year ago, when there were rash outbreaks among children, pediatricians, dermatologists and schools nurses contacted state health departments, who in turn contacted CDC's bioterrorism unit. This demonstrates local concern and interest at the local level.

Dr. Markenson commented that part of the recommendation is to support existing surveillance systems and noting unusual clusters of symptoms, illness and behaviors. Funding existing public health surveillance systems would help improve terrorism capability. We might not need new systems if we can replicate federal level systems at the state and local level.

Mr. Henderson agreed that it would be a good idea to collect information to support actions. In disease surveillance, what are we doing specifically for children? Where and how do we recognize when children are symptomatic or victims of terrorism in schools? Schools have to recognize symptoms and know whom to call first. What is unique with children?

Dr. Reissman extended her congratulations to the committee on even considering trying to get definitions of mental health proxies. CDC has been trying to tap into systems and come up with answers to questions communities might ask. But there are still no proxies for problems that are not purely organic in nature. We know many physical symptoms that are reactions to trauma at home; children react by letting their existing diseases go rampant. This is one way to get a handle on mental health issues. In adults, chest pains and gastric distress are all symptoms of stress.

Pre-Hospital, Critical Care, and Hospital Preparedness
Dr. Jean Wright, Executive Director, Backus Children's Hospital and Richard Ricciardi, Chief, Primary Care Nursing, Department of Ambulatory Care center, Fort Meade, Maryland

Remarks
Our task is more than just adding children to current preparedness plans. The recommendations relate to three phases: preparation, response and mitigation. The focus is on preparedness and communication.

Preparedness for children involves proper nourishment, vaccinations, and environments where children are cared for well. Preparedness for hospitals means being well staffed, with adequate resources, but hospital facilities across the nation not operating at the same level. Therefore money for disaster preparedness has to come from the outside.

All hospitals should have some degree of preparation, even if the care of children is not part of their mission. Best practices for hospitals include inclusion, decontamination and training. The second part of training is sustaining it over the long term. How often to

train? What happens to day-to-day operations during training? Who pays for it? What do you do with real patients during training? It is complicated, difficult and expensive.

A second major recommendation has to do with communication, command and control. What's happening with children out in primary care, faith-based areas, emergency medical systems, other hospitals—how does everyone communicate with each other to facilitate response to a disaster and recovery? How does information get from rural area to hospitals?

A third are would be medical and pharmaceutical supplies. We looked at the NPS list, and found nothing on pain and sedation medications for children.

There is a need to support health care workers in the hospitals. Hospital personnel are thinking of their own children during a disaster. This may be 5 days or even several weeks of activity. Hospitals are primary people, so how do we keep staffing up during a long siege. We haven't had a test of surge capacity. Patients may be there for weeks or months, or we may be even moving staff from one state to another.

A fifth recommendation has to do with decontamination and quarantine. SARS is showing our lack of preparation. We do a poor job with universal precautions.

Sixth, civilian hospitals not well equipped to do triage. Usually they deal with one patient and one outcome. Triage is a military mindset. All hospitals use standardized protocols. How do hospitals manage surge issues, not just when patients peak, but when their care could be handled closer to home (expatriation of patients)? We need exceptions to rules during emergency.

Another question is how do we hold hospitals accountable?
What about special needs kids? Can we use MAPP tools to determine where special needs kids are, who may be mainstreamed in schools and not at home.

Recommendations

- All hospital institutions should have some degree of preparation even if the care of children is not the majority of their daily mission, since they may find themselves providing disaster management and bioterrorism care for children should they be the closest provider or if other institutions are overwhelmed.
- There should be communication systems available for in-hospital communication, bioterrorism surveillance/detection and notification, amateur radios in the event of telephone failure, communications systems between hospitals and local officials, and communication between the hospital and children's specialty centers and other child care facilities.
- There should be an ample supply of medical and pharmaceutical supplies at the hospital and arrangements made with suppliers and government through the National Pharmaceutical Stockpile, of age and size-appropriate supplies, medications and equipment, including ventilators.
- Support for health care workers in hospital

- There should be biohazardous decontamination and protection equipment appropriate for caring for children in quarantine.
- Hospitals should develop and utilize pediatric triage systems that incorporate physiological and logistical differences unique to children, so they can be appropriately triaged according to their needs and available resources.

Discussion

Mr. Smith said that the new HRSA guidance was going out the day after this meeting, with a specific section on children and families.

Mr. Henderson noted that the child escort issue was missing, especially when the system is jammed. Information on child wellness is also missing.

Dr. Wright explained that communication should come first, such as how to communicate with other hospitals that have more beds. Another point was that if a large number of children become ill, each one needs an adult escort until appropriate guardian arrives.

Ms. Greene asked how telemedicine would fit in. It would be one way to meet the challenge of getting children to primary care providers, and could also help with assessment and triage. Mr. Ricciardi responded that his experience with telemedicine has been very frustrating, especially during a disaster. He felt it would be better to see schools as primary providers. Ms. Cono explained how the CDC set up telemedicine links to the University Utah during the last Olympics. They found digital cameras invaluable in diagnosing and treating. Re stockpile issues, a working group met yesterday and identified deficits.

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Next Steps
Dr. Diaz asked committee members to think about the recommendations and feedback from today's meeting and respond by May 7th. Victor Balaban and the committee staff will turn these recommendations into a seamless report. The assignment is two recommendations per person plus action steps and supporting recommendations. Binders will have all the supporting documentation. The Secretary will get a 15-page summary, with supporting materials binder. The next meeting may 21st in DC. There will probably be a conference call before that meeting.

Dr. Diaz asked if there was any public comment and there was none.

Approval of minutes: Ms. Greene pointed out two corrections. The first had to do with the spelling of her name. The second was that "childcare should be moved to the community focus area."

There was a motion to approve the minutes. This motion was seconded, there was a vote and the minutes were unanimously approved.

A final announcement was that a new website specific to this committee's work is now up. The public can send comments to the committee through this website. The address is **http://www.bt.cdc.gov/children/index.asp**.

The meeting adjourned at 4.50 pm.