



National Advisory Committee on Children and Terrorism



National Advisory Committee on Children and Terrorism

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
U.S. Department of Health and Human Services

June 12, 2003

Dear Mr. Secretary,

On behalf of the National Advisory Committee on Children and Terrorism (NACCT), I am pleased to present our recommendations to you. In accordance with the objectives specified in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the goal of our recommendations is to assist you in identifying and preparing a comprehensive public health strategy to ensure the safety of America's children and to meet their physical, medical, psychological and social needs in the face of the threat of terrorism. Such a strategy should comprehensively address all phases of preparation, response and recovery from terror events.

There are more than 70 million children under the age of 18 in the United States today, and more than 22 million are ages five and younger. In the event of a terrorist attack, these children would be among the most vulnerable populations in our society. Protecting children and families should be at least as important as protecting bridges and buildings. Yet, while significant resources have been dedicated to the protection of bridges, national monuments and other physical assets, comparatively little has been done to safeguard the health and well-being of children. As recently as 1997, data collected by FEMA showed that no state disaster plans had pediatric components. A recent study showed that only about 20% of hospitals have access to pediatric emergency physicians, and the majority of emergency personnel have little pediatric training or experience.

While the Department of Health and Human Services (DHHS) and other federal agencies have responded to the September 11 attacks with a number of excellent efforts and initiatives, a great deal more must be done to help the United States be fully prepared to protect its children in the event of terrorist attacks. The unique needs and vulnerabilities of children must be incorporated into disaster plans at every stage of preparation, planning and response in order to facilitate family and community resilience before, during and after terror attacks. Federal, state, and local agencies should immediately initiate programs to enhance the safety and security of children during disasters and terror events, and DHHS should develop mechanisms to support international collaborations to increase our nation's access to lessons learned by other nations with experience with terrorism.

The NACCT has reached remarkable consensus that 1) a comprehensive public health strategy to meet the needs of children in planning and responding to terrorism will require review of all current DHHS programs and guidance to require that a specific focus be placed on meeting the needs of children and families, 2) funding decisions for terrorism-related programs and initiatives should be linked to confirmation that children's needs have been specifically accounted for, 3) structures within DHHS should be created to ensure continued oversight and adequate response to the needs of children and families in DHHS programs and initiatives, 4) significant new pediatric and psychosocial initiatives are needed to address the needs of the nation's children and families in light of the continued threat of terror events, and 5) addressing the needs of children and families in the face of terrorism should be recognized to be an essential part of America's national security response to terrorism.

Your leadership to our Nation during these challenging times has been exemplary. It is our hope that these recommendations will assist you in preparing and initiating new strategies as well as continuing and following up on the excellent work already being done to ensure the public health of America's children by meeting the physical, medical, psychological and social needs of infants, children, adolescents and families in all phases of preparation and response to conventional, chemical, biological, radiological and nuclear terrorism. We are confident, given your long record of passion and support for children and families that the challenge of addressing the needs of children in the event of terrorist attacks is in good hands. The Committee looks forward to working with you and your staff on an ongoing basis as you move forward in carrying out these recommendations. We will provide whatever assistance and expertise is necessary in order to ensure that these recommendations are pursued and that sufficient resources are devoted to this most important of tasks, safeguarding our nation's children from terrorism.

Sincerely,

Angela Diaz, MD, MPH FAAP
Chair, National Advisory Committee on Children and Terrorism

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EXECUTIVE SUMMARY

This document represents the consensus recommendations of the National Advisory Committee on Children and Terrorism (NACCT), a committee composed of a variety of experts and professional organizations from the fields of public health, education, pediatrics, psychiatry, child development, emergency management, disaster planning and child advocacy (see Appendix 1).

The NACCT was established on June 12, 2002, in accordance with the Federal Advisory Committee Act (FACA), for the purpose of making consensus recommendations to the Secretary of the Department of Health and Human Services (DHHS) on matters related to terrorism and its impact on children. The objective of the NACCT, as specified in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, was to provide, within one year, a report to the Secretary that would assess and provide recommendations regarding:

- A) The preparedness of the healthcare system to respond to terrorism as it relates to children¹
- B) Needed changes to the healthcare and emergency medical service systems and emergency medical services protocols to meet the special needs of children
- C) Changes, if necessary, to the National Strategic Stockpile under Section 121 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 to meet the emergency health security of children.

The Department of Health and Human Services is uniquely positioned to provide leadership, planning and a wide range of services to help America's children prepare for and respond to terrorist events. DHHS and other

¹ Please note how the following terms have been defined by the NACCT. "Healthcare" refers to all aspects of children's physical and mental health related to preparedness and response to conventional, chemical, biological, radiological and nuclear terrorism. "Bioterrorism," with exception to referencing the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is hereinafter identified as "terrorism" and includes conventional, chemical, biological, radiological and nuclear threats, events and effects. Finally, the population of the United States referred to as "children" or "pediatric" throughout this document must be understood to include newborns, infants, children and adolescents, including those with special needs.

The Committee also noted terrorism-related risks associated with pregnancy and childbirth. Pregnant women may be injured or exposed to toxic and/or teratogenic agents in the course of terror events, and any large scale disaster plan must also take into consideration the likelihood of women giving birth during or immediately after a terror event. While these considerations are beyond the purview of this Committee and the expertise of its members, this is an important issue for disaster and terror planning that should be explored in the future.

federal agencies responded to the September 11 attacks with excellent efforts and initiatives (some of which are described in Appendix 2). The recommendations contained in this report are designed to further strengthen our nation's resiliency in coping with any major event directly or indirectly affecting the well being of children and families.

The NACCT has reached remarkable consensus that 1) a comprehensive public health strategy to meet the needs of children in planning and responding to terrorism will require review of all current DHHS programs and guidance to assertively require that a specific focus be placed on meeting the needs of children and families, 2) funding decisions for terrorism-related programs and initiatives should be linked to confirmation that children's needs have been specifically accounted for, 3) structures within DHHS should be created to ensure continued oversight and adequate response to the needs of children and families in DHHS programs and initiatives, 4) significant new pediatric and psychosocial initiatives are needed to address the needs of the nation's children and families in light of the continued threat of terror events, and 5) addressing the needs of children and families in the face of terrorism should be recognized to be an essential part of America's national security response to terrorism.²

At the outset, it is important to recognize that the means through which the effects of terrorism are propagated are largely psychological.

Terrorism seeks to create fear and insecurity, and includes the aim of creating internal divisions within society over the long term. Moreover, we would stress it will generally be the *terror generated by a major event*, not the *event* itself, that will have the greatest long-term negative impact on children and families throughout the nation. These recommendations are designed to assist in preparing and initiating strategies to ensure the public health of America's children by meeting the physical, medical, psychological and social



² A fundamental part of meeting the needs of children in the face of the threat of terrorism will be to identify and implement best practices relating to children's physical, medical, psychological and social needs in all phases of preparation, planning, response and recovery from terror events. The consensus reached in these NACCT recommendations, together with those in the recently published report of the National Pediatric Disaster Preparedness and Response Consensus Meeting, both carried out with DHHS funding, are significant steps in that process.

needs of infants, children, adolescents and families in all phases of preparation and response to conventional, chemical, biological, radiological and nuclear terrorism.

It is essential that the needs of America's children be made a priority in planning for future disasters and terrorist attacks, and yet the majority of disaster plans and guidelines do not take into account the unique needs and vulnerabilities of children and adolescents. Federal, state, and local agencies immediately should put the safety, security, and well-being of children and adolescents first and should not wait until later stages of the planning that currently is taking place to prepare for terrorism.

Ensuring that the United States is prepared to protect the physical and mental health of children and families in the event of a terrorist attack is an immense task. At the very least, the NACCT recommends that effective disaster planning for children must:

- a) Address the physical and mental health needs of newborns, infants, children and adolescents and include pediatric experts in all stages of the development of child-specific response plans, training and drills.
- b) Prepare to meet the needs of children in schools and other congregate care settings where children are normally gathered such as child-care facilities, summer camps, juvenile justice facilities, in transit between these places and home, or any number of other settings.
- c) Ensure coordination and integration of response efforts of Federal, state and local agencies with hospitals, relevant professional organizations, community organizations, and non-traditional first responders such as clergy and teachers.
- d) Prioritize returning children to normal routines with appropriate supports as soon as possible after a disaster as a way to promote family and community resilience.

In accordance with the NACCT Charter, three public meetings were held on March 6, April 30 and May 21, 2003, where the members of the NACCT, as well as federal advisors and outside consultants, gave presentations and held discussions to review existing data and response plans. These meetings provided an interactive forum for the Committee to develop consensus recommendations for the Secretary. The Committee members, advisors and consultants were all individuals with nationally and internationally recognized expertise and experience in relevant subject areas including pediatric healthcare, disaster planning,

emergency medicine, child development, public health, education, nursing and pediatric mental health.

Minutes of the NACCT meetings and information about its objectives are available to the public on the NACCT website (www.bt.cdc.gov/children/index.asp). Input from the public was solicited at the meetings, and via an e-mail account created especially for that purpose on the NACCT website.

In order to best position the Secretary and DHHS to take action and adequately address the special needs of children before, during and after terror events, the physical and mental health effects of terrorism on infants, children and adolescents were assessed by the NACCT, and recommendations made, in the following eleven areas:

Objective A of the NACCT: The preparedness of the healthcare system to respond to terrorism as it relates to children.

1. Federal Responsibilities
2. Schools and Other Child Congregate Care Settings
3. Mental Health and Psychosocial Support
4. Primary Care Pediatric Providers
5. Pre-Hospital and Hospital Care
6. Community Involvement
7. Training
8. Health Intelligence
9. Risk Communication and Public Education

Objective B of the NACCT: Needed changes to the healthcare and emergency medical service systems and emergency medical services protocols to meet the special needs of children

10. Emergency Medical Service Systems and Protocols

Objective C of the NACCT: Changes, if necessary, to the National Strategic Stockpile under Section 121 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 to meet the emergency health security of children.

11. Strategic National Stockpile

Below are the Committee's recommendations from each of the eleven subject areas assessed by the NACCT. These recommendations are described in more detail in the "Recommendations" section, along with specific actions that can be taken to make these recommendations a reality.

NACCT OBJECTIVE A: The preparedness of the healthcare system to respond to terrorism as it relates to children.

1 – Federal Responsibilities

- 1.1** Formally recognize the unique needs of children in terror events and similar emergencies by 1) the permanent addition of relevant child emergency public health preparedness subject matter experts to the Secretary’s Council on Emergency Public Health Preparedness, and 2) by creating a working group on children and emergency public health preparedness comprised of relevant subject matter experts and federal officials under the auspices of the Secretary’s Council on Emergency Public Health Preparedness with a charge to ensure that the issues and proposals raised by the National Advisory Committee on Children and Terrorism (NACCT) are carried out.
- 1.2** Assure that the unique physical and mental health needs of children are recognized and resources provided for in all DHHS terrorism preparedness and response funding initiatives, strategic plans and priority setting activities; and include relevant pediatric experts in children’s physical and mental health in the development of all such initiatives, plans and activities.
- 1.3** Conduct a national survey of Federal, state and local terrorism and disaster plans that includes a specific assessment of preparedness and training for the medical and psychological effects of terrorism on children, to provide feedback for implementing changes as part of a continuous improvement strategy for disaster planning.
- 1.4** Convene an ongoing series of meetings with stakeholders and relevant experts to define needs and core competencies necessary for appropriate training, protection and response in relationship to children and terrorism.
- 1.5** Continue to ensure that the needs of children and families are included in all federal disaster response plans by establishing explicit agreements with the Departments of Homeland Security, Defense, Justice, Energy and other appropriate agencies to include provisions for addressing the physical and mental health need of children in all federal terrorism and disaster response plans.

- 1.6** Expand the State Children’s Health Insurance Program (SCHIP) to provide financial mechanisms for States to support post-disaster physical and mental healthcare to all children affected by disasters and terror attacks, regardless of insurance coverage or pre-existing conditions.

2 – Schools and Other Child Congregate Care Settings

- 2.1** Ensure that every major DHHS-funded terrorism initiative, and other federal terrorism initiatives, appropriately addresses the role and needs of schools and other child congregate care settings by providing regulatory requirements, oversight and funding to result in effective linkages between state and local education agencies, schools, public health agencies and other emergency preparedness entities.
- 2.2** Collaborate with the Secretary of Education to formalize partnerships at the Federal, state and local levels, and coordinate activities to ensure that schools are fully integrated into preparedness, response, recovery, and mitigation efforts.

3 – Mental Health and Psychosocial Support

- 3.1** Conduct research relating to identifying patterns of child trauma, resilience, coping and recovery in the aftermath of disasters and terrorism, and the development of relevant public health tools and instruments including simple, reliable and valid measures of children’s physical and mental health outcomes.
- 3.2** Support activities related to the development of infrastructure and capacity for effective surveillance, monitoring and evaluation of children’s post-disaster physical and psychosocial intervention outcomes.
- 3.3** Support the development of a national set of principles and best practices for children’s post-disaster psychological and social intervention. This should include development of training and evidence-based practices for primary healthcare providers, police, firefighters, emergency medical technicians, municipal leaders, schools, clergy and families. Disseminate these principles and best practices widely at the state and local levels.

- 3.4 Ensure inclusion of child and adolescent mental health specialists in terror and disaster planning, preparation and response at the Federal, state and local levels as part of a DHHS-wide plan to address psychosocial preparedness and recovery for children within major DHHS initiatives and Agencies.

4 – Primary Care Pediatric Providers

- 4.1 Assess the central capacity of the public health and healthcare systems to ensure that it is sufficiently equipped to adequately prepare and train Primary Care Pediatric Providers (PCPPs) to plan for and respond to terrorism and disasters.
- 4.2 Evaluate the success of the New York City Medicaid initiative post-September 11, 2001 and consider this as a temporary measure while working to develop a mechanism for providing post-disaster healthcare access for children.
- 4.3 Involve PCPPs in all stages of preparation and response to disaster: from planning to evaluation, case identification and treatment of children, to ongoing care to families and community healing.

5 – Pre-Hospital and Hospital Care of Children

- 5.1 Ensure that all hospital preparedness programs supported by DHHS include provisions for preparing to care for children in the event of a disaster or terrorist act.
- 5.2 Support and enhance existing DHHS programs involving communication and information management systems between hospitals, local health agencies and emergency responders used during a disaster or terrorist event.

6 – Community Involvement

- 6.1 Initiate strategies to assist families, faith- and community-based organizations, childcare facilities and other child-serving systems to increase their capacity to respond to terror events.
- 6.2 Develop and support a multi-site initiative, involving at least six demonstration projects, to identify and implement best practices for integration of Federal, state and local responders with faith- and community-based organizations in emergency management planning, training and

the building of community resilience related to children and families.

7 – Training

- 7.1 Develop training programs to prepare a pediatric healthcare workforce to gain the knowledge, skills and abilities to address the special needs of children and that can be readily integrated into the public health network.
- 7.2 Develop pediatric training programs related to the physical and mental health effects of disasters and terrorism on children that include continuing education to health professionals already in practice; and provide incentives for curricular reform in health professions schools and training programs.
- 7.3 Include a specific pediatric training component in all disaster and terrorism response plans at the Federal, state and local levels, and support sustained training and evaluation by funding ongoing pediatric disaster and terrorism drills for first responders, healthcare workers, and other relevant professionals and trainees.
- 7.4 Support a comprehensive approach to pediatric training on terrorism and children, involving relevant organizations and partnerships.

8 – Health Intelligence

- 8.1 Develop linkages necessary to ensure that the Federal, state and local health intelligence systems support emergency planning, response, and recovery and are competent in the area of health intelligence data related to children's physical and mental health needs related to an act of terror.
- 8.2 Ensure that the emergency response systems utilized to support emergency planning, response, and recovery at Federal, state and local levels fully include trained scientific and epidemiological professionals with expertise in children's health.

9 – Risk Communication and Public Education

- 9.1 Implement risk communication strategies to positively affect the nation as a whole during times of elevated threat levels and actual

terrorist events, in light of the special effects these threats and events have on children.

- 9.2 Develop clear, concise and situation-specific guidance for parents, caregivers and teachers concerning helping children to cope with terrorism and disasters, and ensure that consistent information is disseminated by all DHHS agencies.
- 9.3 Develop and support a translational research initiative to develop more effective methods of communicating to the public and to health and human services professionals that recognize the special needs of children and families.
- 9.4 Maintain a national toll-free number for public information pertaining to children and conventional, chemical, biological, radiological and nuclear events.

NACCT OBJECTIVE B: Needed changes to the healthcare and emergency medical service systems and emergency medical services protocols to meet the special needs of children.

10 – Emergency Medical Service Systems and Protocols

- 10.1 Support and enhance existing DHHS programs related to EMS to ensure that the physical and mental health needs of children are met and that all first responders and EMS personnel receive training in post-disaster physical and mental health needs of children.
- 10.2 Working with the Secretary of Homeland Security, create Pediatric Specialty Teams for the existing Disaster Medical Assistance Team (DMAT) Program. Specifically, create one Pediatric Specialty Team per Region, in addition to providing each regular DMAT Team with a pediatric component including trained providers, equipment and pharmaceuticals.
- 10.3 Conduct research on EMS pediatric emergency and terrorism preparedness and response.

NACCT OBJECTIVE C: Changes, if necessary, to the National Strategic Stockpile under Section 121 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 to meet the emergency health security of children.

11 – Strategic National Stockpile

- 11.1 Establish an annual Pediatric Subject Matter Expert (SME) review process of the SNS program’s pediatric capacity by relevant pediatric subject matter experts to recommend pediatric formulary additions or modifications in order to ensure continued and enhanced pediatric capability and capacity of the SNS program.
- 11.2 Establish a process to determine prioritization of recommended pediatric formulary additions or modifications to the SNS to maintain and enhance pediatric capability and capacity of the SNS program.

Conclusion

Successful responses to terrorism will depend on effective planning and coordination across a variety of government and community resources involved in disaster response. These resources must work together on an ongoing basis to assess and meet the needs of America’s children in the event of terror attacks. Enduring protection will require a variety of sustained, committed efforts that apply preventive and long-term consequence management measures. To this point, it is essential that the issues and proposals raised by the National Advisory Committee on Children and Terrorism continue to be developed. The Committee looks forward to working with the Secretary of the Department of Health and Human Services and his staff to act on these recommendations, and to ensure that sufficient resources are devoted to this most important of tasks, safeguarding our nation’s children from terrorism.

STATEMENT OF PRINCIPLES



Terrorism, and the stress associated with terror alerts, can have devastating effects on children and families. The physical and emotional consequences of

experiencing or witnessing terror attacks can continue long after the initial event and affect many children who are not in the immediate vicinity at the time of the event. Children's immature abilities to understand and process the immediate and long term effects of disasters and terrorist attacks – their own injuries, traumatized or injured parents, loss of loved ones, the disruptions of daily routines, frightening images around them and in the media – make children among the most vulnerable members of affected communities. For example, an extensive mental health survey of over 8,000 New York City public school children conducted six months after the World Trade Center attacks found that a majority of children continued to be affected by the terror attacks, and that the responses were not limited to children who had been near Ground Zero, but were in fact found in children throughout all five boroughs³. Early and well-organized intervention is the key to promoting resilience in these children and families, and to preventing the development of problems in the future.

Lack of comprehensive planning for the needs of children in the event of terrorist attacks is a flaw in America's defenses that must be remedied immediately. For example, in the recent TOPOFF 2 exercises, a five-day, full-scale simulation of how the nation would respond in the event of a weapon of mass destruction attack, Chicago used a vacant school as a medical center for plague victims, and Seattle conducted drills, such as sheltering-in-place, after schools hours. Although school officials were involved in the planning and enactment of the drills, many questions were not considered during the planning and evaluation phases of the exercises, including: Can classes continue to be held? Are school and community plans well-integrated, or in conflict with one another? How would parents, students, and staff respond to the idea that their building was being used to

triage or treat infected people? How could authorities and emergency responders let parents, students, and staff know whether or not the disease or condition was not one that spreads person-to-person? How would the medical needs of children with chronic or disabling conditions be met? How would parents, students, and staff be given assurance that they could safely return to the school building? How would students be returned to their normal routine as quickly as possible?

Snapshot – On the morning of September 11, 2001, approximately 1.2 million children were enrolled in the New York City public schools. Approximately 750,000 of them took public transportation to school every morning, including subways, buses and boats, passing through tunnels and going over bridges. Hundreds of thousands of other children were at home, in day care, or in juvenile justice facilities. In the immediate vicinity of Ground Zero, more than six thousand children were in 7 elementary, middle and high schools, as well as in 28 licensed child care centers, 58 family child care and group homes, and 14 school age child care sites, including one childcare center in the Twin Towers.

Traditionally, most disaster and emergency response plans have taken into account only the needs of adults. As recently as 1997, data collected by FEMA showed that no state disaster plans had pediatric components. A recent study showed that only about 20% of hospitals have access to pediatric emergency physicians, and the majority of emergency personnel have little pediatric training or experience. Children, if they are mentioned at all in emergency plans, are generally assumed to be "small adults".

Children are not simply small adults. Children breathe faster and have faster heart rates than adults, making them more vulnerable to aerosolized biological and chemical agents. Children metabolize drugs differently, requiring different dosages of drugs and different antidotes to many agents, as well as specially sized equipment to administer many treatments. Because of their small size, children have less fluid reserve and smaller circulating blood volumes, and so are more vulnerable to the dehydrating effects of vomiting and diarrhea and go into shock more quickly. Ill and injured children react differently than adults to stress, and their psychological vulnerabilities in the aftermath of disasters and emergencies are still only imperfectly understood. On every level, physical, medical, psychological, emotional and social, children have unique needs and vulnerabilities that must be taken into account if America as a nation is to be properly prepared to protect our children from terrorism.

³ The role of DHHS in conducting this survey should be noted. The Centers for Disease Control and Prevention (CDC) gave technical assistance in the design and implementation of the survey, commissioned and sponsored by the New York City Board of Education. The Department of Education's School Emergency Response to Violence (SERV) Project also provided funds to the New York City Department of Education for the data collection portion of the investigation.

RECOMMENDATIONS

NACCT Objective A – The preparedness of the healthcare system to respond to terrorism as it relates to children.

1 – FEDERAL RESPONSIBILITIES



Public health programs and agencies, at Federal, state and local levels, have planned and prepared responses to many of the health consequences associated with terrorist events for many years. In doing so, public health has a mandate to protect not only the individual, but also the general health of the population in active collaboration with community organizations, universities, hospitals and clinics, providers and professional associations. Public health and its partners must lead efforts to assess, assure access to care and provide credible information about appropriate treatments for children and families. Most importantly, they must continue to shape policies that will ensure that all children are protected to the greatest amount possible from the effects of terrorism. Public health today faces many competing challenges in the area of children and terrorism that include inadequate infrastructure, training of public health professionals and, most importantly, funding.

With this in mind, the Department of Health and Human Services (DHHS) should be commended for including relevant language in the 2003-2004 Requests for Proposals (RFPs) for Bio-terrorism and Chemical Preparedness. This will help states, territories and local entities, where the actual public health measures need to be applied. Some important language specific to addressing children's needs was added to the HRSA National Bioterrorism Hospital Preparedness Program Cooperative Agreement Guidance with input from other federal agencies including the CDC. DHHS should also be commended for including strong language to promote mental health needs – which should also help prepare for the needs of children. However, such language may not go far enough to ensure that comprehensive action is taken to prepare for both the physical and mental health needs of children in events of terrorism.

It is crucial therefore, that DHHS 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 current and future RFPs.

1.1

Formally recognize the unique needs of children in terror events and similar emergencies by 1) the permanent addition of relevant child emergency public health preparedness subject matter experts to the Secretary's Council on Emergency Public Health Preparedness, and 2) by creating a working group on children and emergency public health preparedness comprised of relevant subject matter experts and federal officials under the auspices of the Secretary's Council on Emergency Public Health Preparedness with a charge to ensure that the issues and proposals raised by the National Advisory Committee on Children and Terrorism (NACCT) are carried out.

- Successful responses to terrorism will depend on effective planning and coordination across a variety of government and community resources involved in disaster response. These resources must work together on an ongoing basis to assess and meet the needs of America's children in the event of terror attacks. Enduring protection will require a variety of sustained, committed efforts that apply preventive and long-term consequence management measures. To this point, it is essential that the issues and proposals raised by the National Advisory Committee on Children and Terrorism continue to be developed.

1.2

Assure that the unique physical and mental health needs of children are recognized and resources provided for in all DHHS terrorism preparedness and response funding initiatives, strategic plans and priority setting activities; and include relevant pediatric experts in children's physical and mental health in the development of all such initiatives, plans and activities. Adequate assurance must be provided that the following components are integrated into all stages of terrorism and disaster planning, preparation and response:

- Plans for meeting the physical and mental health needs of children during and after disasters and terror events;
- Plans for the coordination and integration of response efforts of federal state and local agencies with hospitals, relevant professional organizations,

community organizations, and non-traditional first responders such as clergy and teachers;

- Plans for integration of training specifically related to the needs of children and families in terror and disaster planning, preparation and response; and
- Specific plans for the roles and needs of schools and other child congregate care settings, including, but not limited to, day care programs, hospitals, after school programs, houses of worship, community centers, summer camps and juvenile justice facilities

1.3

Conduct a national survey of Federal, state and local terrorism and disaster plans that includes a specific assessment of preparedness and training for the medical and psychological effects of terrorism on children, to provide feedback for implementing changes as part of a continuous improvement strategy for disaster planning.

- There has been no large-scale survey of terrorism preparedness. The CDC, working with the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO) and other relevant organizations, should be provided with specific funding and resources to develop an assessment tool that studies state and local preparedness and training for the effects of terrorism (both mental and physical) on the children under their auspices, and to conduct a national evaluation using that instrument.

1.4

Convene an ongoing series of meetings with stakeholders and relevant experts to define needs and core competencies necessary for appropriate training, protection and response in relationship to children and terrorism. Meeting topics should include:

- Defining the roles and interactions of DHHS and other Federal agencies with state and local public health departments in training, protection and response in relationship to children and terrorism. Meeting participants should include the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO) and other state governmental associations;
- Developing standards of evidence-based best practices for physical and mental health interventions

for teachers, school counselors, school nurses, primary care providers, and families;

- Identifying ways to link federal funding to the inclusion of plans for integration of agencies into state and local pediatric disaster response;
- Developing clear, concise, consistent, evidence-based and situation-specific guidance for parents and teachers concerning helping children to cope with terrorism and disasters;
- Meeting with 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; and
- Identifying core competencies, analyzing current practices and identifying ways to ensure national consistency on issues such as:
 - adequate first responder training to care appropriately for children exposed to disaster or terrorist attack;
 - quarantine of children;
 - planning for special needs children;
 - protection of temporarily and permanently displaced children, foster children and children in the juvenile justice system; and
 - development of pediatric training guidelines for communities.

1.5

Continue to ensure that the needs of children and families are included in all federal disaster response plans by establishing explicit agreements with the Departments of Homeland Security, Defense, Justice, Energy and other appropriate agencies to include provisions for addressing the physical and mental health need of children in all federal terrorism and disaster response plans.

1.6

Expand the State Children's Health Insurance Program (SCHIP) to provide financial mechanisms for States to support post-disaster physical and mental healthcare to all children affected by disasters and terror attacks, regardless of insurance coverage or pre-existing conditions.

2 – Schools and Other Child Congregate Care Settings



Every day 53 million young people attend more than 119,000 public and private schools where 6 million adults work as teachers or staff. Counting students and staff, on any given weekday more than one-fifth of the U.S. population can be found in schools. Children also congregate in other settings including child care programs, after-school programs, youth organizations, summer camps, and juvenile justice facilities.

Schools and other congregate care settings may or may not be the direct targets of terrorism, but they are certain to be affected by terrorism, whether directly or indirectly. In times of crisis, schools are often called upon to act as shelters, community meeting places, and even command centers. Communities can place extra, unfunded burdens on schools in this situation.

In order to adequately address the special needs of children, public and mental health agencies, and other emergency responders, must involve education agencies and schools in their planning processes. Local level coordination is essential, but a good deal of planning occurs at the state and national levels. Collaboration at these levels is also necessary. The best way to address the needs of schools and other child congregate care settings is through collaboration between public health, mental health, medical care, education, emergency management, law enforcement, fire, homeland security and transportation.

2.1

Ensure that every major DHHS-funded terrorism initiative, and other federal terrorism initiatives, appropriately addresses the role and needs of schools and other child congregate care settings by providing regulatory requirements, oversight and funding to result in effective linkages between state and local

education agencies, schools, public health agencies and other emergency preparedness entities.

- Expand CDC's School Health Program by supporting a high-level staff position in every state education agency and health department to coordinate policies and programs focused on the physical and mental health needs of students. As a central part of their mission, these staff should collaborate to ensure that schools are prepared to protect the lives and health of students and staff in emergencies. 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.
- Revise the Federal Response Plan, DHHS/CDC Public Health Preparedness and Response for Bioterrorism Continuing Grant Guidance, DHHS/HRSA National Bioterrorism Hospital Preparedness Program Cooperative Agreement Guidance, and other funded programs to ensure that schools, other child congregate care settings and education agencies are an integral part of preparedness, response, recovery, and mitigation efforts.
- Develop and disseminate information and measurement instruments to assess and improve the capacity of schools and other congregate care settings to prepare for and respond to conventional, chemical, biological, radiological, nuclear and mass trauma (physical and psychological) terrorism.
- Ensure that DHHS conduct and support new research that can improve the preparedness and capacity of schools and other congregate care settings to respond to terrorism with emphasis especially 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 conventional, chemical, biological, radiological, nuclear or mass trauma events, as well as the terror generated before, during and after an event; the ability of school and other child congregate care setting 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.

2.2

Collaborate with the Secretary of Education to formalize partnerships at the Federal, state and local levels, and coordinate activities to ensure that schools

are fully integrated into preparedness, response, recovery, and mitigation efforts.

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

- Adding 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.
- Funding demonstration projects that evaluate the effectiveness of school-based responses to past emergencies (e.g. Columbine high school shootings, September 11th) and expand and evaluate existing emergency planning and response models (e.g., New York City, Los Angeles) for involving education agencies and schools in a coordinated system of response and recovery.
- Ensuring 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.
- Training students, staff, and family members to be first responders.
- Developing additional collaborative efforts built upon the May 2002 teleconference developed by the Department of Education (ED), 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 the agents of terrorism, provide technical assistance on school and community preparedness and response, and serve as a model for state-based collaborations.
- Ensuring that schools are part of community-based planning and training as both community resources and as places where large numbers of children and adolescents are congregated.
- Developing and disseminating guidance for school officials recommending that, in the context of Presidentially declared disasters, school-based screening to identify children and youth with continuing psychological problems be conducted without active parent consent. In such circumstances, parents should be offered the option to opt their child out of the screening by contacting the school or health authority conducting the screening.

3 – MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT



Children exposed to terrorist events and disasters are at risk for developing emotional and psychological reactions. In situations of terrorism involving mass casualties and related threats, the mental health and psychosocial needs of children should be assessed as soon as possible in order to promote psychological resiliency in children and families. Pediatric mental health services will best be provided, not only in the form of direct clinical interaction with children and families, but also by the approaches of a range of law enforcement, emergency responders and community providers with whom children will have contact. Therefore, pediatric mental health training is necessary both for existing emergency responders and for persons in the current local "de facto" child and family mental health system that includes primary care providers, school counselors and nurses, clergy, law enforcement and family members.

While there is a tremendous need for basic knowledge about appropriate treatments and interventions that support psychological and social resilience in children and families in order to reduce the risks for later disorders and/or disabilities, all available data point to the importance of early intervention in promoting post-disaster resilience in children and families. Better post-disaster psychological and emotional functioning of parents and caretakers has been shown to predict better outcomes in children, pointing to the importance of post-disaster family interventions. In addition, physical symptoms and injuries in children can often be the result of emotional distress, and so provide an important method to assess the post-disaster vulnerabilities of children. Therefore, valid, reliable measures of emotional distress and psychological factors must be integrated into all post-disaster medical evaluations of children and families.

Early identification and intervention for emotional distress must take into account the different needs and vulnerabilities of pre-schoolers, children and adolescents

and be sensitive to the differing manifestations of mental health problems (i.e. physical and emotional symptoms, behaviors and functioning) in culturally diverse communities. Effective post-disaster surveillance and monitoring of the physical, emotional and psychological needs of children and families and evaluation of the effectiveness of services and interventions are necessary in order to direct resources and identify individuals and groups in need of assistance.

3.1

Conduct research relating to identifying patterns of child trauma, resilience, coping and recovery in the aftermath of disasters and terrorism, and the development of relevant public health tools and instruments including simple, reliable and valid measures of children's physical and mental health outcomes.

3.2

Support activities relating to the development of infrastructure and capacity for effective surveillance, monitoring and evaluation of children's post-disaster physical and psychosocial intervention outcomes.

- Require the development of cross-Agency collaborative RFP's to address the development of translational research related to psychosocial preparedness and recovery including, but not limited to:
 - 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; and
 - assessment of psychosocial effects, behavioral response, and family and community cohesion factors that promote resilience in the aftermath of disasters
- Provide the DHHS mental health research agencies (e.g. NIH, CDC and SAMHSA) with substantial funding to develop initiatives related to the psychosocial aspects of the effects of terrorism on children and families. These efforts will close knowledge gaps, guide public policy, and inform national and local efforts to promote resilience in children and families. Topics to be funded include, but are not limited to:
 - an integrated three-tier strategy for 1) monitoring children's reactions to national

distress and 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;

- development of standards of evidence-based best practices of post-disaster interventions;
- epidemiology of post-disaster pediatric exposure and mental health and psychosocial reactions.
- the settings where child victims/survivors present for care and what types of care are provided; and
- assessment of effectiveness of training on pediatric providers and their patients/clients including objective changes in provider behavior, mental health outcomes for children and families and sustainability over time.

- Fund programs such as those at the CDC and at the National Child Traumatic Stress Network (NCTSN) 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.
- Support the CDC to enhance the School Health Policies and Programs Study (SHPPS) to collect detailed information on school, district, and state education agency policies and activities to prepare for, respond to, recover from, and mitigate future terrorist attacks and other disasters, and to translate this information into program development.
- Increase funding for efforts currently under way by relevant DHHS agencies (e.g. NIH, CDC and SAMHSA) and by programs such as the 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.
- Develop and fund mechanisms to support systematic cross-national collaborations between our country and other nations with significant experience responding to terrorism. The Secretary should consider collaborations with the State Department (Fogarty Center) and the Department of Homeland Security in furthering this aim.
- The September 11 terror attacks, the later release of anthrax and the Washington DC sniper attacks all demonstrated that the effects of terrorism on the general population reach well beyond traditional mental health concerns with psychological disorders.

In addition, 9/11 demonstrated the need for improved inter-operability between designated first responders as well non-traditional first-responders such as teachers, volunteer organizations, clergy, and others. Moreover, these events demonstrated the need to develop methods to "inoculate" the population against the psychological and emotional effects of terrorism. To increase our nation's ability to be more resilient in the face of attack, the Committee recommends funding comprehensive demonstration projects in at least two high-risk cities, New York City and Washington DC. These demonstration projects should bring together all relevant stakeholders in the lives of children to identify methods to increase system coordination and population resilience, and to systematically implement and evaluate the proposed methods.

3.3

Support the development of a national set of principles and best practices for children's post-disaster psychological and social intervention. This should include development of training and evidence-based practices for primary healthcare providers, police, firefighters, emergency medical technicians, municipal leaders, schools, clergy and families. Disseminate these principles and best practices widely at the state and local levels.

- The Committee has determined that the full range of response to children's psychosocial needs, in all stages of disaster 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 between all child serving systems, ranging from first responders (police, firefighters, EMS) to education authorities and health authorities, specifically including behavioral health specialists. As described below, significant gaps exist in the nation's capacity to mount this type of response. The Committee recommends the following actions to address these gaps.
 - Convening an inter-departmental task force to increase basic competence in responding to child needs across responder systems by reviewing training systems across education, EMS, fire departments, justice, and homeland security to identify and remedy gaps in preparedness and response capacities that address children's needs.

- The Secretary should create incentives for cooperative activity including service co-location between education, primary healthcare and mental health response systems. To further this goal, the Secretary should develop a series of demonstration projects within these systems to develop improved methods of integrating psychosocial response that can then be disseminated.
- Provide increased funding 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.
- Incorporate disaster mental health into the clinical training of all pediatric and mental health disciplines.

3.4

Ensure inclusion of child and adolescent mental health specialists in terror and disaster planning, preparation and response at the Federal, state and local levels as part of a DHHS-wide plan to address psychosocial preparedness and recovery for children and adolescents within major DHHS initiatives and Agencies.

- The best response to a crisis is often a local response. Identify national experts who can provide consultation to local providers regarding optimal post-event care. Provide funding 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 providers, and families. Preparation should also include establishing protocols for collaborating with local responses and groups, and building capacity to accept into treatment children and adolescents with serious terrorism related mental illness.
- 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 families but by the approaches of a range of emergency responders and community providers with whom children will have contact. Therefore, provide increased funding to develop mental health resources for pediatric mental health training both for existing emergency responders and persons in the current local "de facto" mental health system which

includes primary care providers, school counselors and nurses, clergy law enforcement 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 responders and others involved in acute response; and
 - Familiarization 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. 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 particularly in vetting professionals before they become involved in the aftermath of an event.
- Collaborations among emergency responders and community providers should include:
 - Training of best practices into 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, firefighters, EMS, state and municipal emergency planners, public health officials, 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 networks of mental health providers at state and local levels who will be part of the first response team in a terror event;
 - Mapping 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.);

- Identifying desired additional collaborative relationships; explaining them to relevant stakeholders (i.e., existing members of the state, regional and local emergency response teams); assigning responsibilities for developing and reporting on new collaborative efforts in training and planning of integrated services;
 - Practicing communication and mobilization of response team members using simulation scenarios;
 - Establishing protocol for clinical screening of affected children and families from point of immediate contact to follow-up and longer-term epidemiologic and clinical surveillance; and
 - Developing 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. (Additional information specific to the nature of attack can be added at the time of the event.)
- Conduct at least six demonstration projects to implement comprehensive psychosocial preparedness and recovery projects aimed at children and families to demonstrate different models of preparedness and to promote the comparison of such different models with the aim of identifying the best models of psychosocial preparation.

4 – PRIMARY CARE PEDIATRIC PROVIDERS



One of the lessons learned from September 11 is that children exhibit fewer lasting effects of trauma when their parents receive the necessary support and reassurance to return quickly to a stable routine. In preparing for, responding to, and

recovering from potential terrorism involving children and adolescents, Primary Care Pediatric Providers (PCPPs) are quite literally the first line of defense and treatment (as they are for other age groups, as our experience with anthrax in 2001 taught us). For children, the presence of a trusted, accessible, regular source of primary care, who knows the child and his or her family, is as indispensable in responding to real or threatened terrorism as in the management of other complex problems. In turn, we also learned that Primary Care Pediatric Providers can be highly effective in addressing the needs of anxious and distressed parents. They are well placed to identify children in need of services. These skills have been key components of their residency training and are easily transferable to disaster response.

4.1

Assess the central capacity of the public health and healthcare systems to ensure that it is sufficiently equipped to adequately prepare and train Primary Care Pediatric Providers (PCPPs) to plan for and respond to terrorism and disasters.

4.2

Evaluate the success of the New York City Medicaid initiative post September 11, 2001 and consider this as a temporary measure while working to develop a mechanism for providing post-disaster healthcare access for children.

4.3

Involve PCPPs in all stages of preparation and response to disaster: from planning to evaluation, case identification and treatment of children, to ongoing care to families and community healing.

- Maximize the health of children and adolescents through immunization and health/mental health education and primary prevention so that children have greater resilience to mitigate the effects of terrorism.
- Enhance the PCPP's ability to provide services in a bio-psycho-social and culturally competent manner – differentially assessing the needs of children and adolescents and ensuring all these needs are addressed in a holistic manner. This should include enhancing the capacity of PCPPs to screen and treat children at psychological risk for traumatic exposure and loss.
 - Enhance capacity of PCPPs to screen and treat children at psychological risk for traumatic exposure and loss. Ensure the PCPP is cognizant of developmental differences between children and adolescents vis-à-vis impact of trauma, its expression and treatment needs.
 - Conduct training and research on best practices to meet the needs of children.
 - Create and maintain mechanisms for ongoing education, training, and support for PCPPs and their staff.
 - 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 PCPPs' capacity to be the conduit for informing and updating the public via mass media, web sites and educational materials.
 - Supply the PCPP with advanced equipment, personal protective equipment, patient informational materials, staff training and office "stockpile."
 - Collaborate with PCPPs to develop specific pre-event risk communication strategies specific to parents, schools, children and caregivers, in a culturally competent manner, about the unique medical and psychological risks for children in a mass casualty event.

5 – PRE-HOSPITAL AND HOSPITAL CARE OF CHILDREN



In many parts of the United States, the number of providers trained and equipped to handle children is extremely limited. Many areas of the country also lack specialized children's medical facilities. Community and general hospitals, while in most cases having pediatricians on staff, do not have the number, depth or specialty pediatric resources which would be needed in times of disasters. Even those regions with a children's hospital usually have only one such hospital which could easily have its resources exhausted or may be unavailable due to being affected by the event or due to the need for isolation.

Compounding these limitations, the majority of the nation's children's hospitals, and the pediatric departments of general hospitals, have done little if any specific planning around managing widespread chemical, biological, radiological or nuclear exposure among children and youth. While coordination among Federal, state and local officials was good in response to the September 11 attacks in New York City, the secondary coordination with local hospitals was not optimal; nor were any plans in place to involve pediatric institutions or providers in specific disaster preparedness planning for on-going acts of terrorism or disasters.

All hospitals should be prepared to care for children in the event of a disaster or terrorist act. Even if the hospital does not focus on the care of children as its regular business, it may find itself in the role of providing care to children if it is the closest provider, or if other pediatric institutions in the area are overwhelmed.

The Committee recommends that the Secretary support and improve upon the existing DHHS programs that incorporate children in hospital preparedness response to a disaster or terrorist act. Programs which incorporate children into their pre-hospital and hospital preparedness plan should be encouraged, and expanded in two key areas: 1) adequate preparation of all hospitals in the event

they have to care for children; and 2) communication between hospitals, and with disaster management resources (DMAT teams, other children's hospitals), the community, and the media.

5.1

Ensure that all hospital preparedness programs supported by DHHS include provisions for preparing to care for children in the event of a disaster or terrorist act.

- Review existing hospital and pre-hospital preparedness plans for specific inclusion of the care of children and adolescents. This includes Federal, state, and local plans. As a condition of funding, require to inclusion of experts in the medical and psychosocial needs of children and families in both plan development and implementation.
- Increase funding to HRSA's Bioterrorism Hospital Preparedness Program to improve the capacity of the Nation's hospitals and emergency departments to respond to specific pediatric needs during biological terrorist attacks and large scale epidemics. It is important to evaluate the management of surge capacity. Examples include analysis from the SARS epidemic regarding ER capacity, quarantine requirements outside and inside the hospital, the complexity of separating parents (including employees) from their children, and the need to maintain clinical staffing requirements over several days or weeks. In an era of clinical care giver shortage (nurses, therapists), it will be difficult to maintain crisis level staffing for more than a few days without a larger logistical plan for rotating help from outside communities.
- The Committee recognizes that many children may be separated from a parent during the initial hours of triage and stabilization. An alternate system of designating a temporary responsible adult to accompany each and every child through the system is required. Community volunteers (teachers, faith-community members, retired people, etc.) will be needed in this role as the medical community may be overwhelmed taking care of the direct medical needs. A definition of community resiliency should include an assessment of the community's preparedness to take over the care of its children until they can be restored to their families.
- Conduct research to better understand the most effective methodologies for developing pediatric preparedness. Develop a programmatic RFP to designate New York City and Washington DC, and

perhaps eight other cities, as demonstration projects for pediatric medical and 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 insufficient effort has been devoted to psychosocial response. In the care of children and families, the psychosocial component becomes an even more important element. The Initiative should solicit and maximize the development and evaluation of innovative models and alternative approaches to permit the eventual dissemination of effective models.
- Develop a set of pediatric algorithms for the most common conditions, and make them available to every hospital and location that cares for children.
- Expand the ATSDR-supported 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.

use of amateur (HAM) radios to communicate in the event of telephone failure, as well as the use of satellite technology.

- Develop information systems to ensure communication between hospitals, schools, child care facilities, faith based community resources, Primary Care Pediatric Providers, public health departments, pediatric mental health providers, all hospital healthcare employees, local officials and the media.
- Work with the National Association of Children's Hospitals and Related Institutions (NACHRI) to organize a Children's Disaster Network. This network would coordinate the provision of pediatric expertise to the disaster or epidemic sites. In addition the network would serve as a means of handling surge capacity issues – identifying available beds, transportation, clinicians and equipment. This network would facilitate communication links between the hospital and children's specialty care hospital – while freeing affected locales to focus time and attention on public safety and further harm reduction.

5.2

Support and enhance existing DHHS programs involving communication and information management systems between hospitals, local health agencies and emergency responders used during a disaster or terrorist event.

- Continue to include and expand pediatric demographics and pediatric disease presentations in CDC's terrorism surveillance, detection and notification systems.
- Ensure that CDC functions as a hub for providing reliable and timely medical information to hospital and pre-hospital teams. This may include a satellite based communication center, website or other wireless developments.
- Improvements must be made in communications within hospitals, between the field and hospitals, and from hospital-to-hospital. This includes telephones, radios and computers. In addition, we encourage the

6 – COMMUNITY INVOLVEMENT

Nontraditional first responders such as the faith community and members of volunteer organizations are often first on the scene of a disaster and the first resource families turn to in times of disaster. Yet they are rarely included in disaster response plans, and many have insufficient training to handle the needs of children and families in emergencies. The Department of Health and Human Services is uniquely positioned to identify best practices that enhance child, family and community resiliency. The Committee recommends that the Secretary initiate strategies to assist families, community and faith-based organizations, and childcare facilities in responding to the threat of a major terrorist event.



Historically, while there has been considerable emphasis on designated traditional first-responders, a very significant proportion of the services for

recovery from major events are in fact provided by non-traditional responders from social service, faith-based, and community organizations. The opportunity to more effectively engage the vast nation-wide resources of such organizations in our fight against terrorism is evidenced through accounts of such organizations responding to community needs in times of crisis. The engagement of armies of compassion, represented by an array of faith and community-based organizations, can and should be an integral part of the fight against the effects of terrorism on our children and families.

6.1

Initiate strategies to assist families, faith- and community-based organizations, childcare facilities and other child-serving systems to increase their capacity to respond to terror events.

- Convene a summit of community based organizations, including child and family serving systems, with experience in emergency management planning and response to review existing strategies and common practices utilized to build community resilience.
- Provide funding and technical assistance to enable licensing authorities through state child welfare agencies and other state licensing authorities to develop emergency response plans and to provide related training to respond to disaster and terror events. State child care licensing bodies should be requested to include major event planning in their standards of care for such facilities.
- Provide funding for Child Protective Service agencies to develop written plans and procedures for responding to a circumstance that would create a large number of homeless or orphaned children. Service delivery systems capable of meeting the needs of large numbers of bereaved children could be developed.
- Recommend that local emergency management official encourage their faith community to participate in emergency response planning and training (such as completing the National Voluntary Organizations Active in Disasters (NVOAD) training for clergy).
- Develop communication-related initiatives to increase the availability of communication within communities. For example, a pamphlet or web-based document should be designed and written to assist childcare facilities in planning for a major event. Training kits for childcare facilities and staff should be developed to facilitate enhanced preparedness.
- Post the recommendations on family preparedness on the DHHS web site and launch a communication effort through national media to promote the availability of the information. This effort should be closely coordinated with the other federal agencies including the Department of Homeland Security.
- Expand small-grant and outreach programs to provide networking opportunities and foster interaction between Primary Care Pediatric 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 supported 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.
- Provide mechanisms to develop regional response networks or centers to increase cooperation and resource sharing. In addition, identify and develop a

mechanism to establish a network of National Community Response Support Teams comprised of specially trained members of the faith community, mental health providers, and social service professionals equipped to support the leadership of local faith-based organizations, social service organizations, and municipalities affected by a major event.

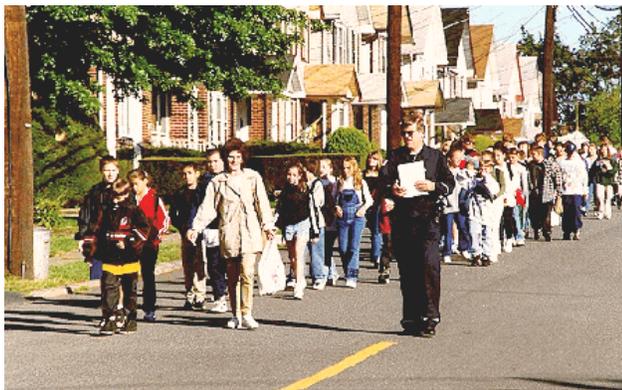
- Adopt a Community Emergency Response Teams (CERT) type curriculum, such as the Los Angeles County model, and approach national service club organizations (i.e. Rotary, Lions, etc.) to adopt the program as an official effort of USA based clubs.

6.2

Develop and support a multi-site initiative, involving at least six demonstration projects, to identify and implement best practices for integration of Federal, state and local responders with faith- and community-based organizations in emergency management planning, training and the building of community resilience related to children and families.

- Include as key elements in the demonstration projects:
 - methods and procedures used to integrate social service and volunteer organizations within the local emergency management plan;
 - methods and procedures used to integrate the faith community within the local emergency management plan;
 - identification of the processes and procedures used to mitigate, prepare for, respond to and recover from the effects of a major event;
 - methods used to develop coordination across major response systems including health, emergency, education, and faith community; and
 - study and presentation of strategies utilized to develop and evaluate methods of creating and sustaining community resilience.
- Evaluate and disseminate nationally the best practices identified in this initiative, in collaboration with the Department of Homeland Security.

7 – TRAINING



Training and drills are essential components of any successful disaster or terrorism response plan, but the training components of existing disaster and terrorism response plans make little or no provision for the unique needs and vulnerabilities of children. Because children respond differently from adults when they are exposed to a terrorist attack, they will require special interventions, which in turn necessitate special training for all responders, whether Federal, state and local governments or community and volunteer organizations.

It is essential that the United States develop and train an interdisciplinary workforce of pediatric healthcare personnel to prepare for and respond to a terrorist attack as well as to address the crucial need for integration of healthcare professionals into the public health network.

7.1

Develop training programs to prepare a pediatric healthcare workforce to gain the knowledge, skills and abilities to address the special needs of children and that can be readily integrated into the public health network. Training should include:

- recognizing indications of a terrorist event in their infant, child and adolescent patients;
- treating infant, child and adolescent patients in a safe and appropriate manner; and
- rapidly and effectively alerting the public health system of such an event at the community, state and national level.

7.2

Develop pediatric training programs related to the physical and mental health effects of disasters and

terrorism on children that includes continuing education to health professionals already in practice; and provide incentives for curricular reform in health professions schools and training programs.

7.3

Include a specific pediatric training component in all disaster and terrorism response plans at the Federal, state and local level, and support sustained training and evaluation by funding ongoing pediatric disaster and terrorism drills for first responders, healthcare workers and other relevant professionals and trainees. Recommendations include:

- 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) in real disaster drills.
- 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 Federal, state and local systems' capacity for pediatric patients.
- Mandate the inclusion of responders with pediatric experience as part of response teams in all disaster and terrorism drills.
- Ensure that simulation software as developed for disaster and terrorism planning accounts for events with pediatric patients in proportion to their existence in the population. Events may disproportionately affect children, including having children as a majority of the victims. Simulation software and drill design must also 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". In addition, simulation software should account for the existence of children with special healthcare needs.
- Involve children with special healthcare needs as part of the pool of victims in disaster and terrorism drills.
- Add a pediatric component to the development of HRSA's Bioterrorism Educational Incentives for Curriculum Development and Training Program.
- Support 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.

7.4

Support a comprehensive approach to pediatric training on terrorism and children, involving relevant organizations and partnerships.

- Initiate Request for Proposals (RFPs) for pediatric training to be conducted by relevant organizations, such as the American Public Health Association (APHA), National Association of City and County Health Officials (NACCHO), American Red Cross (ARC), and Association of State and Territorial Health Officials (ASTHO), to enhance the reach of terrorism training related to children.
- Ensure that pediatric training is provided to relevant nontraditional first responders (e.g. clergy, school staff, members of social and volunteer organizations, parents, etc.)

8 – HEALTH INTELLIGENCE



Health Intelligence, the monitoring of the nation's health status, is a crucial element in protecting America's children from terrorism. In order for a disaster health intelligence system to be in a constant state of maintenance and readiness, it must be the same system that is used for day-to-day public health and emergency medical systems, employing real-time networks that are fully supported and improved to serve the jurisdiction's physical and mental health needs of children.

Local and state public health agencies must have the capacity to analyze and report on patterns of pediatric 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, and schools. Venues where children and families would likely be sheltered in emergencies must have the capacity to report physical and mental health needs that occur. This would include, but not be limited to, schools, nursing homes, large employers, etc.

Merely having data is not enough. It must be analyzed and reported in real time. Our current system of monitoring population health status is not sensitive to children's propensity for adverse outcomes related to civil disturbance that occur apart from their own direct injuries. Our current methods of analysis would identify no pediatric-specific patterns of symptoms or signs ("surveillance definitions") as needing a public health response. We do not even require, let alone support, that emergency response procedures include the scientific staffing and analysis to design and set up research studies in the context of an emergency response for children. But this is exactly what is needed if future emergencies are to be met with more effective planning and responses to meet the physical and mental health needs of children.

8.1

Develop linkages necessary to ensure that the Federal, state and local health intelligence systems support emergency planning, response, and recovery and are competent in the area of health intelligence data related to children's physical and mental health needs related to an act of terror. This can be accomplished, at least in part, by:

- funding to allow DHHS, 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 for children;
- doubling the size of the current Epidemic Intelligence Service (EIS), recruiting more pediatricians and pediatric health specialists into it, and assigning at least one terrorism-specific EIS Fellow to each state and each local public health jurisdiction with a Metropolitan Medical Response Team;
- doubling the size of the Global EIS program to assure, among other goals, that lessons learned abroad can be applied to the U.S.; and
- funding 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), to create specific pediatric components to both programs.

8.2

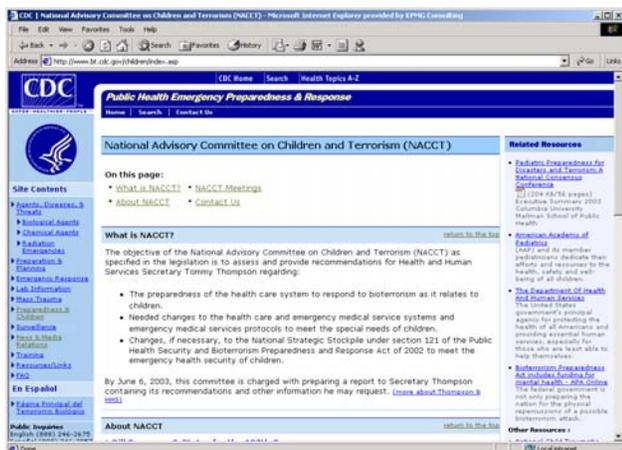
Ensure that the emergency response systems utilized to support emergency planning, response, and recovery at Federal, state and local levels fully include trained scientific and epidemiological professionals with expertise in children's health. This should allow emergency response systems to:

- Provide real-time analysis and pattern interpretation of children's 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 children adversely affected by the emergency. Even if the children are not directly injured, their family members, neighbors, caretakers or co-workers may be;
- Design and conduct intermediate- and long-term epidemiological studies and analyses of patterns of

children's 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 include:
- coordination of all scientific studies of the effects of the emergency be by the emergency response epidemiologists;
 - processing of all requests for data be through the emergency response epidemiologists who would then make a single request for all the needed data from participating institutions; and
 - ensuring that all research reports be such that decisions about authorship and attribution of scientific conclusions be negotiated centrally early in the process.

9 – RISK COMMUNICATION AND PUBLIC EDUCATION



In the wake of disasters and terrorist attacks and alerts, families need current, accurate information about ongoing events and on talking about them to their children. Enhanced communication abilities during times of crisis serve to enhance resilience and mitigate the detrimental impact of a major event on the emotional and mental health of children and families, including those communities not experiencing the direct effects of a terror event or disaster. It is essential to recognize that efforts to enhance child, family and community resiliency in times of national emergency must include working through the vast communication resources of the media. Although the media hold special independence in the United States, developing appropriate cooperative communication methodologies can ensure effective information dissemination in times of crisis. A major outcome of poor communication is the potential for undercutting public trust and future willingness to listen and adhere to subsequent warnings and directions.

The information available on websites from federal agencies such as the CDC, NIH, SAMHSA and FEMA, as well as relevant professional organizations such as the American Academy of Pediatrics (AAP), the American Psychological Association (APA) and the American College of Emergency Physicians (ACEP), contains many consistent themes in materials on risk communication to parents, including: maintain daily routines, avoid exposure to the media, and anticipate children's questions. However, much of the other content varies a great deal: different sites give widely differing advice on how much information to give children, nor is much of the material presented in ways that relates to children's age level and maturity.

The importance of health-risk communications prior to and following warning of potential exposures as well as actual disasters has been underestimated. Few of the currently available materials are based on research, and almost no guidance exists on how to disseminate information to

parents or on which messages have most relevance and clarity. Research and experience with health risk communications, informed by basic processes involved in forming and shaping attitudes, affect, and behavior can help to shape communications.

9.1

Implement risk communication strategies to positively affect the nation as a whole during times of elevated threat levels and actual terrorist events, in light of the special effects these threats and events have on children.

- Identify broadly credible spokespeople who can address the nation with advice on how families can cope with the mental and emotional effects of a major event. The spokespeople should have the support of appropriate qualified personnel to formulate advice and recommendations for children and families. (First Lady Bush was highly effective in delivering advice to parents post-9/11.)
- Expand initiatives such as the DHHS partnering with Sesame Street 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.

9.2

Develop clear, concise and situation-specific guidance for parents, caregivers and teachers concerning helping children to cope with terrorism and disasters, and ensure that consistent information is disseminated by all DHHS agencies.

- Convene a meeting of representatives of government agencies, national media sources, educators 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 pediatric mental health professionals during times of crisis.
- Establish a *National Mental Health Preparedness and Communication Network*, a web-based information system accessible by community mental health providers and organizations, in which DHHS 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.

- Distribute widely basic information about appropriate preparation for disaster to all potential congregate settings for children. Delineate mechanisms for identifying such settings and ensuring appropriate distribution.

9.3

Develop and support a translational research initiative to develop more effective methods of communicating to the public and to health and human services professionals that recognize the special needs of children and families.

- Develop RFPs to allow federal agencies to develop clear, concise, consistent, evidence-based and situation-specific guidance for parents, teachers and other relevant care providers on helping children to cope with terrorism and disasters.
- Expand existing DHHS research and programs that are developing messages for parents and caretakers based on what is known about decision-making behavior, and for Centers for Public Health Preparedness (CPHP) to establish systems to inform parents and caregivers what systems are in place in schools, healthcare facilities and communities to deal with terrorism threats
- Create a mechanism to enact systematic multi-national collaboration to share information and methodologies utilized to prepare for, mitigate, and respond to the impact of terror on children, families and communities.
- Provide funding to DHHS mental health research agencies (NIH, CDC and SAMHSA) to conduct a translational research 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:
 - communicating effectively about 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 that prevents negative consequences (e.g., panic, stigma, blaming, requests for unnecessary or inappropriate services) and promotes

adaptive and responsible behavior to minimize risk and injury;

- potential scenarios for the use of biological agents, and the appropriate health-related behavior or response;
- information the public needs to form a realistic appraisal of personal risk and 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.
- perceptions of trustworthy spokespeople best suited to communicate risk messages; which messages are most effective, are sensitive to different values, raise or lead to ethical questions, etc.; and
- factors influencing understanding of and compliance with public health directives about vaccination, prophylaxis, local and school disaster plans, including evacuation, reunion and unaccompanied minors.

9.4

Maintain a national toll-free number for public information pertaining to children and conventional, chemical, biological, radiological and nuclear events.

- Broaden the missions of the CDC/ATSDR 24-hour hotline and emergency response teams and the Poison Control Centers (PCC), and integrate them to create a national toll-free number to serve as a national source of public information for chemical, biological, radiological and nuclear events. The CDC/ATSDR 24-hour hotline and emergency response team is already 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. Together with the Poison Control Centers (PCC), the hotline can become an integral and vital part of the health system and part of the continuum of necessary emergency services, particularly in light of chemical, biological, radiological and nuclear terrorism threats.

NACCT Objective B – Needed changes to the healthcare and emergency medical service systems and emergency medical services to meet the special needs of children.

10 – EMERGENCY MEDICAL SERVICE SYSTEMS AND PROTOCOLS



While preparation for terrorism is important, the general approach to emergency response and management cannot be forgotten. Terrorism response is a subset, which requires a valid public health structure, health system, medical system, emergency medical system, and overall approach to disaster preparedness.

Children's unique health and mental health needs require special consideration in the area of emergency preparedness for terrorism. However, many facilities lack the specialized equipment needed to care for children, and many emergency personnel have not been provided with the necessary education or training to provide optimal care to children. Increased funding should be provided to programs such as the Emergency Medical Services for Children (EMSC) grant program in order to assist local communities in providing the best emergency care to children in the event of terrorist attacks.

10.1

Support and enhance existing DHHS programs related to EMS to ensure that the physical and mental health needs of children are met and that all first responders and EMS personnel receive training in post-disaster physical and mental health needs of children. 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 programs 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; and
- 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 DHHS Emergency and Terrorism Preparedness Activities.
- Assurance that all DHHS Emergency and Terrorism Preparedness activities which involve EMS require that pediatric considerations be included in these efforts.
- Provision of increased funding 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.

10.2

Working with the Secretary of Homeland Security, create Pediatric Specialty Teams for the existing Disaster Medical Assistance Team (DMAT) Program. Specifically, create one Pediatric Specialty Team per Region, in addition to providing each regular DMAT Team with a pediatric component including trained providers, equipment and pharmaceuticals

- Pediatric Specialty Teams within the DMAT program will provide this nation with a constant source of pediatric trained providers and equipment to supplement local resources in times of terrorism or natural disaster. While many DMAT teams do have some pediatric providers and some equipment, there is not a clear focus to address the needs of children in all responses and to provide a uniquely pediatric capable response when required.

10.3

Conduct research on EMS pediatric emergency and terrorism preparedness and response. This can be accomplished through:

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

NACCT Objective C – Changes, if necessary to the National Pharmaceutical Stockpile under section 121 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 to meet the emergency health security of children.

11 – STRATEGIC NATIONAL STOCKPILE (SNS)



The Strategic National Stockpile (SNS) was established in 1999 to assist state and local governments in the delivery of essential medical materials during an emergency.

The mission of the SNS program is to deliver pharmaceuticals and other medical materiel to the site of a national emergency. The SNS program comprises pharmaceuticals, vaccines, medical supplies and medical equipment that exist to augment depleted state and local reserves for responding to terrorist attacks or other emergencies. These supplies are stored in strategic locations around the U.S. to ensure rapid delivery anywhere in the country. The SNS program may deliver a 12-hr Push Package when the threat is unknown and a broad medical response is needed. Alternatively, Vendor Managed Inventory (VMI) shipments can be tailored to respond to a defined threat and provide medical products specific to the suspected or confirmed threat.

The SNS stands ready for deployment to any US location within 12 hours, and on September 11, 2001 the SNS program delivered fifty tons of medical supplies to New York City within seven hours of the World Trade Center attacks. Between October 15 and November 29, 2001, 3.75 million doses of antibiotics for preventative post-anthrax exposure treatment were delivered to postal workers, mail handlers and occupants of affected buildings.

The SNS program has established significant buying power and rapid purchasing capability through the Department of Veterans Affairs National Acquisition Center. Through this mechanism, medical supplies that are not part of the formulary and have adequate market availability may be procured and rapidly delivered to areas of need without the direct stockpiling of these products.

The SNS program's intent is to provide medical supplies and material that meet the needs of all populations including children. The current formulary provides pediatric specific medical equipment including intravenous catheters, airway management equipment, suction and feeding catheters, and antibiotic formulations. A review by

the National Advisory Committee on Children and Terrorism strongly supports the addition of pharmaceuticals and medical supplies as identified by the SNS pediatric gap analysis and SNS burn/blast and radiation review.

11.1

Establish an annual Pediatric Subject Matter Expert (SME) review process of the SNS program's pediatric capacity by relevant pediatric subject matter experts to recommend pediatric formulary additions or modifications in order to ensure continued and enhanced pediatric capability and capacity of the SNS program.

11.2

Establish a process to determine prioritization of recommended pediatric formulary additions or modifications to the SNS to maintain and enhance pediatric capability and capacity of the SNS program.

General SNS Recommendations

- Establish a working group to review pediatric treatment protocols for events involving biological, chemical, or radiological agents. The primary goal is achievement of a national standard for treatment protocols.
- Establish a working group to develop a list of emergency use Investigational New Drugs (INDs) needed for treatment of pediatric population in for events involving biological, chemical, or radiological agents.
- Review all state and local communities' distribution plans for pediatric specific equipment.
- Increase the visibility of the pediatric capabilities of the SNS program.
- Evaluating purchasing mechanisms for pediatric specific equipment.
- Ensure that state and local communities evaluate their pediatric equipment and medical inventories and capacities to treat pediatric patients and coordinates this assessment with neighboring states.
- Ensure state and local communities dedicate time and staff resources for distribution and administration of pediatric resources.

- Currently the Strategic National Stockpile (SNS) utilizes 2000 U.S. Census data for use in calculating equipment and pharmaceutical needs. The Committee recommends that specific data for pediatric population be obtained through future research on the impact of disaster on the pediatric population and more specific population demographics of communities.
- Include tetanus toxoid for emergency use in the strategic planning of the National Immunization Stockpile.
- Alternative sedatives and analgesics
- Additional IV antibiotics
- Alternative concentrations of intravenous antibiotic solutions

Formulary Specific SNS Recommendations

- The Committee recommends that SNS program use 9 years of age as the cutoff age for determining the requirements for antibiotic suspensions. The Committee favors antibiotic suspension formulations over chewable tablets.
- The Committee recommends that the 12-hr Push Package be designed to have a pediatric specific container/s. This will assist in the distribution of pediatric supplies.
- The Committee recommends review of Epogen for treatment of anemia secondary to trauma to reduce the need for blood transfusions.
- The Committee recommends the inclusion of cytokines for treatment of radiation induced neutropenia.
- The Committee recommends that sufficient quantities of thiosulfate for the treatment of 1000 pediatric patients be added to the formulary.
- The Committee recommends that there is an emergency use IND developed for Mark 1 Jr Kits.
- The Committee strongly recommends that future SNS formulary additions include assets to treat burn/blast and radiation injuries. At a minimum that these additions be sufficient to treat 2500 pediatric patients.
- The Committee strongly supports the addition of the following pharmaceuticals and medical supplies as identified by SNS pediatric gap analysis, and SNS burn/blast and radiation review.
 - Additional airway management equipment
 - Medication Delivery Systems such as spacers and masks
 - Additional ancillary supplies for IM administration of medications

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Appendix 2 – Selected DHHS Accomplishments and Current Initiatives Relating to Children and Terrorism

The gaps in America's preparedness for the effects of terrorism on children identified in these NACCT recommendations should not obscure the fact that DHHS has responded to the crisis with a wide array of important programs and initiatives including:

Agency for Healthcare Research and Quality (AHRQ)

- In February 2003, AHRQ and HRSA's EMSC program provided funding for the National Pediatric Disaster Preparedness and Response Consensus Meeting to develop consensus recommendations, delineate research methodologies and define a research on the needs of children in disasters. The conference report has been published and distributed.

Agency for Toxic Substances and Disease Registry (ATSDR)

- ATSDR actively supports and maintains a national network of Pediatric Environmental Health Specialty Units (PEHSUs) that provide expert consultation, training, and public education on chemical exposures in infants and children. Co-funded by the Environmental Protection Agency (EPA), these PEHSUs are a valuable asset in the all-hazards approach to preparedness and disaster planning, and proved instrumental after the terrorist attacks in 2001. Each PEHSU encompasses, in one regional facility, a multidisciplinary complement of specialists from critical fields of expertise. They are actively training clinicians 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.
- ATSDR publishes and disseminates extensive informational resources in clinical toxicology with specific sections dealing with health issues affecting infants and children. The *ATSDR Toxicological Profiles*, *Tox FAQs*, and *Medical Management Guidelines* account for the special vulnerabilities of children to acute and long-term chemical exposures.

Centers for Disease Control and Prevention (CDC)

- The CDC has responded to public health emergencies for decades, and has been preparing for bioterrorism since 1998. The nature of public health is such that many activities are designed to benefit the health and well being of entire communities, including children, even when they are not specifically designated as

recipients. The CDC has responded to the special needs of children and terrorism by using existing resources, modifying existing programs and initiatives, providing technical assistance, and whenever possible initiating new projects, to assess and respond to the unique needs and vulnerabilities of children in the aftermath of terrorism and disasters. There is a great deal more that could be accomplished with resources specifically designated for the emergency public health preparedness of children. Among the many new and ongoing CDC efforts to prepare children and families for potential terrorism:

- CDC's Office of Terrorism Preparedness and Emergency Response (newly created in December 2002) provided all management, resources and staffing for the research and writing of these recommendations of the National Advisory Committee on Children and Terrorism.
- CDC Preparedness Grants: Through the states, the CDC last year disseminated approximately \$918,000,000 dollars to improve national state and local health preparedness.
- The Strategic National Stockpile (SNS) delivers antibiotics, vaccines and pediatric equipment and pharmaceuticals designed for children anywhere in the United States within 12 hours of a federal decision to deploy. (This has now been transferred to the Department of Homeland Security but the CDC will interact with states to order deployment in an emergency).
- Information and fact sheets on children and terrorism are being made available on the CDC web site.
- The National Center for Injury Prevention and Control (NCIPC) is developing guidelines and assessment tools for rapid assessment of injuries and mental health, for children and adults, in the immediate aftermath of terror attacks, large-scale disasters and emergencies. NCIPC is also conducting an investigation into the behavioral and psychological responses to the sniper attacks in the Washington, D.C. metropolitan area which includes an assessment of effects on children and families, and is supporting projects assessing adolescent and adult exposure and reactions to the September 11 World Trade Center attacks.
- A study of the World Trade Center evacuation is being conducted by the CDC, under NCIPC leadership, in coordination with a study by the National Institute for Standards and Technology. These studies together are expected to yield

information that will enhance the safety of occupants in tall buildings by improving understanding of human behavior, and emergency response, as well as enabling improvements in US building and fire codes, standards and practices.

- The CDC gave technical assistance to a survey commissioned and sponsored by the New York City Board of Education that assessed the mental health effects of the September 11 attacks on over 8,000 school children in New York City public schools. The Department of Education's School Emergency Response to Violence (SERV) Project also provided funds to the New York City Department of Education for the data collection portion of the investigation.
- CDC's Epidemic Intelligence Service Officers were deployed immediately after the World Trade Center attacks. One hundred thirty six CDC EIS officers have been deployed to assist state and local public health agencies since September 11, 2001. Many others were assigned to monitor for signs of bioterrorism-related illnesses in New York, Florida, New Jersey, Washington, D.C. and Connecticut in response to the 2001 anthrax release.
- The National Center for Environmental Health has proposed a chemical/radiological illness surveillance initiative to ensure early detection of a release of a biological, chemical, or radiological agent. This will include preparing for post-event surveillance, initiation of a data-sharing system among laboratorians, epidemiologists, and health departments, and the deployment of response teams.
- In May 2002, the CDC, the Department of Education, the Federal Emergency Management Agency (FEMA) and the Federal Bureau of Investigation (FBI) collaborated to host a teleconference to provide state and local education, 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.

Food and Drug Administration (FDA)

- FDA has a public health mandate to facilitate the availability of safe and effective drugs, vaccines, and medical devices for individuals exposed to a biological, chemical, radiological or nuclear agent. The agency is working to get medical countermeasures off investigative status and approved with appropriate use information including for special populations such as children. In particular,

the Center for Drug Evaluation and Research (CDER) contains an office devoted to Counter-Terrorism and Pediatric Drug Development.

Health Resources and Services Administrations (HRSA)

- HRSA manages two programs which directly focus on bioterrorism and other public health emergencies and three programs which to varying degrees have significant common interest with terrorism and other public health emergencies.
 - The Bioterrorism Hospital Preparedness Program strives to improve the capacity of the Nation's hospitals and emergency departments to respond to biological, chemical, radiological, and explosion events of terrorism or other public health emergencies. The program allows for State and regional planning among local hospitals, EMS systems, community health centers, poison control centers, and other healthcare facilities to improve their preparedness to work together to combat terrorist attacks.
 - The goal of the Bioterrorism Curriculum Development and Training Program is the development of a healthcare workforce that possesses the knowledge, skills and abilities to (1) recognize indications of a terrorist event in their patients; (2) treat their patients in a safe and appropriate manner; and (3) rapidly and effectively alert the public health system of such an event at the community, State and national level.
 - The Emergency Medical Services for Children (EMSC) Program assists States to improve emergency care for children, as well as enable States to continue to promote regionalized care.
 - With funding provided by the EMSC Program and the Agency for Healthcare Research and Quality, Children's Hospital at Montefiore convened the *Pediatric Preparedness for Disasters and Terrorism: A National Consensus Meeting* in Washington, DC in 2003.
 - The EMSC initiative for Enhancing Pediatric Patient Safety (EPPS) is a demonstration project 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.

- With an EMSC grant, the Children's Hospital of Philadelphia (CHOP) studied the mental health impact of emergencies on children and supported the development of the "After the emergency is over: post-traumatic stress disorder in children and youth" fact sheet.
 - With EMSC funding, the University of Massachusetts developed and conducted the Pediatric Disaster Life Support (PDLS) Program, a two day training workshop for emergency medical professionals.
 - EMSC Program funding was utilized to develop a training video for the JumpSTART pediatric multi-causality triage protocol.
- The Poison Control Centers Program assists in stabilizing the availability of this 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 Trauma/Emergency Medical Services Program goal is to facilitate the development of national trauma system infrastructure where each State has a legislatively defined trauma system, which coordinates regional systems to administer quality, cost effective care at the local level.

National Institutes of Health (NIH)

National Institute of Child Health and Human Development (NICHD)

- In July of 2002, NICHD hosted a research agenda-building workshop, in collaboration with nine other federal agencies including the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), the Office of Behavioral and Social Sciences Research (OBSSR), and the Fogarty International Center (FIC) of the National Institutes of Health, the Centers for Disease Control (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Special Education Programs of the Department of Education, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the National Institute of Justice (NIJ) in the Department of Justice, on Children Exposed to Violence, including war and terrorism. Based on this workshop, the NICHD has published a program announcement with setaside funds (totaling approximately \$3 million per year) on research on children exposed to violence, including

the epidemiology, identification, and assessment of children exposed to war/terrorism, and consequences, services, and interventions for these children.

National Institute of Mental Health (NIMH)

- NIMH has been supporting research on the mental and behavioral health consequences of mass trauma, including disasters and terrorism for many years. Research conducted after various types of disasters (Oklahoma City Bombing, Hurricane Andrew; Three Mile Island disaster; 1989 San Francisco Bay area earthquake; 1991/92 Iraqi missile attacks on Israeli civilians; and the terrorist attacks on New York City on 9/11/01) has enabled NIMH to provide guidance on the magnitude and range of mental and behavioral health consequences of mass trauma, what steps can be taken to minimize adverse outcomes, and the effectiveness of intervention strategies. Shortly after the September 2001 attacks on the Pentagon and World Trade Centers, NIMH took steps to fund new research (10 studies) and enhance existing data collection (9 studies) specific to the attacks. These projects focus on:
 - Epidemiology of exposure and reactions.
 - The settings where victims/survivors present for care and what types of care are provided.
 - Mental health impact of bioterrorism.
 - The health impact of chronic threat of terrorism.
 - Psychobiological mechanisms by which trauma infers risk for adverse outcomes in children and adults.
 - Interventions (psychotherapy and medication) to reduce the risk of disorder and disability.

Substance Abuse and Mental Health Services Administration (SAMSHA)

- SAMSHA is providing funding to the National Center for Child Traumatic Stress/Terrorism and Disaster Branch and the broader 37 site National Child Traumatic Stress Network. This growing program has three components: 1) National Center for Child Traumatic Stress; 2) Intervention Development and Evaluation Centers; and 3) Community Treatment and Service Centers. Each of these are resources for both states and local entities to collaborate with on terrorism preparedness, and SAMHSA has held a number of training courses for public health and private providers.

- SAMHSA has developed “A Guide for Intermediate and Long-Term Mental Health Services After School-Related Violent Events”, a guide prepared through a Federal inter-agency project with the Department of Education Project SERV (School Emergency Response to Violence). The guide was prepared as part of a project entitled “The Mental Health Component of Project SERV”, and it provides guidelines for school staff and community mental health personnel to establish and maintain immediate, intermediate, and longer-term mental health recovery services necessary to restore the social and emotional equilibrium and well being of students and staff after violent events.

