National Advisory Committee on Children and Terrorism
May 21, 2003
Washington, DC

The meeting was called to order at 9:10 by Dr. Angela Diaz, Chair of the Advisory Committee.

Committee Members Present:
Dr. Angela Diaz, Chair, Mt Sinai Medical Center, New York
Kevin Dinnin, Baptist Child and Family Services, San Antonio, Texas
Brenda Greene, National Schools Boards Association
Dr. Alexander Kelter, California Department of Health Services
Dr. Bobbie Maniece-Harrison, Dept of Health Studies, New York University
Dr. Steven Marans, Yale University School of Medicine
Dr. Angela Mickalide, National SAFE KIDS Campaign
Dr. Richard Mollica, Massachusetts General Hospital
Richard Ricciardi, Department of Ambulatory Care Center, Fort Meade
Dr. Peter Rumm, Wisconsin Department of Health and Family Services
Dr. Jean Wright, Backus Children's Hospital, Savannah, GA

The Executive Secretary, Joseph Henderson was not present. Amy Loy represented him.

Federal Advisors Present:
Dr. Robert Amler, ATSDR
Dr. Joanne Cono, CDC
Dr. Lloyd Kolbe, CDC
Cyndi Shaffer, CDC
Dr. Wanda Jones, DHHS
Dr. Woodie Kessel, DHHS
Dr. Rosemary Roberts, FDA
Rick Smith, HRSA
Dr. Margaret Feerick, NIH
Dr. Farris Tuma, NIH
Dr. Dori Reissman, CDC
Dr. Nicki Pesik, CDC
Andrea Argabrite, HRSA
William Modzeleski

Consultants Present
Dr. Claude Chemtob, Mt Sinai School of Medicine
Colonel Theodore Cieslak, Brooks Army Medical Center
Dr. Louis Cooper, AAP
Dr. Fred Henretig, Children's Hospital of Philadelphia
Dr. Irwin Redlener, AAP

Committee Staff
Victor Balaban
Amy Loy

Others (sign-in list)

Sue Martone
Shannon Manzi
Erika Stewart
Lisa Barrios
Benjamin Becker
Lauren Baskin
Susan Eads Role
Ellen Gerrity
Wendy Davis, HRSA
Heather Doyle
Tom Canter (?), Washington Times
Sumana Chatterje
Drew Bernstein
Elizabeth Evans
Von Roebuck
Angela Fazah, Maximum Technology Corp.
Sharon Bell, Maximum Technology Corp.

Dr. Diaz congratulated the committee on getting everything done on time, and explained that they would continue to refine the recommendations in today's meeting. She asked if there were any questions or corrections to the minutes of the last meeting. Since there were none, there was a motion to approve the minutes; that motion was seconded and passed.

Emergency Medical Service Systems and Protocols, Dr. Irwin Redlener

> **Recommendation #1**: **The Secretary should support and enhance the existing HHS programs, which assure that the needs of children are met in the EMS system.**
>
> This can be accomplished 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
    - 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 Activities
- Assurance that all HHS Emergency and Terrorism Preparedness activities that involve EMS require that pediatric considerations be included in these efforts
- Increased funding should be provided to programs such as the Emergency Medical Services for Children (EMSC) to develop mental health resources for EMS providers, including pediatric triage tools and information regarding the importance of pediatric mental health in emergency and terrorism preparedness and response.

Recommendation #2: The Secretary should increase funding for research on EMS pediatric emergency and terrorism preparedness and response. This can be accomplished via:

- Establishing EMS pediatric emergency and terrorism preparedness and response as a Maternal and Child Health (MCHB) Research Priority
- Establishing research funding for studies related to EMS and Pediatric Emergency and Terrorism Preparedness including triage, assessment, treatment and including mental health, in the form of RFPs and RFAs from NIH and its institutes
- Creating mechanisms for funding Pediatric Emergency and Terrorism Preparedness research gaps identified by the EMSC program

Recommendation #3: Because acts of terrorism or other disasters may occur at unpredictable times and places, it is important that emergency planning explicitly account for the possibility of children being congregated in various settings. These settings include, but are not limited to, schools, day care programs, after-school programs, youth organizations, summer camps and others.

Basic information concerning appropriate preparation for disaster needs to be widely distributed to all potential congregate settings for children. Mechanisms for identifying such settings and ensuring appropriate distribution should be delineated.

Comments:
Under Recommendation #1, there is one sub- bullet that reads: "Targeted issues grants focused on emergency and terrorism preparedness." Dr. Redlener said there should be a specific focus on children.

The last sub-bullet of that recommendation," Increased funding should be provided to programs such as the Emergency Medical Services for Children (EMSC) to develop mental health resources for EMS providers including pediatric triage tools and information regarding the importance of pediatric mental health in emergency and terrorism preparedness and response," should talk about children and families, not just children.

Dr. Mollica recommended that the document say "children, adolescents and families," not just "children." The language needs to be explicit. He also said he was uncomfortable with the word "health," because policy makers don't always think about mental health. It is important to eliminate any ambiguity of terms.

Dr. Rumm wondered about starting the document with a list of definitions, as one way to resolve ambiguity and insistencies. Dr. Marans added that the introduction could also have an overarching set of principles, showing consensus about such issues as health/mental health, research and surveillance, clinical utility, needs assessment, etc. Dr. Modzeleski cautioned that there are times when the terms mental health and physical health should not be used synonymously. He recommended being explicit throughout the document. Dr. Jones added that policy makers might turn to just one section of the document, pulling things out of context. She supported specifying physical and mental health, and children, adolescents and families.
Dr. Amler noted that one purpose of this report was to remind policymakers that this is a heterogeneous group of people. Ms. Greene reinforced the idea of having some overarching recommendations and principles, and noted that she had devised a few already.

Dr. Redlender turned the group's attention to the third recommendation regarding the focus of emergency planning, which should not just be schools but all potential areas where children congregate, including daycare centers, after-schools programs, camps, etc. He wanted to make sure basic information would be available at those levels.

There was also a suggested recommendation that HHS should work with the Department of Homeland Security to establish regionally-based pediatric response teams that would be available on a 24/7 basis. Dr. Rumm explained that this would be a volunteer secondary response team, based on a CDC model. Dr. Cono added that CDC was focused more on epidemiology, surveillance and outbreak containment, but not medical services. The latter would call for local response teams, which would have specific responsibilities. Dr. Rumm recommended these teams be created at the regional HHS level, with regional pediatric experts. There are plenty of volunteers, but there are issues of coordination, licensing, etc. to be resolved. This could build on existing emergency preparedness system, of which DMATs are a part, with one or two pediatric specialty systems. Rick Smith added that this could also fit into HRSA's regional planning

Dr. Manice-Harrison pointed out that in her last draft under training, she had suggested an increase in the number of fully formed pediatric DMAT teams, and that all DMAT teams add pediatric component to their current training.

Dr. Jones referred to Recommendation #3 and requested that juvenile detention centers be added. The current wording seems to be focused on middle class youth.

Dr. Chemtob pointed out that the French emergency response system has a significant number of people on reserve, trained and ready to be activated. Dr. Jones noted that the Department was working on a medical reserve corps and Dr. Kessell clarified that it was in the Office of the Surgeon General. Dr. Cieslak added that Texas had something called the Texas Medical Rangers.

Dr. Kessel was concerned that pediatricians should not care for pregnant women, and that obstetricians should be included. Dr. Rumm also wanted to include mental health .

Dr. Marans cautioned that many states are missing levels of expertise, so the priority should be to provide specific support to primary providers, particularly at the local level. Dr. Redlener added that it would be important to delineate under what circumstances different levels would be deployed and how. The Academy of Pediatrics has been asked by the Task Force on Terrorism to identify all people who are or would become experts in this area. Dr. Marans asked if there was a way of using existing networks already mobilized and tap the expertise of the Academy via state and local health offices. Dr. Reissman wondered if there was any way to integrate with the American Red Cross approach to reach needed expertise.

Dr. Redlener noted that these were part of larger infrastructure issues having to do with coordination among existing and new agencies, private and public sector organizations. It would not be advisable to throw in new experts and layers in during a disaster. It is preferable to coordinate in advance with what's already on the ground. Dr. Amler added that one way to test efficiency of such coordination is during drills. No plan survives first contact with event.

Dr. Cooper asked where pediatricians fit into overall state plans and whether a state-by-state assessment was needed.

Dr. Rumm said he was disappointed that in the recent HRSA and CDC RFPs, children's issues were not mentioned and there are therefore no mandates to assess pediatric preparedness. This should be a seminal recommendation.

Dr. Kessel noted that the Committee's recommendations lean toward funding, rather than organization. During 9/11it was impossible to coordinate all the volunteers. Recommendations about organizing all pediatric resources and creating registries would add strength to this section. Dr. Kolbe pointed out that CDC has been trying to work more closely with local, private sector people to develop better working relationships. Dr. Rumm responded that at the state and local level, evaluation, feedback and oversight were just as important as funding. There is good language in the HRSA grant, but the amount of money dedicated to children's health needs is only a very small percentage of the whole. There needs to be specific language for next year.

Dr. Mickalade asked whether FEMA had a civilian corps. Dr. Shaffer responded that there was insufficient funding to move that forward.

Dr. Marans noted that there were two issues on the table, funding and an existing body of knowledge. The Academy has developed recommendations and knowledge. One recommendation to the Secretary could be to mandate formal linkages between funding and inclusion of pediatric expertise in planning, preparedness and response at state and local levels.
Dr. Redlener suggested acknowledging throughout the document that pediatric departments at medical centers can be tremendous resources and they need to be encouraged.

Strategic National Stockpile, Dr. Pesik

> **Recommendation #1: 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.**
>
> **Recommendation #2: The Committee recommends that a process be established to determined prioritization of recommended formulary additions or modifications to maintain and enhance pediatric capability and capacity.**

Comments:
Regarding the second recommendation, Dr. Pesik explained that CDC has specialists continually making recommendations for modifiying the formulary, but there is no way to prioritize recommendations. It is partly threat driven (burn and blast, radiation). There needs to be an overall system for prioritization (based on national shortages, surge capacity and other criteria).

Mr. Ricchardi underscored the importance of logistics when discussing pediatric teams and coordination. People in the field using the equipment should be part of the decision making, and need to be familiar with equipment. Dr. Pesik responded that CDC was working with local communities to help them understand what type of supplies and equipment might be brought in so they are prepared to use them. They bring in subject matter experts for each topic, including pediatrics, transport specialists, etc.

Children and Schools – Brenda Greene

> **Recommendation #5: The Secretary should ensure that each major content area in DHHS-funded terrorism initiatives, and in other federal terrorism initiatives, addresses the role and needs of schools.**
>
> This can be accomplished by:

- Providing dedicated fiscal resources and regulatory oversight to ensure that state and local health departments, and other agencies involved in this work, truly build partnerships with state and local education agencies and schools.
- Expanding CDC's School Health Program by supporting staff in every state education agency and health department to focus on the health and mental health needs of students, including emergency preparedness and response. State school health leads, in education and health agencies, should work closely with state mental health, law enforcement, emergency management, and homeland security agencies and should receive at least a one-week course on the essentials of terrorism preparedness and risk communication.
- Revising the Federal Response Plan, HHS/CDC Public Health Preparedness and Response for Bioterrorism Continuing Grant Guidance, HHS/HRSA National Bioterrorism Hospital Preparedness Program Cooperative Agreement Guidance, and other funded programs to indicate the need for schools and education agencies to be an integral part of preparedness, response, recovery, and mitigation efforts.
- Developing and disseminating information and instruments to improve schools' ability to prepare for and respond to chemical, biological, radiological, and mass trauma (physical and psychological) terrorism.
- Ensuring that HHS conduct and support new research addressing issues affecting preparedness of schools and their ability to respond to terrorism with emphasis on the impact of preparedness activities on student mental health and wellness; the availability and preparation of school health and mental health personnel to triage and respond to chemical, biological, radiological or mass trauma events; the ability of school staff to balance the needs of their own children and families with those of the children in their care; and the identification of "best practices" related to preparedness and recovery mental health services.

Recommendation #6: The Secretary should work with the Secretary of Education to ensure that schools are fully integrated into preparedness, response, recovery, and mitigation efforts.

Specific activities on which HHS and ED can work together include:

- Add funds to the School Emergency Response to Violence Project (SERV) contingency fund, increasing the government's capacity to respond in a fast and flexible manner to meet the critical needs of schools and students after a crisis in the school or community.
- Fund demonstration projects that expand and evaluate existing models (e.g., New York City, Los Angeles) for involving education agencies and schools in a coordinated system of response and recovery.
- Ensure that schools place a high priority on returning students to school and their normal routines as quickly as possible after an event as one important method for supporting their resiliency.
- Train students, staff, and family members to be first responders.

- Provide funding for additional collaborative efforts, building upon the May 2002 teleconference developed by the Department of Education, Centers for Disease Control and Prevention (CDC), Federal Emergency Management Agency (FEMA) and Federal Bureau of Investigation (FBI) to provide state and local education, public health, mental health, emergency management, law enforcement, and homeland security agencies with updated information on biological, chemical, and radiological threats; answer questions about school preparedness and response; and describe roles of partnering agencies in the case of a terrorist threat.
- Ensure that schools are part of planning and training if the use of their facilities is cited in emergency response planning documents. For example, many states have said they would use schools as sites for mass vaccination clinics if there were a smallpox event, but it is unclear if the schools know of these plans or who would be calling to gain access to the buildings in case of emergency; nor is it clear if plans are in place to assist with staffing the clinics and maintaining the infrastructure.

Comments:
Ms. Greene explained that some changes had been made in the above recommendations since the last meeting. In the introduction, a paragraph about the TOPOFF drill was added. She noted that schools were apparently not included in that drill even though it was assumed that they would be included as sites for dispensing medications.

Ms. Greene said she would like to add that national level activities would occur at state level as well. Dr. Rumm suggested funding one senior official to coordinate between state health departments and departments of public instruction. Preparedness for children would be part of that mission. He also wondered why there was no language about day care. Ms. Greene explained that day care had been put into the community arena.

Dr. Cooper suggested that anxiety might be reduced if terrorism were part of subject matter in classrooms, in social studies and history classes. Ms. Greene explained that this was in the larger report under curriculum decisions.

Dr. Kessel was concerned about how to differentiate what needs to be done from how to do it in the recommendations. We need to help policymakers understand implementation, beyond just increasing funding.

Dr. Modzeleski made a series of comments. He cautioned that it is important to be careful about what is said to children and how. Parents are concerned about what's being discussed in school, and high school is different from elementary school. These are state and local issues, and school boards make the ultimate decisions. Are we talking just about public schools students, or private/parochial as well? A significant number of children are not in public school. He felt the new paragraph on TOPOFF was vague about whether schools were included. The recommendations need to show exactly where school plans for emergencies are inconsistent with community plans. Too often there is a lack of coordination and communication. He thought the recommendations should be

reviewed to make sure they are clear to people without medical, or mental health training. More specificity is needed. Finally, it would be important to review efforts in the past and capture lessons learned.

Dr. Marans commented that a major issue of community planning is how quickly communities can return to normal life and stability, starting with schools. Ms. Greene explained that this was captured in one of her overarching recommendations, as well as specific recommendations for schools.

Dr. Reissman noted that both recommendations talk about hazards—chemical, biological, radiation, but they don't mention terror and fear. This is an opportunity to infuse a public health perspective of mental health. Where can schools be brought up in other sections? Ways to undercut fear need to be interwoven throughout the document. Dr. Balaban responded that these concerns were addressed in the risk communication section.

Dr. Chemtob said a major impediment to working in schools is their immune system/barriers, unless prior relationships are set up. This committee is recommending preparing schools to become part of an emergency response and providing a structure that can be activated, including psychologists. Schools are one of few *de facto* community structures left. Under the first recommendation, he proposed that there be a mechanism for providing technical assistance to schools to help them make that shift. Under the next recommendation, he suggested that the best way to help children is through Public Health screening, but the guidance must be clear about what is permitted in emergency context, e.g., use of passive consent for screening. Otherwise, schools tend to take most conservative position. Dr. Rumm added that this should be joint collaboration between CDC and the Dept of Education. Creating synergy through coordination at state levels needs a specific bullet under the recommendations.

Ms. Greene emphasized the need for a written report of the TOPOFF exercise to see what heppened with children.
Dr. Modzeleski pointed to the Fairfax county smallpox plan as a model that is built around schools working with law enforcement and public health officials.
Ms. Greene was concerned that the recommendations make it clear where children will be educated if schools are taken over, and how to deal with mental health issues. Mr. Dennin indicated that some communities are using churches rather than schools because they are empty most of the time.

Dr. Reissman, who participated in TOPOFF representing mental health, found that children were hardly acknowledged. Separation of children from families has not been addressed in the recommendations, but schools will become virtual parents during quarantine. It is still confusing as to how information is going to move, so psychosocial input is needed at every level. People don't see beyond saving lives right now.

Dr. Wright was concerned about the lack of chaperones, whether children are in school, hospitals or the EMS section. Dr. Amler added that there would be a need to identify individual children taken to hospitals, the morgue, etc.

Surveillance and Assessment (Health Intelligence) -- Alex Kelter

Recommendation #24: The Secretary should assure that the health intelligence systems that are necessary to support emergency planning, response, and recovery are fully supported to be competent in the areas of children's physical and mental health data.

- Funding should be provided to allow HHS, working through the CDC and HRSA, to require that the Health Alert Network be linked on a 24/7 basis to all hospitals that care for children, particularly tertiary care centers.

- In order for health intelligence systems to be in a constant state of maintenance and readiness, they must consist of the day-to-day public health and emergency medical systems tied together in real-time networks that are fully supported and improved to accommodate the jurisdiction's mental health needs and the needs of children.

- Centralized local and state public health agencies must have the capacity to analyze and report on the patterns of physical and mental health diagnoses, conditions and services being rendered in real time. This requires the jurisdiction-wide participation of:
  - All public and non-public physical and mental health institutions
  - All hospital and pre-hospital services
  - All pediatric hospitals and trauma systems, including Emergency Medical Services for Children (EMSC) providers
  - Schools (absenteeism has been proposed as a "syndromic surveillance" system).

- Venues where people would likely be sheltered in place must have the capacity to report physical and mental health needs that occur in schools, nursing homes, large employers, etc.

- "Surveillance definitions" (or "case definitions") specific to pediatric and mental health diagnoses and conditions should be developed through a consensus process, and subsequently training and education should be conducted on these definitions for private, local, state and federal participants who participate in these local and state health intelligence networks so that there is a consistent flow of interpretable information available in emergency operations centers and government offices to support policy and emergency response decision-making by incident commanders and elected officials. These case definitions should be developed in conjunction with the Council of State and Territorial Epidemiologists (CSTE) to determine which conditions are currently legally reportable, and which conditions and diseases that pertain to children may need to be added to the Nationally Notifiable Disease List.

- Evacuation plans should include the specific needs of seriously physically and mentally ill children (and their caretakers), those who are being home schooled, and those who are living at home and therefore not accounted for in the emergency response plans of any health institutions. Such children may be on hard-to-obtain medications, home dialysis machines, respirators, or may have other sophisticated needs that complicate such emergency procedures as shelter-in-place and evacuation.

Recommendation #25: The Secretary should assure that the emergency response systems utilized to support emergency planning, response, and recovery at both the local, state and federal levels fully include trained scientific and epidemiological professionals in order to:

- Provide real-time analysis and pattern interpretation of health intelligence data to support policy and emergency response decision-making by incident commanders and elected officials

- Design and maintain study instruments to support short- and intermediate-term scientific studies of those adversely affected by the emergency, be they patients, their family members, neighbors, caretakers or co-workers

- Design and conduct intermediate- and long-term epidemiological studies and analyses of patterns of injury and illness to inform mitigation measures that would reduce susceptibility and risk in future such emergencies. Examples might include:
  - Injury patterns in buildings that would inform future building design and retrofit, or would suggest changes in building evacuation techniques or shelter-in-place decisions
  - Illness patterns that would inform future immunization, sheltering or isolation and treatment decisions
  - Protect the medical records departments of hospitals and emergency departments from repeated, high-volume requests for records from independent scientific researchers. Features of this process could include pre-arranged relationships with hospitals and nursing homes that:
    - All scientific studies of the effects of the emergency be coordinated by the emergency response epidemiologists
    - All requests for data be processed through the emergency response epidemiologists who would then make a single request for all the needed data from participating institutions
    - All research reports be coordinated such that decisions about authorship and attribution of scientific conclusions be negotiated centrally early in the process.

Recommendation #26: Early detection of a release of a biological, chemical, or radiological agent is necessary for mounting effective responses. Funding should be provided to expand and integrate ATSDR's Hazardous Substance

Emergency Event Surveillance System and the CDC collaboration with the American Association of Poison Control Centers to broaden their Toxic Exposure Surveillance System (TESS), and to create specific pediatric components to both programs.

These programs can be expanded and improved into a surveillance network for detecting chemical and radiological terrorism events by allowing chemical and radiological illnesses that may indicate a terrorism event may be detected in a timely, effective, and integrated manner.

Comments:
Dr. Kelter said he wanted to discuss bridges among recommendations and structural issues. He suggested inserting a sentence about the health significance of children separated from parents. Recommendation #24 could be rewritten and bridged to Recommendation #3, which talks about coordination with state, city and county public health officials and operational planning roles. Recommendation #24 also talks about roles of different public health specialists in response and planning.

Dr. Kelter agreed with an earlier recommendation to include correctional facilities for young people as a venue. His main suggestion for Recommendations #25, regarding epidemiological capacity for surveillance and research, was that it should be bridged to Recommendations #7, #17 and #19, all of which talk about research and studies. Recommendation #25 lends itself to another recommendation, namely that the Secretary needs to assure epidemiological and science capacity in emergency response and planning. One way to do this is to increase size of the CDC and global epidemic intelligence programs. As epidemic programs expand, they should recruit pediatricians and augment training of all EIS officers, with additional information re the needs of children and mental health needs.

Dr. Rumm responded that there is no federal funding for training programs, and schools of public health aren't doing basic preparedness. There needs to be recognition and targeting of other sources, which are currently ignored at the national level.
Dr. Kelter replied that the Secretary would be sensitive to anything called epidemic intelligence. The reason for making a recommendation would be to add county and city jurisdictions to the list of places assigned EIS officers. Any place with response teams, should have EIS officers. Dr. Rumm commented that most EIS officers stay at CDC, and Dr. Kelter added that those in the states have too much to do already.

Dr. Redlener felt that the larger question was a fundamental weakness in underlying infrastructure and that the Committee was trying to add a sophisticated level onto imperfect (crumbling) infrastructure. How do we incorporate that concern into this document and the recommendations? It is not possible just to recommend that the Secretary should fix whole the public health infrastructure and make sure there is a medical home for each child.

Dr. Mollica pointed out that surveillance is an exciting and innovative issue for mental health. It is an issue of priority and capacity building. Mental health hasn't been top priority at CDC. This is a great opportunity to think about surveillance in a new way and produce useful, valid information for many diverse populations. Dr. Kelter wondered if that was a priority for this report.

Dr. Marans thought these were overlapping points, in terms of establishing a critical mass of information. He preferred a centralized approach with government leadership, using language that gets at the issue specifically, for example, the role of time surveillance with more information on the natural history of children's responses to terror and disaster experiences, including the terror of threat. This makes it possible to accurately access needs over time and eventually interventions.

Dr. Jones pointed out that mental health wasn't part of CDC's mission and wondered if SAMSA was prepared to talk about that. Dr. Rumm noted that the CDC RFP does call for mental health assessments at the state level, but it is not specific about what surveys and who should be targeted. This committee could make it a specific recommendation, defining what should be assessed on children.
Dr. Kolbe noted that terror is an agent and a psychological phenomenon that needs to be measured so that it can be addressed. CDC could work with NIH and SAMSA to develop an understanding of what is to be measured and put systems in place.

Dr. Risssman pointed out that there were already some collaborative efforts in agencies to look at community resilience. The data on mental health may come from other proxy indicators, such as more accidents or more crime. She also noted that the idea of response was not included in the recommendations. It is important to understand people's perceptions of danger, trust, safety, in order to direct interventions.

Dr. Redlener commented that when dealing with terror as an entity, it would help to be able to maximize experiences in other countries that deal with terrorism regularly, e.g., Israel, northern Ireland, etc.
Dr. Marens felt there needed to be an infusion of resources for existing CDC capacities, taking the experiences of other countries and setting up a joint, centralized interagency task force on terrorism.

Dr. Chemtob wondered whether it would be necessary to have legislation or regulations that permit surveillance in times of emergency, with a shift from privacy to health concerns. In NY after 9/11, the first compehensive needs assessment of children's MH was carried out, but children were anonymous. It was done to bring in money, not to help children.

Dr. Kessel asked whether there was a need to be specific about phases of events andwhat information would be helpful for each phase. Dr. Kelter replied that this was why the recommendation should bridge with research recommendations. Dr. Kessel suggested linkage back to specific topics.

Dr. Marans asked how one would bridge clinical needs, since these are not isolated topics; they all relate and need to be bridged. At what points is surveillance introduced and what are the time points for data collection? Dr. Chemtob replied that communities have to be surveyed before the event. This is a political issue, but it's also cultural issue. People get confused about the implications of surveying for mental health. In NY the fundamental infrastructure was so deficient they couldn't handle the money that came in.

Primary Care Providers and Pediatricians, Dr. Angela Diaz

Recommendation #10: Ensure that all children have physical and mental health coverage and a medical home with a Primary Care Pediatric Provider (PCPP) in the aftermath of disasters and terror attacks.

- The Committee recommends that programs such as the Centers for Medicare and Medicaid Services (CMS) administered State Children's Health Insurance Program (SCHIP) be expanded to provide a financial mechanism for states to provide post-disaster physical and mental health care to all children affected by terror attacks, regardless of insurance coverage or presence of pre-existing conditions.

- Funding should be provided to evaluate the success of the New York City Medicaid initiative post September 11, 2001 and consider this as a temporary measure while working to permanent post-disaster health access for children.

Recommendation #11: Involve Primary Care Pediatric Providers (PCPPs) in all stages of preparation and response to disaster: from planning to identification and treatment of children to ongoing care to family and community healing.

- Funding should be increased for programs such as the AHRQ-funded Pediatric Disaster Preparedness and Response Conference to develop standards of evidence-based best practices for physical and mental health interventions for teachers, school counselors/nurses, primary care practitioners, and families. The goal is to build a coalition of experts and professional organizations from the fields of pediatrics, disaster planning, emergency medicine, emergency response, trauma, and mental health.
- Supply the PCPP with advanced equipment, personal protective equipment, patient informational materials, staff training, office "stockpile."
- Collaborate with PCPPs to develop specific pre-event risk communication strategies specific to parents, schools, children, caregivers about the unique medical and psychological risks for children in a mass casualty event
- Create mechanisms to allow PCPPs to be conduits for informing and updating the public via mass media, web sites, and educational materials.
- Create mechanisms to allow PCPPs to partner with public health officials, schools, and community-based organizations in ongoing surveillance of health and mental health status of children exposed to terrorism.

- Enhance the PCPP's ability to provide services in a bio-psycho-social manner, assessing all needs of children and ensuring all these needs are addressed in a holistic manner.
- Enhance capacity of PCPPs to screen and treat children at psychological risk for traumatic exposure and loss.
- Create and maintain mechanisms for ongoing education, training, and support for PCPPs and their staff.
- Ensure the PCPP is cognizant of developmental differences between children and adolescents vis-à-vis treatment needs.

Comments:
Dr. Diaz's first point was that in case of terrorism, outreach will have to be done to make sure all affected kids are identified and receive all needed services in terms of physical and mental health. In addition, make sure primary care providers are involved at every step, with training and understanding of special needs of children, and collaborate with other community agencies to best serve the needs of children. Her major concern was how to deal with the present system to maximize the ability of children and families to be resilient.

Dr. Rumm pointed out that pediatricians have significant experience in rash detection, psychosocial risk behaviors, etc. We should recognize the depth of rigorous training that ties into pediatric care, perhaps in an introductory paragraph.

Dr. Cooper said he had struggled with terminology of provider roles and wondered if it would be better to just say pediatricians. Mr. Ricciardi responded that people at the front are often family practitioners, nurse practitioners, and training shouldn't be limited to pediatricians. Dr. Mollica added that in extreme situations, it's often a nurse or social worker or bicultural workers (paraprofessionals) who work with traumatized children, especially in culturally diverse communities. Regarding the issue of every child having a medical home, including mental health, what do we do with uninsured children, families and adolescents, where children/families don't have good experience around health care? How will you access these children, get them into system, and pay for it, especially for mental health services?

Dr. Cooper, returning to the discussion of terminology, said it was more important to include than exclude, but he had trouble with word "provider" and suggested saying "clinician." A harder question is what to do about those without access to care. Emergency room is not primary care, which is continuous and longitudinal. Emergency Medicaid might be one way to assure rapid access to care in the event of a disaster.

Dr. Redlener pointed out the dilemma that in a disaster, huge numbers of people are not directly affected, but are highly anxious about their children. If the connections are not there pre-event, it can impede disaster response. There is a huge rush on emergency rooms after an event because people have nowhere else to go. Preparedness includes having an active, available resource for health care information services that pre-dates the event.

Dr. Kessel noted that the whole issue of temporal, sequential systems of care has to be addressed--continuous, continuing, first contact, follow-up care, which in turn raises the question of how to fix the whole system of care, rather than just the parts. Dr. Cooper replied that everyone agrees that all citizens should have health services, the question is how to weave that issue into this report.
Mr. Dennin felt that the administration would not support a recommendation for universal health care coverage at this time, but it could provide a post-disaster mechanism. Dr. Wright noted that there was no point in trying to create a pediatric system when the overarching adult system doesn't exist. Dr. Rumm cautioned against softening the wording of the recommendations too much.

Dr. Jones pointed out that there are programs and systems in existence, even though they aren't perfect. Emergency Medicaid after 9/11 and expansion of community health centers do provide some form of safety net. The best services are provided when children in continuous systems, but the other systems are out there. Capacity and surge response needs to be part of those systems.

Dr. Balaban commented that in the literature, there was an underlying assumption that children are small adults. The recommendations should specify that all medical personnel with specialized pediatric training should be incorporated into the system.

Dr. Redlener suggested that a compromise could be to articulate explicitly that preferably all children should be connected to a primary care relationship, prior to any event, as a preparedness modality. Also mention that other programs already in the pipeline should be greatly expanded/accelerated in order to be prepared for terrorism.

Dr. Mollica expressed concern about the need for interpreters when extreme violence hits culturally diverse communities that are already in situations of violence. There is no mechanism in many states for paying for bicultural workers and interpreters, which means we can't reach out to local communities because we don't have cultural and linguistic capacity. Dr. Diaz added that in New York two-thirds of cultural minority young people are not insured, and 70% to 80% deal with violence and depression every day. They need help now so they are more prepared for a terroristic event.

Dr. Dennin cautioned that if we politicize this particular issue too much, we're programming ourselves for failure.
Dr. Marens felt that primary health providers are not adequately prepared after a disaster to identify psychosomatic presentations or do triage. This is an opportunity to create guidelines and do training of primary providers.

Dr. Feerick liked the idea of pediatric providers being trained and able to screen, but was concerned about training, ethics and licensing for psychological treatment.

Dr.Tuma reminded the group that there were other major reviews that should tie into these recommendations, such as the IOM review about to be released.

Dr. Rumm wondered how to pay for psychological care after an event. The New York model should be studied for pros and cons.

Mr. Ricciardi felt that the committee should just look to its original charge and stick to that in terms of recommendations. Ms. Greene responded that the challenge is making recommendations without a clear context. The introductory paragraph should lay out some of these issues, such as all children having a medical home.
Dr. Kessell cautioned that when using terms about insurance, such as reimbursement, access, or services, it is important to be specific about dimension.. Some families are insured but don't have access to services or take advantage of them.

Community Involvement, Kevin Dinnin

Recommendation #14: An RFP should be developed to identify best practices for inclusion of non-traditional first responders in emergency management planning, including: clergy, educators, members of faith-based and community-based organizations, community leaders, health and human service providers and community workers.

Elements to be included in the RFP:

- Integration of non-traditional first responders such as faith-based, social service and volunteer organizations within local emergency management plans.
- Identification of the processes utilized to mitigate, prepare, respond and recover for and from the affects of a major event.
- Funding to support development of integration of response plans within states and communities, to include congregate care settings, including, but not limited to, day care centers, hospitals, schools, houses of worship, and community centers.

Recommendation #15: Programs such as President Bush's Faith-based and Community Initiative (FBCI) should be funded to provide child and family mental health training to members of faith and community-based organizations.

- Programs such as the CDC-sponsored Institute for Public Health and Faith Collaborations should be funded to include pediatric components in all training curriculum for community-based faith and health teams.

- Funding should be provided for the establishment of a National Community Response Support Team comprising specially trained clergy, mental health providers, and social service professionals to provide post-disaster support to members of local community, social service and faith-based organizations affected by a major event.

Recommendation #16: Expand funding to small-grant and outreach programs to provide networking opportunities and foster interaction between pediatric primary care providers and local volunteer, social service and faith-based organizations as a way to develop community-based disaster response networks among local groups and individuals involved in community-based efforts for children.

- Programs such as the Community Access To Child Health (CATCH) Program sponsored by the American Academy of Pediatrics (AAP) and the SAMHSA-funded Massachusetts Initiative of Multicultural Community Outreach (MIMCO) can serve to strengthen the pediatric disaster mental health response infrastructure of communities by complementing existing community programs and training community workers in the special needs of children in emergencies. Target audiences can include community leaders, clergy, health and human service providers, educators and community workers.

- Adopt a Community Emergency Response Teams (CERT) curriculum, such as the Los Angeles County model, and approach national service club organizations (e.g., Rotary, Lions) to adopt CERT as an official program of USA-based clubs.

Comments:
Community involvement as a way to approach whole terrorism issue through resiliance. The effect of terror on society (economic and psychological) can be greater than the event itself.

Mr. Dinnin distributed a new list of recommendations that can be done quickly and at little cost:

- Identify a credible spokesperson who can address the nation on how families can cope with the mental and emotional effect of a major event. The spokesperson should have the support of appropriate qualified personnel to formulate advice and recommendations for children and families.
- Establish the National Mental Health Preparedness and Communication Network, a web-based information system accessible by community mental health providers and organizations, in which HHS and its agencies can post information that would be helpful to those actually interacting with persons and can dispel myths.
- Develop mechanisms to develop regional response networks or centers to increase cooperation and resource sharing across regions, in addition to identifying and developing a mechanism to establish a network of national community response support teams comprising the faith community, mental health providers, and social service organizations, equipped to support the leadership of local faith-based organizations and social service organizations affected by major events.
- Create a mechanism to support systematic, multi-national collaboration to inform of efforts to prepare for, mitigate and respond to the impact of terror on children,

families and communities. Funding should be made available to support research on issues as a result of this collaboration.

National events affect people at the local community level. How can we make them feel safer and be engaged in the process?

Dr. Kolbe noted that it can take a very long time between demonstration projects and going to scale. He asked how demonstration projects would be taken to scale. Mr. Dinnen replied that it would start with a summit to eventually establish best practices. Dr. Marans requested a larger explanation of what was meant by demonstration projects. Program evaluation is labor intensive and expensive. Mr. Dennin explained that communities would be given funds to demonstrate how they have gotten over barriers and issues that block coordination between faith and law enforcement community, for example, and create models that could be replicated, especially at the municipality level.

Training
Bobbie Maniece-Harrison

Recommendation #21: The Secretary should support sustainable training and evaluation by funding ongoing disaster and terrorism drills.

- Regional disaster drills must include significant proportions of pediatric victims and child-related scenarios, and actively involve the major pediatric care providers within the community (e.g., children's hospitals, pediatric societies, day care centers, schools, etc).
- Federal, state and local emergency managers should conduct drills that include exclusively pediatric victims or a majority of pediatric victims such as occurring in a school, day care, school bus, etc… to adequately test the systems capacity for pediatric patients.
- Mandate the inclusion of responders with pediatric experience as part of response teams in all disaster and terrorism drills.
- Simulation software as developed for disaster and terrorism planning should account for events with pediatric patients in proportion to their existence in the population, events which, as is often case, will disproportionately affect children and events which will have as a majority of the victims are children.
- Simulation software and drill design should account for the variety of ages, developmental levels and sizes of children who would require care during a disaster or terrorism event and not merely create a single group labeled children.
- Disaster and terrorism drills should involve children with special health care needs as part of the pool of victims. In addition simulation software should account for the existence of children with special health care needs.

Recommendation #22: The Secretary should convene a panel of experts to assess all federal bioterrorism preparedness plans. The panels should specifically review:

- The extent of the training component
- Training related to the needs of children
- Training and preparedness of the community
- Make recommendations of training needs

Recommendation #23: The Secretary should support an initiative whereby pediatric experts and academicians collaborate to identify core competencies necessary for responders to adequately and appropriately care for children exposed to a bioterrorist attack. The initiative should:

- Identify the type of training needed
- Develop training modules to meet the needs of children
- Develop training guidelines for the community
- Make recommendations for the inclusion of training in professional training programs (medical school curricula, nursing program curricula, residency programs, school personnel, etc.)
- Standardize training requirements

Other Specific Recommendations

- Increase funding and add a pediatric component to the development of HRSA's Bioterrorism Educational Incentives for Curriculum Development and Training Program.
- Increase funding of programs such as the EMSC-funded Pediatric Disaster Life Support (PDLS) Program, a two-day training workshop for emergency medical professionals, developed and conducted at the University of Massachusetts.

Comments:
Dr. Maniece-Harrison said she took out training needs from the other reports, for all responders, fire, police, EMS systems, teachers, etc. There is a need for training based on the unique needs of children, and building interdisciplinary workforce. Two new recommendations are as follows:

- **The Secretary should mandate that a specific pediatric training component be included in all bioterrorism plans at the federal, state and local level. All plans already in existence should be reviewed and a pediatric component added if necessary. Funding to state and local communities for bioterrorism preparedness should be contingent on their plans, including a training component to meet the needs of children. Funding should provide states and local communities with adequate equipment and supplies suitable to the needs of children. There is a need for an increase in pediatric DMAT teams. All existing DMAT teams need to add a pediatric component to their training.**

- **Pediatric and public health experts should be included on all bioterrorism planning at all levels to advocate for the needs of children; assess current**

bioterrorism training and ascertain the extent to which training for children is included; and develop a comprehensive pediatric training component for all levels of responders that can be standardized, with core competencies and skills. School guidelines should also be developed.

Dr. Redlener informed the group that many children's hospitals surveyed had plans in process, but were missing standardized protocols on key issues, especially on the medical side. Training is difficult in the absence of state of-the-art information and knowledge. This is where academic centers and pediatric departments have a role in providing expertise.

Dr. Mickalde wanted to see something in the recommendations about precautions taken to protect children when they are involved in drills. If patients are made out to look nearly dead in drills, it could frighten children. Mr. Ricciardi emphasized the need for evaluation of drills, based on core competencies and standards. When children are involved in drills, there must be parental approval and follow up. A drill is real to children, with loud noises and screaming. Dr. Jones reminded the group that drills will include pregnant women, not just children.

Mr. Dinnin pointed out that the challenge is to look beyond the major communities. How do we do training and replicate models in very small communities and border towns?

Dr. Kessel said he was struggling with generality vs. specificity in the training. There has to be basic training, but sometimes providers need to know what not to do, or when to seek help. Dr. Redlener replied that there would be a layered approach to training, from hard core exact doses, to logistics, managing kids, decontamination of a two-year-old, etc. There is a range of training needs, but it will start with basic treatment and psychosocial issues.

Dr. Mollica wondered about pedagogical issues in different training cultures and environments. For example, training clergy is different from training health care providers.

Dr. Cieslak cautioned that training is a big component and could get out of hand. It is important to define who is being trained and in what. One approach is to have a matrix (3 x 3 x 3) with "who" on one axis (professionals, paraprofessionals, laymen) and "when" on the other axis (just in time vs situation specific) and the "what" (core level vs graduate education). Which of the 27 blocks are we trying to reach?
Dr. Shaffer reminded the group to include deaf, blind and mentally retarded children.

Mental Health, Steven Marens

Recommendation #7: Funding should be provided for an HHS-wide development and funding plan to address Psychosocial Preparedness and Recovery for children within major HHS initiatives and Agencies. Funding should be provided to support research and activities relating to surveillance,

monitoring and evaluation of children's post-disaster intervention outcomes, identifying patterns of trauma and recovery, and the development of simple, valid measures of outcomes.

- The Secretary should require the development of cross-Institute collaborative RFP's to address the development of translatable research related to psychosocial preparedness and recovery, and the development of focused research on preparedness including:
  - Protection of first responders and their families
  - Research on crowd behavior in emergencies
  - Research on risk communication
  - Research on group decision making and crisis simulation
  - Assessment of psychosocial impacts, behavioral response, and family and community cohesion factors that promote resilience in the aftermath of disasters

- The HHS mental health research agencies (NIMH, CDC and SAMHSA) should be provided with substantial funding to develop initiatives related to the psychosocial aspects of the effects of terrorism on children and families in order to close knowledge gaps and acquire information that will guide public policy. Topics to be funded include an integrated three-tier strategy for 1) monitoring children's reactions to national distress/disruption, 2) assessing local area impact of specific events, and 3) assessing intervention outcomes that will inform national and local level efforts to promote resilience in children and families.

- NIMH, CDC and SAMHSA funding should be increased and RFPs developed for pediatric and family research, including, but not limited to, the following areas:
  - Development of standards of evidence-based best practices of post-disaster interventions.
  - Pediatric epidemiology of post-disaster exposure and reactions.
  - The settings where child victims/survivors present for care and what types of care are provided.
  - Assessment of the effectiveness of training on pediatric practitioners and their patients/clients, including objective changes in practitioner behavior, mental health outcomes and sustainability over time

- Programs such as the SAMHSA funded National Child Traumatic Stress Network (NCTSN) and CDC's School Health Policies and Programs Study (SHPPS) should be funded to develop mechanisms to integrate child and adolescent mental health assessment and surveillance with outreach and triage, so information can be translated into program development.

- Increase funding for efforts currently under way by CDC, NIMH and SAMHSA and by programs such as the SAMHSA-supported National Child

Traumatic Stress Network (NCTSN) to develop brief, reliable and validated pediatric instruments for surveillance, monitoring and evaluation of outcomes in the aftermath of disasters and terror attacks.

Recommendation #8: Establish a national model for training in mental health acute response and crisis intervention to terror and disaster events.

- The Committee has determined that the full range of response to children's psychosocial needs, to include preparedness, mitigation, response and recovery, is best provided by developing an integrated response system that deploys multiple systems in a coordinated response. Thus, an effective national response to the psychosocial needs of children must depend on close and effective cooperation among all child serving systems, ranging from first responders (police, fire EMS) to education authorities to health authorities, specifically including behavioral health specialists. There are significant gaps, as described below, in the nation's capacity to mount this type of response. The Committee makes the following recommendations to address these gaps.
  - Increase basic competence in responding to child needs across responder systems. To this end, the committee recommends convening an inter-departmental task force to review training systems across education, EMS, fire, justice, and homeland security, and to identify and remedy gaps in preparedness and response competencies to be added that address children's needs.
  - Increase intersystem coordination at the local level. It is recommended that the Secretary create incentives for cooperative activity including service co-location between education, primary health care, and mental response systems. To further this goal, it is further recommended that the Secretary develop a series of demonstration projects to develop system integration and coordination focusing on developing improved methods to integrate psychosocial response that can then be disseminated.

- Increased funding should be provided to programs such as the Emergency Medical Services for Children (EMSC) to develop mental health resources for EMS providers including pediatric triage tools and information regarding the importance of pediatric mental health in emergency and terrorism preparedness and response.

- Disaster mental health should be incorporated into the clinical training of all pediatric and mental health disciplines.

Recommendation #9: Federal funding to states should be linked to mandated inclusion of mental health specialists in the terror and disaster planning, preparation and response. Collaboration between mental health specialists and others involved in emergency preparedness and response should be at the federal, state and local levels.

- The best response to a crisis is often a local response---national experts should be identified in advance and be prepared to provide consultation to local providers regarding optimal post-event care. Funding should be provided for contracting with teams of multi-disciplinary and culturally diverse experts with input from parents and children to prepare toolkits of best practices for mental health interventions for teachers, school counselors/nurses, primary care practitioners, and families.

- In the immediate aftermath of disasters, acute mental health services will best be provided not only in the form of direct clinical interaction with children and their families but by the approaches of a range of emergency responders and community providers with whom children will have contact. Therefore, increased funding should be provided to develop mental health resources for pediatric mental health training both for existing emergency responders and the current local *de facto* mental health system, which includes primary care practitioners, school counselors and nurses, clergy and family members. In order to maximize their acute response effectiveness, acute response providers will need:

    - Cross-training that familiarizes mental health professionals with activities of first providers and others involved in acute response
    - Familiarizing other professionals with principles of child, family and community responses to trauma/overwhelming distress (both psychological and physiological) in a developmental context and how these principles inform therapeutic interventions—both clinical and non-clinical
    - The best response to a crisis is a local response---national experts should be identified in advance and be prepared to provide consultation to local providers regarding optimal post-event care.
    - Disaster mental health approaches—both the federal disaster mental health model and the American Red Cross model—tend to discourage, under-recognize, and under-utilize specialized expertise that may exist across disciplines. This should be addressed pre event and in vetting professionals before they become involved in the aftermath of an incident.

- Collaborations among emergency responders and community providers should include:
    - Training of best practices in primary care, social work, community, volunteer and faith-based organizations
    - Developing formal relationships among various mental health providers and with other professionals that are already involved in emergency planning for acute response to terror events (e.g., police, fire, EMS, state and municipal emergency planners, public health, etc.)
    - Identify mental health representative(s) that will participate in emergency response planning and as part of emergency response teams that are mobilized at the time of an event—participation in both areas should occur at state, regional, and local levels

- Identify a network of mental health providers at state and local levels who will be part of the first response team in a terror event
- Immediately map existing mental health resources at state, regional and local levels as well as existing working relationships/collaborations between mental health resources and services providers relevant to the care of children and families at times of terror events (e.g., law enforcement, protective services, hospitals and primary care facilities, schools, juvenile justice system, government, etc.)
- Desired additional collaborative relationships should be identified and explained to relevant stakeholders (i.e., existing members of the state, regional and local emergency response teams)—responsibilities for developing and reporting on new collaborative efforts in training and planning of integrated services should be assigned
- Practice of communication and mobilization of response team members using simulation scenarios should be encouraged
- Establish protocol for clinical screening of affected children and families from point of immediate contact to follow-up and longer-term epidemiological and clinical surveillance
- Materials that educate professionals and parents about recognizing and monitoring potential acute and longer-term impact of terror events on children's functioning and development as well as principles guiding intervention should be prepared in advance (additional information specific to the nature of attack can be added at the time of the event).

Comments:
The aim of terrorism is to terrify. Psychological aspects must be addressed from the outset, using multiple therapeutic interventions from a whole range of providers. A general statement at the beginning of the document would help. At consensus meetings, we learn that there is no one treatment for acute responses to trauma or disaster, but we can take what we know and apply it to basic recommendations.

Re recommendation #7, Dr. Marans noted that federal agencies should be included. In addition, he would say monitoring evaluation and intervention strategies. He also felt there was too much in this section, and that some should be highlighted while the rest goes into accompanying materials.

Ms. Greene pointed out that the bullet on the bottom of page 12 was not quite accurate. Dr. Feerick recommended saying "intervention development". Dr. Marans suggested "best practices or principles that govern treatment interventions."

For Recommendation #8, Dr. Marans cautioned against saying "establish a national model," since there isn't one model. He would say "establish national models for training and principles of mental health acute response in crisis intervention to terror and disaster events, which involve pilot research and program evaluation." We know a great deal about principles of psychological disorganization under acute distress, and a great deal about children's development, but these are often not included in training. For

Recommendation #9, very few states have mental health agencies at the table in emergency response planning. Dr. Rumm commented that this was mandated in the new RFPs, but it doesn't include children.

Dr. Mollica said there had been a discussion about whether there should there be up-front policy on mental health. Mental health is seriously marginalized. How can mental health be brought into the center of discussion? Also, somewhere in the document there has to be discussion about developmental competence issues, cultural competence for culturally diverse communities, and gender issues.

Dr. Reissman noted that while the RFP has language around psychosocial issues and mental health, a next step would be to talk about joint development of school-based community resilience plans. She wondered whether this section was talking about public health aspects of psychosocial interventions or just clinical service delivery. It might require different language. Dr. Marens responded that it needs to be more than just clinical services, and if so, there have to be basic requirements and basic competence. The bottom line is that mental health and EMS need to know what each other is doing. Cross training of professionals is missing. In order not to marginalize public health, the report needs to talk about the mission and the context of the recommendations.

Dr. Chemtob pointed out that there has been great investment in material things but not in intangible things such as psychosocial reactions. During the anthrax scare, five people died, but how many were terrified? Fear, working together, psychological casualities are all distinct issues. We need a basic program of research, to look at crowd dynamics, etc.

Dr. Rumm replied that there has been no mental health capacity in state public health departments and there is resistance to change. A specific recommendation is that there be at least one mental health expert in government structures, or someone who knows where to find experts.
Dr. Mollica noted that in Massachusetts the Department of Mental Health was taking over many medical issues of terrorism. However, regarding surveillance, training, and interventions, the contextual environments (community volunteers, families, etc.) shape the discussion and knowledge necessary to provide effective outcomes.

Dr. Cooper commented that the Secretary would not remember every word the Committee sends him, so it is important to emphasize a few things. High on this group's list of unmet needs are psychosocial and emotional issues.
Dr. Tumus felt that this report shouldn't define mental health, but should be concerned with people who develop serious psychiatric disorders as well as the needs of the larger population in response to disaster and terrorism.

Dr. Feerick noted that the document seemed to be more focused on acute services. The first sentence should include practices as well as treatment and interventions. Minor language changes would make the recommendations broader, addressing the social and emotional needs of children.

Mr. Dennin added that it's not just the event that must be addressed, it's the effect on the nation and the economy due to anxiety. How many children miss school the next day is more important as an effect of terrorism than the actual attack on a specific locale. Look at the airline industry and where the money is flowing. Airlines have voice in Congress, but children don't. How can we reach out and establish resilience so we can continue to be a free society. The sniper attacks are a good example of major economic impact.

Public Health Departments, Government Agencies, Peter Rumm

Recommendation #1: **Federal funding to states through any terrorism-related grant or cooperative agreement should be linked to mandated inclusion of pediatric components in terror and disaster planning, preparation and response. All funds deliverable to states should be made conditional on adequate assurance that pediatric considerations are met.**

How well the States and Territories respond to the CDC and HRSA 2003 and out year RFPs that specifically call for preparedness for children's needs to be monitored closely. HHS as the lead agency for the protection of our residents' health status should work closely with other federal agencies to assure that the states and territories comply with the intent of the language in the RFPs and make targeted progress in all focus areas. Strong oversight by federal agencies and state health departments is needed to ensure that local health departments and other collaborators under their auspices use the funds appropriately and in fact place an emphasis on terrorism preparedness for children.

Recommendation #2: Funding should be provided for a national survey of terrorism preparedness that includes a specific assessment of preparedness for the medical and psychological effects of terrorism on children.

There has been no large-scale survey of terrorism preparedness. Specific funding should be given to the CDC, working with the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO), to refine current state and city preparedness tools and complete an overall evaluation that requires states and territories to complete an assessment tool that studies their preparedness for the effects of terrorism (both mental and physical) on the children under their auspices.

Recommendation #3: After September 11, many Federal, State and City agencies reported confusion over their roles and responsibilities in responding to the needs of children in the aftermath of the terror attacks. Funding should be provided for HHS to convene a meeting with the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and other state governmental associations to:

- Operationally define the roles and interactions of HHS and State Public Health Departments in training, protection and response in relationship to children and terrorism.
- Identify ways to link federal funding to the inclusion of plans for integration of agencies into state and local pediatric disaster response.
- Analyze current practices and identify ways to ensure national consistency on issues such as:
  - quarantine of children
  - planning for special needs children
  - protection of temporarily and permanently displaced children, foster children and children in the juvenile justice system.

Recommendation #4: It is essential that the issues and proposals raised by the National Advisory Committee on Children and Terrorism continue to be developed. The Committee recommends that the Secretary formally recognize a working group to focus on children and terrorism under the auspices of the Secretary's Council on Emergency Public Health Preparedness.

Comments:
Take the first five pages of the document and put them in an appendix.
Send a message to the Secretary that we need stronger language in next year's RFP on children's preparedness. We don't have framework for assessment of children's needs and this needs to be centrally located.
There needs to be follow-up on this committee's recommendations.

Dr. Redlener suggested that the Secretary designate an empowered individual to make sure agencies are following up on the committee's recommendations. Ms. Greene added that this could be an overarching recommendation. She then asked why Recommendation #1 says federal funding to states. Dr. Rumm said it should read states, territories, and larger local municipalities.
Dr. Rumm suggested that follow up might be better done by contracting a professional organization/entity. There may be a change in administration, and there is also a credibility issue.
Dr. Modzeleski noted that the issue of accountability is derived from how the recommendations are prioritized and what recourses are allocated.
Dr. Balaban said his understanding was that this committee's mandate ended with the report, therefore a working group would be more feasible.

Hospital Preparedness, Pre-Hospital and Critical Care, Dr. Wright and Mr. Ricciardi

Recommendation #12: All hospital institutions should be prepared to care for children in the event of a disaster or terrorist act since they may find themselves in the role of providing care to children, should they become the closest provider, or if other institutions in their area are overwhelmed.

- Increase funding to HRSA's Bioterrorism Hospital Preparedness Program to improve the capacity of the Nation's hospitals and emergency departments to respond to biological terrorist attacks and situations involving large scale epidemics. The program will also allow for State and regional planning among local hospitals, EMS systems, community health centers, poison control centers, and other health care facilities to improve their preparedness to work together to combat terrorist attacks.

- Increase funding for the EMSC initiative for Enhancing Pediatric Patient Safety (EPPS). The purpose of the EPPS demonstration project is to support the assessment and/or implementation of an existing strategy or tool with the potential for improving patient safety in pediatric emergency care delivery in multiple prehospital and hospital emergency department settings.

- Increase funding to the ATSDR-supported and maintained Pediatric Environmental Health Specialty Units (PEHSUs). This national network of pediatric specialty clinics provides expert consultation, training, and public education on chemical exposures in infants and children. Co-funded by the EPA as well as by local grants, these proved instrumental after the terrorist attacks in 2001. They are training primary healthcare providers to recognize chemical "toxidromes" and triage and treat chemical exposures. They also provide community-based education and information on long-term health issues of concern.

- Funding should be provided to expand initiatives such as HHS partnering with the National Association of Children's Hospitals and Related Institutions (NACHRI) to explore the possibility of developing a Children's Collaborative Network for expert health services linkages to all US care facilities - rural-urban; level 1 hospital and other care sites

- There is a lack of knowledge regarding effective methodologies for developing pediatric preparedness. In order to address this need for capacity building, it is recommended that the Secretary develop a programmatic RFP to designate New York City and Washington D.C., and perhaps eight other cities, as demonstration projects for pediatric psychosocial preparedness. The model for this initiative is FEMA's initiative of developing ten disaster-resistant cities as models for increasing preparedness and mitigation. FEMA has focused on physical aspects of preparedness and mitigation but there has been insufficient efforts paid to psychosocial response. The initiative should solicit innovative models and maximize the development of alternative approaches to permit the conjoined evaluation of the different models in order to eventually disseminate effective models.

  - Creation, revision, distribution and ongoing evaluation of pediatric emergency and terrorism response plans.

- Funding to support integration of response plans within state and community to include but not limited to hospitals, schools, faith-based community resources, primary care pediatric health providers, public health departments, and mental health providers

Recommendation #13: The Secretary should support and enhance the existing HHS programs involving communication systems used during a disaster or terrorist event. Information management systems are a critical link in hospital preparedness. HHS and the CDC should work closely with other federal agencies to provide the following:

- Creation and improvement of in-hospital communications, including but not limited to telephones, radios and computers.
- Develop information systems to ensure communication exists among hospitals, schools, childcare facilities, faith-based community resources, primary care pediatric health providers, public health departments, pediatric mental health providers, all hospital health care employees, and local officials.
- Support the Amateur (HAM) radios to communicate in the event of telephone failure.
- Develop a means of bioterrorism surveillance/detection and notification.
- Facilitate communication links between the hospital and children's specialty centers and other child health care facilities.
- The CDC, through website and additional electronic and satellite technology, should develop and staff a communications center which will function as a hub for medical information.

Comments:
Dr. Wright recommended that the bullet points for Recommendation #12 be re-ordered. The first bullet should be reworded to say, "in order to address this capacity building, we need to look at and include several models—9/11, Columbine, sniper incident—and glean lessons from similar circumstances." Then where it says "increased funding to HRSA's bioterrorism hospital preparedness, add "pediatric needs" or child, adolescent and family needs. NACRI is good at organizing, distributing information, mobilizing other hospitals, etc. We never have addressed the special needs kids, whether it is schools for the deaf or the child with diabetes in a regular classroom. There is a need for mapping and for a chaperone to stay with each child until a family member arrives. Drills need to be robust and meaningful.
Recommendation 13 has to do with information management. This has been arranged to address pediatric demographics. There is a whole range of surveillance mechanisms depending on demographics.
The next part has to do with developing information systems between hospitals, schools and other facilities. We might have to dust off ham radios for communications.
There are three bullet points on networking in hospitals, schools and other facilities for children.

Ms. Greene noted that when communications down after the recent spate of tornados, CNN could still communicate with satellite dishes.

Mr. Dinnen added that there are tremendous resources in local communities, but they aren't integrated into emergency management. Being able to access local resources in times of crisis is critical. Dr. Rumm suggested language to reflect that the greatest need is in local communities.

Risk Communication and Public Education: Dr. Mickalide

Recommendation #17: Funding should be provided to allow federal agencies and organizations to develop clear, concise, consistent, evidence-based and situation-specific guidance for parents and teachers concerning helping children to cope with terrorism and disasters.

- Funding should be increased for existing programs at NIMH, CDC and SAMHSA that are developing messages for parents and caretakers based on what is known about decision-making behavior, and for CDC-funded Centers for Public Health Preparedness (CPHP) at universities to establish systems to inform parents and caregivers what systems are in place in schools, health care facilities and communities to deal with terrorism threats

- Encourage all stakeholders to disseminate the same information to parents via websites, print materials, public service announcements and other communication channels.

- HHS should identify a broadly creditable spokesperson who can address the nation with advice on how families can cope with the mental and emotional affects of a major event. The spokesperson should have the support of appropriate qualified personnel to formulate advice and recommendations for children and families. For example, First Lady Laura Bush was highly effective in delivering advice to parents post-September 11.

- Funding should be provided to expand initiatives such as the HHS partnering with Sesame Workshop to understand the implications of their research findings on children 6-11 years of age pre-and post 9/11, entitled, "A View From the Middle," and its importance to media programmers, outreach coordinators and public television leaders.

Recommendation #18: Funding should be provided for a meeting of representatives of government agencies, national media sources and child mental health professionals to establish an accord on ways in which the media can communicate important information utilizing the guidance and/or counsel from official government sources and mental health professionals during times of crisis.

CDC, NIMH, SAMHSA and the Bureau of Primary Health Care (BPHC) should be funded to establish a National Mental Health Communication Network, a web-based information system accessible by community mental health providers, schools and other relevant organizations, in which HHS agencies can post official information and recommendations on specific events. Information provided from the CDC, Public Health Service, etc. will be extremely helpful in mitigating anxiety and post–traumatic stress often exacerbated through media reporting.

Recommendation #19: The Secretary should provide funding to DHHS mental health research agencies (NIMH, CDC and SAMHSA) to conduct a translatable initiative for developing evidence-based risk communication strategies. Research is needed to determine the most effective methods of communicating to the public and guiding health and human service systems. Specific topics include:

- How to communicate effectively both risks and protective strategies. Given the importance of health-risk communications prior to and following potential exposures, research is needed on developing and disseminating information to prevent negative consequences (e.g., panic, stigma, blaming, requests for unnecessary/inappropriate services) and promote adaptive and responsible behavior to minimize risk and injury.
- What are potential scenarios for the use of biological agents, and what health-related behavior/response is desired and what behavior should be discouraged?
- What information does the public need to form a realistic appraisal of personal risk as well as realistic means of coping with it?
- Possible psychosocial consequences for persons undergoing testing, as well as their relatives. Research is needed on communicating risk information to subjects and family members to reduce distress and best use risk status data to plan for treatment.
- Who is perceived as trustworthy; who is best suited to communicate risk messages; which messages are most effective, sensitive to different values, which messages raise or lead to ethical questions, etc.
- What factors will influence understanding of and compliance with public health directives about vaccination, prophylaxis, local and school disaster plans, including evacuation, reunion and unaccompanied minors.

Recommendation #20: Funding should be provided to ATSDR and HRSA to maintain a national toll free number for public information on chemical and biological events.

- ATSDR staff have considerable hands-on experience in the integrated response to chemical emergencies such as spills, explosions, and other uncontrolled releases. ATSDR maintains a 24-hour hotline and emergency response team that is fully integrated with the CDC Emergency Operations

Center and has worked closely with the EPA, FEMA, FBI, Coast Guard, and other response agencies at the federal, state, and local level.

- The HRSA Poison Control Centers (PCC) are an integral and vital part of the health system and part of the continuum of necessary emergency services which should be available to all Americans, particularly in light of the new bioterrorism threats. The missions of the ATSDR hotline and the PCC should be broadened to serve as a national source of public information for chemical and biological events.

Comments:
Mr. Dinnen explained that the national mental health communication network was originally a web-based information system that community mental health providers could access, that could be disseminated through various government entities. Dr. Rumm added that it would be nice to have a consolidated place for all federal resources on risk communication, social marketing, etc.

Dr. Mollica noted that the media have significant impact on children, and asked if there were any national guidelines. All the bad health news gets out on CNN, but there is nothing to help children. Dr. Mickalade explained that the media have to make public service announcements. Dr. Reissman noted that CDC already has a public health hotline with this information, plus a clinicians' network available through ListServe.

Regarding Recommendation #18 and the announcements about duct tape and plastic, Dr. Jones was concerned about significant health issues and the necessity of coordination with homeland security and other agencies.

Public Comment.
Drew Bernstein, ASTO, Senior Director for Preparedness and Bioterrorism, wanted to speak about BTAP (Bioterrorism Accountability Indicators Project). He could not share results yet, but children and terrorism was discussed intensely by the working group. That assessment was left out of BTAP because many issues needed to be addressed from a clinical standards perspective, but would not measure capacity and preparedness. He cautioned that from a state perspective, there are a number of unfunded mandates in the recommendations. Everyone agrees on the concepts, but need financial support to implement them.

Dr. Ellen Garrity, Senior Policy Advisor for the National Center for Child Traumatic Stress, told the Committee that she was part of the discussions on Capitol Hill setting up this committee and felt that committees members had the power and freedom to speak the truth. You can say what is really going on and what is really needed. There are two charged issues on the Hill: children and terrorism. You can talk about children, health and mental health in unprecedented ways and you can talk about money as well. Take advantage of this historical opportunity.

Next steps:

Timeline:

- Revised recommendations by May 27th, Tuesday.
- Refining and incorporating suggestions from today.
- Executive summary by May 30th.
- Final changes by June 3rd.
- Conference call June 5th to finalize and approve.
- Send supporting materials by June 6th (reports)
- Revised materials by June 16th
- Final supporting materials by June 20th.

Dr. Rumm expressed appreciation for Victor Balaban's work.
Dr. Redlener announced that results of the Consensus Conference last February would be released soon. He would like to be able to reference work with this committee.

Dr. Wright had a question about style, i.e., should the Committee say things politely and softly, or just directly speak to the issue?
Dr. Kessel commented that the issue was not to put receivers of information on the defensive, but to get their attention. It would be better to point out solutions and not dwell on the problems.
Dr. Mollica thought the recommendations should to be crystal clear, not just bullets, but policymakers don't want to get into minutia.

Dr. Cono pointed out that as a panel of experts, Committee members don't share the same terminology, so someone should review the document for jargon.
Dr. Balaban informed that consultants would help with format and visual presentation.
Dr. Redlener commented that policy makers need to hear briefly and explicitly what is really doable within a defined period of time. There will be a list of three or four things that can be accomplished for children.
Dr. Rumm added that recommendations should have specific action items, perhaps prioritizing the most time-sensitive items, but keep them all as they stand.

Mr. Dinnen wondered about having the Secretary's office respond to the report. Dr. Redlener added that it was not unusual for this type of committee to make a formal presentation to the Secretary. All of the recommendations are important, but some of the most important recommendations aren't the most doable.
Dr. Chemtob pointed out that many constituencies will read this document. Sub-groups will seize issues/recommendations and advocate for them. Dr. Jones added this is an action-oriented administration and Secretary. Some things can be done today, but are two or three years down the road because of funding and legislation. People will be reminding the secretary, so refine the recommendations to be clear action steps, not starting with 'provide funding for."
Dr. Kelter commented that too many priorities is no priority. Clarity begins at home. We don't have to have eleven categories; there are lots of overlaps, synergy and density.

Dr. Rumm said that the overarching action items are the ones that will be acted on.

It was noted that there was a wealth of information that needed to be organized in such a way that the most issues are affected with the greatest economy of words. What one thing would leverage all the others? What would make us a bold advocate for children? What's critical for children and no one else is contemplating it?
Dr. Kolbe suggested that the Committee members look at all their recommendations, clean them up so they are precise with no jargon, precise, and keep them with modifications. Then take one action item from each of reports generated and try to merge some of them.
Dr. Kelter pointed out that this was an opportunity to step up to the plate and take a swing against World Series pitching. The first page is the only page that counts. Let the hard work and findings be reflected in the larger document.
Mr. Dinnen felt that some components in this report would attract private sector cooperation.

After some additional discussion about process, Dr. Diaz thanked all those present for their hard word and adjourned the meeting at 4:45 pm.