

2022-2023 Recommendations from the National Advisory Committee on Children and Disasters (NACCD): The mental health crisis in the aftermath of the COVID-19 pandemic and other lessons learned

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ASPR





NACCD

National Advisory Committee
on Children and Disasters

2022-2023 NACCD Recommendations (January 18, 2023)

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Introduction and Method of Work

The current National Advisory Committee on Children and Disasters (NACCD or the Committee) was reauthorized by Congress in June 2019¹ and inaugurated on [February 17, 2021](#). The Secretary of the Department of Health and Human Services (HHS) approved the charter of the NACCD to “provide advice and consultation to the Secretary of HHS to assist him in carrying out these and related activities as they pertain to the unique needs of children in preparation for, responses to, and recovery from disasters.”² Operation and management of the NACCD, including the authority to task the committee and receive recommendations, has been delegated to the Assistant Secretary for Preparedness and Response within the [redesignated Administration for Strategic Preparedness and Response](#) (ASPR). The NACCD is governed by the provisions of the Federal Advisory Committee Act (FACA), Public Law 92-463, as amended (5 U.S.C. App.).

The NACCD is comprised of 13 non-federal members, as required by Congress, selected from among subject matter experts who applied through a public announcement in the Federal Register. Those individuals have been appointed by the Secretary of HHS as Special Government Employees and are the voting members of the NACCD. The NACCD is also comprised of 10 federal (non-voting) members who are *ex officio* representatives from agencies within HHS and other Executive Branch departments. A full roster for the NACCD is in Appendix 1 of this report. Following the inaugural meeting, the voting members of the NACCD elected David Schonfeld, MD, FAAP, to serve as the chairperson.

Since its inauguration, the NACCD formed two working groups (subcommittees) to conduct the work of drafting recommendations. Those working groups, Community Preparedness, Response, and Recovery Working Group and Healthcare Response, Recovery, and Prevention Working Group, developed the recommendations, which were then proposed to the full committee for review in this draft report. Consistent with standard procedures for the National Advisory Committee (NAC) Program in ASPR, the voting members are responsible for drafting recommendations, considering

¹ Section 2811A of the Public Health Service Act (42 U.S.C. § 300hh-10b), as amended, by the Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAIA), Public Law No. 116-22.

² For a full copy of the NACCD charter, see [the ASPR website](#).

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advice from ex officio representatives and other subject matter experts, which are published on the ASPR website for public review and discussion prior to a final vote.

In developing this first set of recommendations for the new NACCD, the working groups held numerous meetings with federal and non-federal subject matter experts in a variety of disciplines. While not formally tasked, the designated federal official (DFO) has asked the NACCD to focus on three main topics:

1. Children's disaster mental health challenges
2. Key lessons from the COVID-19 pandemic
3. Pediatric healthcare surge during respiratory infectious disease epidemics

Recognizing that these are complex issues areas, the NACCD is making several of its highest priority recommendations in this report to address the immediate and persistent challenges in public health emergency preparedness, response, and recovery affecting children in the United States. The committee members recognize there may be additional recommendations needed in these issue areas and they will work to develop recommendations on those and other high-impact issues for subsequent reports.

Additionally, the NACCD recognizes that since the reports of the National Commission on Children and Disasters (2010) and the original NACCD (2015-2018), significant efforts and progress have been made in general disaster preparedness, response, and recovery, including many activities that address the specific needs of children. Nevertheless, many issues remain relevant in today's deliberations, especially in the aftermath of COVID-19 and the extraordinary impacts that the outbreak and the outbreak response has had on children.

NACCD Findings and Recommendations

For the purpose of the recommendations that follow, "children" refers to all children from birth to at least 21 years of age. Unless age groups are specified, "children" is synonymous with "infants, toddlers, preschoolers, school-age children, adolescents, and youth." It is critical to attend to the needs of all children throughout this age range and not just one portion of the spectrum; the needs of children are not adequately met until the needs of children of all ages are addressed.

Children are a part of families that are embedded within communities. Much of the disaster response and recovery services that aim to benefit children are provided to children directly rather than taking full advantage of the positive role that families and communities can play in supporting children. Healthy children can only exist in healthy families and healthy communities. Opportunities to support families and communities, including K-12 schools and childcare systems, are essential to disaster response and recovery efforts. It should be assumed throughout these recommendations that "children" relates to "children, families, and communities" whenever relevant and possible.

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Children who live in poverty or rural/remote communities and/or who are members of disenfranchised minority or ethnic groups experience a disproportionate share of the impact of disasters, as evidenced recently during the COVID-19 pandemic and other natural disasters. They have the greatest pre-disaster vulnerabilities and fewest external resources. Children with disabilities and other special healthcare needs have additional pre-disaster vulnerabilities as well and require specific accommodations and supports to survive and cope with a disaster. These needs are too often overlooked and not adequately factored into preparedness and response efforts, let alone recovery. Considerations of these unique vulnerabilities should be incorporated into implementation of the recommendations that follow.

The NACCD emphasizes that promoting resiliency in children, families, and their communities, while also building a more robust public health system prior to a disaster, not only minimizes the negative impact of disasters but is more cost effective overall, reducing the financial and human resource costs of a disaster. While the NACCD charter requires a focus on disaster preparedness, response, and recovery, and therefore the focus of the recommendations that follow, the appointed members of the NACCD would like to stress that prevention and wellness in general are critical to positive disaster outcomes.

Recommendations regarding the children's disaster mental health crisis

1. ***A children's disaster mental health working group to support emergent and urgent mental health services for children.*** HHS should convene a working group of federal agencies and non-federal partners, including state partners that have implemented effective solutions and representative professional organizations and community groups, to identify mechanisms to specifically address the shortage of emergent and urgent mental health services for children. Among others, one of the primary goals of that working group should be to identify mechanisms and resources to help reduce the need for "boarding" children with behavioral health crises in emergency departments and pediatric inpatient units even when they do not have concurrent physical health needs that require such a medical setting. During public health emergencies, the lack of surge capacity for children's behavioral health exacerbates the shortage of emergency department, acute care, and critical care beds. To support this work, HHS will need to develop a system for real-time, national monitoring of such boarding, ideally within the next six months. The working group should be convened within 3-6 months and issue initial recommendations within one year, establishing a goal of reducing pediatric boarding by 75% in two years.
2. ***Funding mechanisms for disaster behavioral healthcare where and when local/regional resources are exhausted.*** To address long-term behavioral health consequences in communities where mental health services are insufficient or compromised by disaster, HHS should establish alternative funding mechanisms, including as needed legislative proposals or specific funding requests from Congress, for disaster mental health and coordinate with other agencies, such as the Department of Homeland Security (DHS), to do the same. Current

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funding for disaster response and recovery services for children's mental health needs is insufficient in both amount and duration of funding. The Federal Emergency Management Agency (FEMA) Crisis Counseling Program, the Department of Education's School Emergency Response to Violence (Project SERV), and other disaster response initiatives fail to address critical gaps in local and regional mental health resources. The recently funded disaster response grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) may be a useful model but should become part of the annual budget rather than funded on a one-time basis. Disaster response programs should include psychosocial services, care management, and supportive services addressing grief and loss in addition to the treatment of trauma disorders and other mental illnesses.

3. ***Pre-disaster training and just-in-time training for those who routinely care for children.*** The NACCD emphasizes the prior recommendation in the [*2010 National Commission on Children and Disasters Report to the President and Congress*](#) that HHS should enhance pre-disaster preparedness and just-in-time training in pediatric disaster mental and behavioral health. Such training should include psychological first aid, bereavement support, and brief supportive interventions to be used by mental health professionals and other individuals, such as teachers, who work with children. As a result of limited access to formal mental health services and treatment following a disaster, communities depend on persons who are not mental health professionals but who routinely interact with children. Teachers and other school staff, first responders, health care professionals, childcare and early education providers, child welfare and juvenile justice professionals, and members of the faith-based community, can provide basic support services and brief interventions. These individuals must have basic knowledge to recognize signs of distress, assist children in adjusting and coping, and identify children who require more advanced care. These interventions and services should also include effective intervention for families, recognizing the important role that caregivers and other family and community members can play in supporting children's recovery. More mental health professionals, especially those working in schools and other child congregate care settings, should also receive specialized training related to disaster mental health care for children.
4. ***Grants for disaster mental health training for clinicians and non-clinical professionals in the health system.*** Additional HHS grants should provide training for clinical and non-clinical healthcare staff in disaster mental health for children following a human caused or a natural disaster, including related to trauma, grief, and loss, to build capacity throughout the mental health system and broader community. This should include broad training in supporting children with bereavement and other grief and loss for a wide range of non-clinical professionals, including educators and other school staff. Such training may utilize readily available training materials, such as those provided by the [*Coalition to Support Grieving Students*](#), that are freely available and widely endorsed as well as newly created curricula as needed. Similar training in psychological first aid for non-mental health professionals should also be made available. Funding for such efforts may require additional resources from Congress.

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5. ***Proactive funding for behavioral health recovery interventions in schools.*** Rather than emergency-related supplemental funding for mental and behavioral health interventions, HHS should convene a working group among HHS agencies and other departments as needed to review and develop a strategy to enhance funding for health and human services recovery efforts within schools and other child congregate care sites. Alternatively, funding from HHS could directly support such programs within schools and other child congregate care sites.

Recommendations based on key lessons from the COVID-19 pandemic and other pediatric respiratory infectious disease epidemics

6. ***Improve systems for pediatric-specific data for disaster response.*** HHS should partner with other federal agencies and (if needed) lead the development of a strategic approach to defining, collecting, sharing, analyzing, and reporting on pediatric-specific data that are required for effective medical and public health emergency response. Such an effort should include development of a nationwide catalogue of existing systems or networks that contain (or could contain) data specific to children, whether generated by the health system or other community structures (e.g., schools and childcare facilities), evaluation of the representativeness (equitability) and completeness of those data systems, and a standardization scheme for data collection and aggregation. Among the initial goals of such an approach, a national pediatric disaster data system should accurately reflect the pediatric healthcare capacity across the country, highlighting where there are gaps relative to population size and, utilizing nearly real-time data, indicating where there are gaps in the availability of functional pediatric emergency, acute care, and critical care hospital beds during a response. Such a system would ideally include indicators for the implementation of specific public health measures, such as immunizations, and the flexibility to adapt to new data requirements for an unplanned or novel health threat.
7. ***Increase pediatric capabilities of the National Disaster Medical System.*** ASPR should identify additional funding for the National Disaster Medical System (NDMS) to significantly improve the program's capacity for pediatric emergency medical response. This would necessarily include hiring more pediatric specialists, including those certified in critical care and behavioral health, as well as more substantive baseline training for a significant portion of non-pediatric intermittent responders. The goals and standards for enhanced pediatric capabilities in NDMS could be developed through a subcommittee of the NACCD or other mechanisms that involve inputs from non-federal experts, such as partners that are already funded through the Pediatric Disaster Centers of Excellence (PDCoE) or the Pediatric Pandemic Network (PPN). Furthermore, the capacity for pediatric disaster care in NDMS should be further expanded through development of resources, procedures, and partners that can support ad hoc, durable, field-deployable tele-critical care consultation services and

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emergency telehealth. Funding for such efforts may require additional resources from Congress.

8. ***Pediatric disaster response annexes.*** Leveraging lessons and evidence from the PDCoE and PPN, among others, HHS should continue to incentivize Health Care Coalitions to evaluate and refine implementation of their respective pediatric response annexes. Existing evaluation tools, such as the Emergency Medical Services for Children (EMSC) Pediatric Readiness Assessment, could be mandated in lieu of other recognized evaluation systems, with data reported to PDCoE partners for analysis and additional evidence generation. HHS should also coordinate with non-federal partners to pilot a program to evaluate the effects of federal and respective state policies and regulations on pediatric emergency response plans, focusing on elements of specific plans that cannot be effectively implemented under existing legal frameworks. While more discussion is needed for the NACCD to develop specific recommendations, HHS could also begin collecting data from health system partners to begin establishing an evidence-base for the effectiveness and shortfalls in policy and regulatory waivers that are executed during a declared public health emergency.
9. ***Conduct scientific responses to public health threats insulated from political considerations.*** HHS needs to take additional steps to ensure that the United States is always prepared to implement an immediate, effective, and coordinated public health response that is guided by scientific knowledge and protected from undue political influence. Echoing recommendations previously made by the [National Biodefense Science Board \(NBSB\) in December 2021](#), the NACCD also recommends that HHS act to develop a centralized, core public health emergency communication and coordination function that is inherently insulated from political considerations, similar to the Congressional Budget Office or the Federal Reserve Bank, that has the ability to independently develop, directly distribute, and frequently update public health messages using scientific principles with inputs from the nation's leading experts.
10. ***Ensure the federal government can implement necessary measures during a public health crisis.*** HHS needs to work directly with state legislators and Congress to ensure that the federal government, in collaboration with state and local governments and partners, can implement necessary public health measures during a pandemic or other public health crisis. Pandemics, by definition, are not geographically restricted to one location or state and the Nation needs the means to protect all who live in the United States, including territories and Tribal entities, (and other countries) when required. Among other things, the federal government needs the authority to effectively conduct mass vaccination programs and guide use of personal protective equipment in public settings (e.g., masking) that is not restricted by individual state actions.

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11. ***Ensure federal access to complete pediatric immunization data during pandemics and other infectious disease emergencies.*** HHS must improve real-time collection, aggregation, and analysis of population-wide (i.e., entire U.S.) data on immunization status in the event of a pandemic or other infectious disease emergency, providing adequate protections for the privacy of individuals without compromising complete and ready access to critical data. Local or state restrictions to such access should not be permitted in a federally declared public health emergency.

Recommendations on other high priority matters related to children and disasters

12. ***Additional staff positions in ASPR for children's disaster preparedness, response, and recovery.*** As the new Administration expands and reorganizes as a new Operating Division of HHS, it should establish appropriate staffing with senior-level representation for children's issues as well as the staff to carry out recommendations that expand and develop new solutions to address the disaster preparedness, response, and recovery needs of children, their families, and caregivers. Doing so would ensure that the needs of children are represented in the development and implementation of every program, policy, and event response. Such a position(s) requires formal placement in the organizational chart with strategically recognized responsibilities to advise the Assistant Secretary and coordinate directly with ASPR, other federal programs, and non-federal partners consistent with the National Response Framework Emergency Support Function 8 and National Recovery Framework Recovery Support Function. The NACCD will support the "children's disaster staff" in ASPR as this role evolves, providing recommendations as needed for additional functional responsibilities and advice to aid in implementation of specific program elements across the agency.
13. ***Federal working group focusing on gaps in general disaster preparedness related to the needs of children.*** HHS should formally charter a federal children's disaster preparedness working group that will continuously monitor progress toward remedying gaps in preparedness for children's needs during and after a disaster, including coordinating support for a national surge in pediatric healthcare. The working group should also be prepared to respond and expand as needed in the aftermath of a disaster. This group must include members from each relevant entity within HHS and partner with the children's working group (or similar entity) in key stakeholder organizations.
14. ***Benchmarks for the Biomedical Advance Research and Development Authority (BARDA) for emergency medical countermeasures (MCM) for children.*** ASPR should coordinate with federal programs, partners, and stakeholders to determine pediatric-specific benchmarks for research, development, and acquisition of pediatric emergency medical countermeasures (MCM). Examples of such benchmarks, subject to consensus, might include:

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- a) Every research activity funded by Biomedical Advanced Research and Development Authority (BARDA), if not specifically for a pediatric medication, formulation, or delivery device, will include a timely plan to conduct research and development that will lead to a pediatric formulation, appropriate delivery device, and/or age- or size-based dosing instructions. If needed, an additional, appropriate timeframe (benchmark) for development of a pediatric formulation or protocol should be determined through the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE), which can be reexamined periodically as needed based on scientific challenges.
- b) BARDA and regulatory agencies should be prepared to concurrently fund and coordinate development of pediatric formulations or protocols for pediatric use when responding to a novel public health threat, such as COVID-19.
- c) At least 25% of emergency medical countermeasures (MCM) purchases for the Strategic National Stockpile (SNS) (including vendor-managed reserves) will include pediatric formulations or contingency protocols for adaptation to pediatric uses.
- d) Regulatory agencies will be prepared to include protocols under emergency use authorization for adaptation of adult MCM for pediatric use when it seems likely that a pediatric formulation will not be available soon and the impacts of a novel public health threat on children are apparent or uncertain.



Appendix 1: NACCD Roster

VOTING MEMBERS

David Schonfeld, MD - Chairperson

Director, National Center for School Crisis and Bereavement, Children's Hospital Los Angeles, and Professor of Clinical Pediatrics, Keck School of Medicine, University of Southern California Los Angeles, CA

Claire Barnett, MBA – Working Group Co-Chair

Executive Director, Healthy Schools Network, Inc. Saratoga Springs, NY

Nancy Blake, PhD, RN

Chief Nursing Officer, Harbor-University of California Los Angeles Medical Center Los Angeles, CA

Rita Burke, PhD, MPH – Working Group Co-Chair

Associate Professor of Population and Public Health Sciences and Pediatrics, Keck School of Medicine, University of Southern California Los Angeles, CA

Cindy Calderón, MD

Executive Director and Past President, Puerto Rico Chapter of the American Academy of Pediatrics San Juan, PR

Rachel Chamey, MD

Professor of Pediatrics, Epidemiology and Biostatistics, Saint Louis University and Medical Director of Disaster Preparedness, SSM Cardinal Glennon Children's Hospital St. Louis, MO

Sarita Chung, MD – Working Group Co-Chair

Associate Professor of Pediatrics and Emergency Medicine, Harvard Medical School and Director of Disaster Preparedness, Emergency Medicine Division, Boston Children's Hospital Boston, MA

Mark Cicero, MD

Associate Professor of Pediatrics and Director of Pediatric Disaster Preparedness, Yale University School of Medicine New Haven, CT

Arthur Cooper, MD, MS

Professor Emeritus in Surgery and Director of Pediatric Surgical and Trauma Services, NYC Health + Hospitals New York, NY

Brent Kaziny, MD, MTM&H, MS

Associate Professor of Pediatric Emergency Medicine, Baylor College and Medical Director of Emergency Management, Texas Children's Hospital Houston, TX

Leslie Rubin, MD

Associate Professor, Department of Pediatrics, Morehouse School of Medicine and Adjunct Associate Professor, Emory University School of Medicine; President and Founder, Break the Cycle of Health Disparities, Inc.; and Medical Director, Rubin Center for Autism and Developmental Pediatrics Atlanta, GA

Jeffrey Upperman, MD – Working Group Co-Chair

Professor of Pediatric Surgery and Chair of the Department of Pediatric Surgery, Vanderbilt University Medical Center; Surgeon-in-Chief, Vanderbilt Children's Hospital Nashville, TN

Debra Weiner, MD, PhD

Emergency Medicine Physician, Boston Children's Hospital and Assistant Professor of Pediatrics, Harvard Medical School Boston, MA

EX OFFICIO REPRESENTATIVES

Department of Health and Human Services

Byron Mason, Deputy Director, Office of Human Services Emergency Preparedness and Response, Administration for Children and Families

Jennifer Johnson, Deputy Commissioner, Administration on Disabilities and Director, Office of Disability Service Innovations, Administration for Community Living

Daniel Dodgen, Senior Advisor for the Office of Strategy, Policy, Planning, and Requirements, Administration for Strategic Preparedness and Response

Derek Eisnor, Medical Officer in the Division of Clinical Development, Biomedical Advanced Research and Development Authority, Administration for Strategic Preparedness and Response

Dionna Green, Acting Director of the Office of Pediatric Therapeutics, Office of Clinical Policy and Programs, U.S. Food and Drug Administration

Rosalind B. King, Associate Director for Prevention and Program Director for the Population Dynamics Branch, *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, National Institutes of Health

Melinda J. Baldwin, Special Assistant to the Director of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Celeste Philip, Deputy Director for Non-Infectious Diseases, Centers for Disease Control and Prevention

Michael Warren, Associate Administrator for the Maternal and Child Health Bureau, Director of the Division of Child, Adolescent and Family Health, Health Resources and Services Agency

Department of Education

Meredith Miller, Director of the Disaster Recovery Unit, Office of Elementary & Secondary Education

Environmental Protection Agency

Jeanne Briskin, Senior Advisor

Department of Homeland Security

Lauralee Koziol, National Advisor on Children & Disasters, Federal Emergency Management Agency