

The Mitigation and Recovery of Mental Health Problems in Children and Adolescents Affected by Terrorism



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I. Introduction

This focus group report provides a basic scientific overview of the existing knowledge of the mental health impact of terrorism on children and adolescents in the U.S. and the preparedness of the U.S. health care system to cope with past and possible future terrorist attacks. Major gaps in service delivery and treatment interventions are addressed, with priority given to those policies that are in urgent need of support to fill existing gaps in order to: 1) maximize the recovery of children and adolescents affected by terrorism; and 2) “inoculate” them against the negative mental health consequences of possible terrorist attacks on our nation in the future.

II. Magnitude of the Problem

Little scientific evidence exists to date on the mental health effects of terrorism. The risk and resiliency of children and adolescents can only be hypothesized from recent post-September 11, 2001 (9/11) studies undertaken in the U.S. and from the existing studies that have focused on the mental health impact of mass violence and extreme life situations related to war and ethnic conflict.

Research has revealed that the psychological effects of terrorism on adults, who most frequently play the role of primary caregiver, will certainly have a direct and indirect effect on the mental health and overall impact of the terrorist event on children and adolescents.

A number of recently published studies have attempted to assess the mental health impact of terrorist attacks on adult populations. A study by Schuster et al. (2001) assessed the immediate mental health effects of 9/11 on a national representative survey of 560 adults living in the U.S. In this study, 44% of adults reported one or more substantial symptoms of distress related to the attack. This study was followed by a study by Galea et al. (2002) for the New York Academy of Medicine. Using random telephone interviews of 1008 adults living south of 110th Street in Manhattan five to eight weeks after the attacks, they found that 7.5% of respondents reported symptoms consistent with posttraumatic stress disorder (PTSD) and 9.7% reported symptoms consistent with depression. Among respondents who lived south of Canal Street (near the World Trade Center), the prevalence of PTSD was 20%.

A study by Schlenger et al. (2002) using a web-based epidemiological approach evaluated the probable presence of PTSD in a national sample of 2,273 adults. Their findings confirm the higher prevalence of PTSD in those respondents from New York City (11.2%) than other less affected parts of the country (4.0%). The most recent report by Delisi et al. (2003) conducted in-person interviews of adults in New York City (1,009) between December 15, 2001 and February 28, 2002. A total of 56.3% of individuals had some evidence of emotional distress three to six months after the terrorist attacks.

Although these preliminary studies are not based on culturally validated psychiatric diagnoses for PTSD and depression, they, however, reveal rates of mental health stress many times the baseline of PTSD and depression in non-traumatized U.S. populations of 1 to 3% and 5 to 8%, respectively (U.S. Department of Health and Human Services 1999). They are also consistent with earlier studies conducted after the bombing of the Alfred P. Murrah Building in Oklahoma City in 1995. North et al. (1999) found that six months after the event, 34% of 182 survivors who had been in or near the building had diagnosable PTSD. A study by Tucker et al. (1999) found that many individuals traumatized by the Oklahoma City Bombing continued to have persistent symptoms despite treatment.

Data on the mental health of children and adolescents following the September 11 attacks are extremely limited. The study by Schuster et al. (2001) showed that 35% of children had one or more stress symptoms, and 47% were worried about their own safety or the safety of loved ones. In the study by Schlenger et al. (2002), more than 60% of adults in New York City households had one or more children upset by the events of September 11. In this study, adult reports indicated that 19.8% of the most upset children were having trouble sleeping, and were described as “irritable”, “grouchy”, easily upset and fearing separation from parents.

Hoge (2002) reported that after 9/11 there were significant increases in the number of visits by children of military personnel for anxiety disorders and acute stress reactions at military facilities within 50 miles of Washington, DC, as compared to similar time periods during the previous two years. Stuber et al. (2002), using the New York Academy of Medicine study of 1,008 adult residents of New York City, found substantial levels of exposure among 112 children who lived below 110th Street. For example, 41% of children saw parents crying about attacks, 32% had parents who had witnessed the disaster in person, more than 10% of the parents reported that a friend or relative had been killed and 17% knew a teacher or a coach who lost someone in the disaster.

Hoven’s study for the New York City Board of Education (2002), which assessed the reactions of 8,266 students in New York City school system grades 4 through 12 to the New York City attacks, is the most comprehensive study to-date of the mental health effects of terrorism on children. The exposure rate of children throughout the city was high. Virtually all children in Ground Zero (the area of the attacks on the World Trade Center) schools had been personally exposed to the attacks. Two-thirds of children in the other areas of the city also experienced exposure; many fled for safety (26%), continued to smell smoke (41%) and were having difficulty returning home on September 11, 2001.

In the entire city, 11% of public school children had a family member or close friend exposed to the attacks, including 1% who had a family member killed.

In this study, estimates of psychiatric disorders as compared to pre-9/11 baselines (Shaffer et al. 1996) are demonstrated in Table 1. These findings are consistent with the survey of 3,000 middle and high school students approximately seven weeks after the 1995 Oklahoma City bombing (Pfefferbaum et al. 1999).

Table 1: Prevalence of Mental Health Problems Post 9/11 Among New York City School Students Compared to Pre-9/11 Community Estimates, Grades 4-12

	Depression	PTSD	Separation Anxiety	Agoraphobia	Conduct Disorder*	Alcohol Abuse*
NYC Post 9/11	8%	11%	10%	15%	10.9%	5.1%
NIMH-MECA	6%	2%	8%	5%	4%	3%

* Measured for Grades 9-12 only

Scientific studies that have measured the impact of mass violence on the mental health of children have consistently demonstrated the high prevalence of symptoms of depression, anxiety and PTSD. As Table 2 reveals, traumatized children in these studies have many times the prevalence rates of mental health problems as compared to non-traumatized children in the U.S.

Table 2: Effects of war and trauma on children and adolescents

	PTSD	Depression	Total Problem Score % in Clinical Range	SCREENING TOOL	SOURCE
6 Year follow up of 30 Young Khmer refugees	50% 1984 38% 1990	41% 1987 6% 1990	N/A	K-SADS-E	Sack W et al (1993)
170 Cambodian adolescent refugees	26.5%	12.9%	N/A	K-SADS-E	Sack WH et al (1996)
480 Croatian refugee children	N/A	11.28%	N/A	CDI	Zivcic I et al. (1993)
59 Young Cambodian-Americans	Current 24% Lifetime 59%	19%	N/A	SCID-NP	Hubbard J et al (1995)
182 Cambodian refugee camp adolescents and their parents	N/A	N/A	CBCL 53.8% YSR 26.4%	CBCL YSR	Mollica R et al. (1997)
209 Khmer Adolescents	12.9-41.2%	N/A	N/A	SSADS SCID	Sack WH et al. (1995)
99 Cambodian refugees	Point 31.3% Lifetime 37.3%	Point 68.4% Lifetime 86%	N/A	SSADS Interview	Savin D et al (1996)
Cambodian refugees in US	Point 28.6% Lifetime 37.1%	Point 17.1% Lifetime 37.1%	N/A	SSADS Interview	Id.
12 Bosnian adolescents in US	25%	17%	N/A	CTEI	Weine S et al (1995)
147 Bosnian children refugees	N/A	25.90%	N/A	Self Report	Stein B (1999)
492 Israeli children during Scud missile attacks	24.9%	N/A	N/A	SRQ	Schwarzwald J et al. (1993)
150 Palestinian mothers and their children	N/A	N/A	58.8%	CBCL	Gabarino J et al. (1996)
234 Children in the Gaza Strip	Point 40.6% 1 Year 10%	N/A	N/A	CPTS-RI	Thabet AA et al. (2000)
Children (US)	N/A	Point 2%	N/A	DSM-III-R Interview	AACAP (1998)
9-17 year-olds (US)	2%	6 month 6%	N/A	DISC-2.3	Shaffer D (1996)

Kiddie Schedule For Affective Disorders And Schizophrenia (KSADS); School Children Version Schedule For Affective Disorders And Schizophrenia (SSADS); Child Depression Inventory (CDI); Child Behavioral Checklist (CBCL); Youth Self Report (YSR); Communal Traumatic Experiences Inventory (CTEI); Child Posttraumatic Stress Reaction Index (CPTS-RI); Stress Reaction Questionnaire (SRQ); American Academy of Child and Adolescent Psychiatry (AACAP).

III. Terrorism Mental Syndrome: Does it exist?

The mental health symptoms in children and adolescents affected by terrorism in the U.S. and studies undertaken on populations who have experienced war and displacement show reactions that are consistent with the child's level of development. These common trauma reactions by school age are shown in Table 3. Severe reactions are frequently related to the American Psychiatric criteria based upon the DSM IV for PTSD,

depression and generalized anxiety (Fazel and Stein 2002).

It is not known whether terrorism has *event-specific* mental health effects on children and adolescents different from DSM IV. For example, research has not determined whether a *terrorism mental health syndrome* exists and what are its specific subjective, personal and behavioral manifestations at different developmental levels. Physical and somatic symptoms may also characterize this syndrome in children and adolescents (Hassett 2002; Norris 2001). More than two decades ago, significant confusion and debate existed as to whether a unique mental health syndrome was associated with torture. The concept of a torture syndrome was eventually abandoned once standard psychiatric diagnoses were found to adequately define the major symptoms found in torture survivors worldwide.

Table 3. Summary of Common Trauma Reactions by Age

Reactions	Preschool	School Age	Adolescents
Fears, worries	X	X	X
Physical complaints	X	X	X
Attention, memory problems	X	X	X
Nightmares, sleep problems	X	X	X
Post-traumatic play	X	X	
Regression, separation anxiety	X	X	
Anger, hostility, aggression		X	X
Apathy, withdrawal, avoidance		X	X
Sadness, depression		X	X
Sense of foreshortened future		X	X
Survivor Guilt			X
Risky, dangerous behavior			X

Source: The Center for Victims of Torture: Overview and Effects of Torture on Children and Adolescents

A number of issues must be addressed in order to understand where this field stands on this issue.

First, existing research has not phenomenologically described the full range of personal reactions, symptoms and behaviors experienced by American children exposed to terrorism (Halpern-Felsher et al. 2002) with a few notable exceptions. A study by Halpern-Felsher et al. (2002) revealed the heightened perceptions of adolescents of their vulnerability to death after the 9/11 attacks. A recent study by Beauchesne et al. (2002) post-9/11 discusses the effects of fear on children. Koplewicz et al. (2002), after the 1993 bombing of the World Trade Center, studied children's responses to the Oklahoma City Bombing. A very unique study by Seidemann et al. (1998) investigated how children make sense of their traumatic life experience at different levels of development. This was accomplished by focusing on letters mailed to injured patients in an Oklahoma City Children's Hospital.

Second, without a phenomenological description of the range of mental health responses of children and adolescents to terrorism, a threshold for identifying those children and

adolescents at serious risk for diagnosable mental illness cannot be established. Clearly, the mental health impact of terrorism must move beyond simple descriptions of PTSD-like symptoms (North and Pfefferbaum 2002) to in-depth assessment of changes in personality, physical and social functioning. It is absolutely essential for public policy and planning of mental health services to incorporate an assessment instrument that measures disability caused by terrorism, including disability related to problems in the family, school and the community. While large numbers of children may be emotionally affected by terrorism, it is possible that many children might have serious performance difficulties that are unrelated to mental health symptoms. The New York City study (Hoven 2002), unfortunately, did not assess the impact of terrorism on children's school performance although this information may have been collected. Ultimately, evidence-based criteria need to be established that can identify descriptively those children and adolescents in need of intervention whether or not they have a psychiatric diagnosis.

Third, all phenomenological descriptions of emotional distress in children and adolescents affected by terrorism must be culturally validated given the cultural diversity of American communities. It has been well established that children will express their emotional distress by emphasizing symptoms of emotional suffering compatible with their cultural background and the cultural context in which they live. For example, Mollica et al. (1997) found, in a community study of Cambodian children living in a refugee camp on the Thai border, that these children had a high prevalence of symptoms of somatization and social withdrawal commonly associated with emotional distress in Khmer adults. This knowledge applied in the context of assessments within diverse U.S. communities supports the idea that Western diagnostic criteria for children (e.g. depression and PTSD) must be culturally validated in non-English speaking populations.

Fourth, the cultural meaning and psychological potency of terrorism needs to be ethnographically and phenomenologically described for children of all ages and at all developmental levels. Although children may develop symptoms consistent with a diagnosis of PTSD following a terrorist attack, the socio-cultural and subjective response of a child who lost a parent in a terrorist attack might be extremely different from the reaction of a child who has witnessed the attack. As Difede et al. (1997) have pointed out, the PTSD diagnosis often does not capture major transformations in worldviews caused by extreme life experiences. Moreover, children and adolescents who live in communities where violence is routine may also experience terrorism as a less significant threat in comparison to the more immediate physical and emotional dangers present or feared in their local communities on a daily basis.

Fifth, accurate and culturally informed descriptions of terrorist-caused symptoms, behaviors and personal responses, including the assessment of problems in physical and social functioning, must be defined and codified in order to establish age-dependent identification and screening processes. The development of culturally valid and reliable identification and screening measures that can be easily utilized in clinic and community settings would be an important first step in a "call to action" in the effort to help relieve the suffering of children and adolescents affected by terrorism and its threat.

Sixth, it is essential that children be empowered to provide input into all aspects of their recovery. This is especially critical as research has consistently shown on numerous occasions that parents usually underestimate the violence experienced by their children and provide different estimates of their children's psychiatric symptomatology as compared to child reports. The difference in parental perceptions may be true, in particular, when parents themselves are depressed and feel hopeless and despairing about their own violent aftermath, thereby, resulting the projection of their negative feelings onto their children (Mollica et al. 1997). Finally, the input of children is likely to be a valuable resource in identification and services development. It should be noted that even at relatively young ages, children from all cultures are usually able to articulate the source of their upset and offer potential solutions.

IV. Risk and Resiliency Factors

Research on children exposed to mass violence reveals that the devastating mental health effects on children are in most cases, primarily due to effects on parents, unmet survival needs and interference with developmental tasks (UNICEF, UNHCR). In particular, studies have shown that the greatest effects on children in these situations occur when parents are killed or injured. The disappearance of a parent or sibling such as that which occurred on September 11th is especially potent and difficult for the child and surviving family members to overcome. To date, mental health interventions for children are based on the unproven but generally accepted premise that maximum recovery is facilitated by:

1. Restoration of good parenting
2. Establishing safety
3. Reestablishing family and child routines

Once these basic conditions are met, children reveal remarkable resiliency and recovery from mass violence.

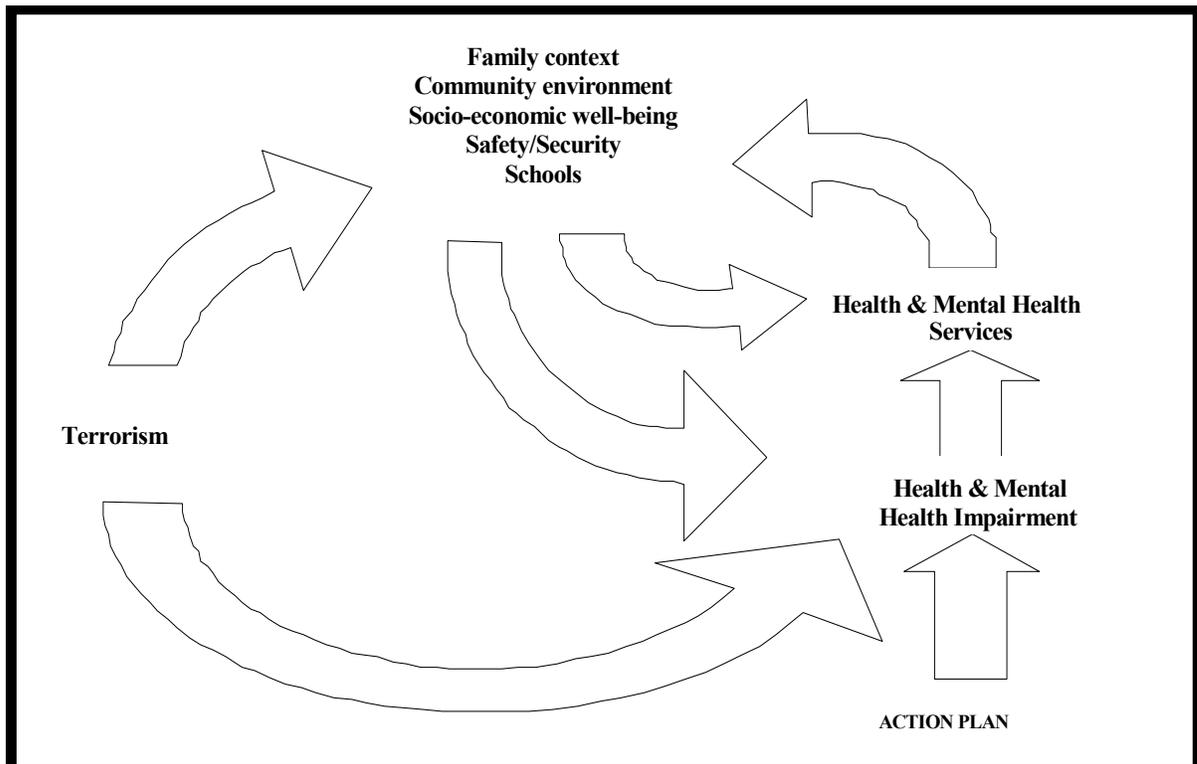
The basic conditions necessary for the mental health and well-being of children and adolescents in complex emergencies, referring to conflict and displacement, most likely also apply to children affected by terrorism, in spite of the fact that U.S. children exposed to terrorist acts may not be returning to the environments of famine, displacement and disease that characterize war-affected populations. However, any future biological, chemical or nuclear attack could seriously disrupt and threaten the survival of children over longer periods of time.

Risk factors in adults and children that have been identified by post-9/11 studies on children as having significant association with mental health outcomes include: female gender, minority status, prior history of emotional problems and previous experience of violence. Analysis of risk factors to date, however, has had limited application for treatment interventions and/or prevention.

Figure 1 illustrates a comprehensive model of risk and resiliency that needs to be filled in by future scientific research. In this model, a terrorist event can have direct health and

mental health consequences for children and adolescents. The terrorist event will also effect the child’s existing family context, community environment, school activities, socio-economic well-being, safety and security. Studies to date have not focused on the transformation of these macro areas by terrorism nor the subsequent consequences of trauma-related transformations on the child’s and adolescent’s mental health status. Each of these ecological areas can function as a risk factor (i.e. making a child more vulnerable) or a resiliency factor (i.e., protecting children from harm or contributing to their recovery).

Figure 1: Contextual framework for mental health action plan for children and adolescents affected by terrorism



Preliminary results are revealing the potential significance of the major risk and resiliency factors. For example, Hoven et al.’s study (2002) of New York City Public School children found that prior to 9/11 nearly two-thirds of the school children had already been exposed to serious violence including having seen someone killed or injured and/or experiencing the violent or accidental death of a close friend or family member. Pre-9/11 violence was a major concern for these children, which was exacerbated by terrorism. It has been demonstrated that a prior history of violence compromises the ability of children to cope with future violence (US Department of Health and Human Services 1999).

Delisi et al. (2003) is the only recent study to address the economic effects of terrorism. In this study, 28.9% of respondents had their employment negatively changed by the 9/11

disaster. Little is known of the respective impact of terrorism on schools, local community activities and the family, and their impact on the mental health status of children.

Along these lines, a valuable tool for policy planners that is currently not available, would be an scientifically based and comprehensive list of those coping factors that could serve to best “inoculate” U.S. children and adolescents against the mental health effects of terrorism (Susser et al. 2002). Recent 9/11 studies suggest that active coping strategies such as planning or seeking support were found to be the only methods protective against on-going stress (Schuster et al. 2002); while the use of avoidance and denial appeared to the least effective strategies for children and adults (Silver et al. 2002; Whittesley et al. 1999). These initial findings are compatible with other studies that have revealed the importance of stress-related coping strategies in the face of extreme violence (Gidron et al. 1999; Benight et al. 2000; Tucker et al. 1997; Tucker et al. 2000; Pfefferbaum et al. 2001).

In addition, based on scientific understanding of how best to protect children and adolescents in the U.S. in the event of another terrorist attack, a major public health education campaign should be designed immediately that will ensure efficacy in preparing families and communities in protecting and preparing children and adolescents. The U.S. media should play a seminal role in public health education prior, during and after an attack. Research shows that television exposure may have had a less than salutary effect on children (Schuster et al. 2001, Schlenger et al. 2002, Pfefferbaum et al. 1999) after the terrorist attacks on 9/11 and the Oklahoma City bombing. These results suggest the potent impact of the media on children and adolescents, and as such, presents an important role for the media to play in producing positive mental health outcomes.

V. Mental Health Interventions

As Figure 1 demonstrates, the essence of any mental health intervention to address the impact of terrorism, and its threat, must include an evidence-based mental health action plan – one that is built on existing knowledge and capacity. Unfortunately, outreach and the availability of psychiatric services are seriously limited and do not currently have the capacity to reach those who could greatly benefit from it. Both the U.S. Surgeon General’s Report (U.S. Department of Health and Human Services 1999) and The White House Conference on Mental Health (1999) highlight existing shortages and limitations. The Conference document states that, “the Nation is facing a public crisis in mental health for infants, children and adolescents. The Surgeon General’s Report presents a comprehensive analysis of the state of scientific knowledge relevant to the treatment of childhood mental health disorders as well as the causes of the unmet needs of children remaining high with only 20% of affected children in the U.S. receiving mental health services.” For example, currently there is a dearth of child psychologists or social workers capable of meeting the mental health needs of the nation’s children (Thomas-Holzer 1999).

The lack of utilization of mental health services has been highlighted in a number of the studies undertaken following 9/11. Hoven et al. (2002) found that at least two-thirds of New York City school children with probable PTSD following the 9/11 attacks had not sought any mental health services from school counselors or mental health professionals. Stuber et al. (2002) found that 22% of the children in her New York City study sample had received some form of counseling related to their experience after the disaster, primarily from their schools. Delisi et al. (2003) in their recent report found that only 11.3% of their respondents in New York City had received and help; only 26.7% of those (adults) were receiving counseling or psychiatric treatment. The efficacy of interventions in the previous studies as well as the barriers to health-seeking behavior and access to mental health services were not determined.

In spite of the limitations and availability of psychiatric services to children, the majority of families primarily seek help for trauma-related suffering from their indigenous healing system (i.e., primary health care practitioners, clergy, family members and the school system). This was found to be the case in the U.S. following the 9/11 terrorist attacks. Schuster et al. (2001), for example, found that over 90% of respondents had coped by consulting their clergy and an equal number their friends and relatives. This study neglected to focus on the role of general practitioners as a source of assistance in this context. Melnyk et al. (2002) conducted a national survey to determine the relationship between children and adolescents affected by terrorism and pediatric health care providers. They found that knowing how to cope with the stresses of recent events was the greatest worry for parents, children and teens.

The potential for reaching children through the primary care system is great (Farmer et al. 2003). Each year, for example, it is estimated that there are more than 150 million pediatric visits to primary health care providers in the U.S. per year (NAMCS 1998). Primary care practitioners play an active role in the identification and treatment of children with mental health disorders (Ringeisen et al. 2002) and are prescribing the majority of psychotropic drugs to children and adolescents. Children and adolescents with mental health problems, moreover, would prefer to be treated by their primary care provider rather than mental health specialists.

The role of primary care providers and the capacity and presence of other healers existing within the community in addressing mental health issues should not be ignored and should be the focus of a mental health action plan to address the effects of terrorism and the threat of future events. As international experience in resource poor post-conflict societies has taught us, a mental health action plan is most effective if it is centered in a non-stigmatizing environment easily accessible to all citizens. It should reach out to those public sectors where children and adolescents are most likely to be identified and readily treated.

Best practices for Mental Health Interventions, Curriculum Development and Training

Evidence-based studies of best practices of mental health interventions for children and adolescents affected by terrorism are extremely limited. Similarly, state-of-the-art knowledge of mental health interventions capable of being effectively used in culturally diverse populations by local and community practitioners such as primary health care, school based practitioners and families, has not been codified and is not therefore available for training and dissemination. Furthermore, potentially dangerous practices may be on the increase. For example, while it is likely that there has been an increase in the prescription of psychotropic drugs by primary care practitioners and mental health specialists to children and adolescents secondary to an increase in their distress as a result of terrorism, this information is not currently available. It is important that all practitioners have knowledge of the proper use of psychotropic drugs in culturally diverse communities.

The beginning of any training process must be founded on adequate knowledge of culturally effective and evidence-based mental health interventions. Yet, to date, such research-based knowledge does not exist. An immediate priority is, therefore, for national experts representing scientific and local communities to build a contemporary portfolio that can immediately sustain a mental health action plan until more in-depth research has been conducted and results are made available. Once these best practices are made available, a major emphasis must be placed on the training of the indigenous healing system.

Training lies at the foundation of an effective mental health care system and is critical in ensuring the effective identification and treatment of mental health problems in the context of terrorism. Moreover, the mental health training needs of the existing indigenous healing system are unknown. For example, it is not known whether existing mental health training approaches indeed are effective in modifying provider behaviors or influencing treatment outcomes. A systematic review of mental health trainings (Beuver et al. 2001) of primary health care providers of non-traumatized children and adolescents revealed that case-controlled evaluations were rare. In addition, few of the reported studies indicated changes in professional behavior or improvement in patient mental health status as a result of the trainings. However, standards that have been developed in primary care medicine working with non-traumatized populations can be applied to the practitioners within the indigenous healing system working with individuals who have survived a terrorist event. Systematic assessments of the efficacy of mental health training related to terrorism for primary care and school practitioners and families have not yet been undertaken.

Building the mental health capacity of the existing healing system in the U.S. will require much more than evidence-based interventions and science-based training curriculum. Elements of capacity-building must also include attention to financing and other motivational incentives (Wells et al. 2002). As Wells et al. have stated, "Achieving deeper changes in practice structure and function may require policy changes, particularly

more effective formulation and implementation of insurance coverage mandates that state and federal avenues have already initiated.”

RECOMMENDATIONS

Current recommendations for the mitigation and recovery of the mental health impact of terrorism on American children and adolescents include:

ASSESSMENT OF THE MENTAL HEALTH IMPACT OF TERRORISM

Undertaking cross-sectional and longitudinal studies in culturally diverse communities of the impact of terrorist events on psychiatric symptoms, personality, disability, and risk and resiliency factors.

Conducting ethnographic and quantitative studies that assess the impact of terrorist experience on children’s and adolescents’ psychological well-being and development over time with specific focus on determining a *terrorism mental health syndrome*.

DEVELOPMENT OF STANDARDS OF EVIDENCE-BASED BEST PRACTICES

Contracting teams of multi-disciplinary and culturally diverse experts, with input from parents and children, to prepare toolkits of best practices for mental health interventions for teachers, school counselors/nurses, primary care practitioners, and families.

Conducting evidence-based research (e.g. RCTs) to assess effectiveness of training on practitioners and their patients/clients including objective changes in practitioner behavior, mental health outcomes and sustainability over time.

INTERVENTIONS

Developing culturally valid and reliable screening instruments for the identification of mental health problems by teachers, school counselors/nurses, primary care practitioners, and families.

Conducting evidence-based studies (e.g. RCTs) on the effectiveness of interventions for children and adolescents by teachers, school counselors/nurses, primary care practitioners, and families.

PREVENTION ACTIVITIES

Designing, implementing and studying the efficacy of a public education campaign to “inoculate” children and adolescents against terrorism using the national and local media.

POLICY

Establishing through national polls the readiness and needs of teachers, school counselors/nurses, primary care practitioners, and families to cope with children and adolescents affected by terrorism.

Establishing national guidelines for the proper use of psychotropic drugs in culturally diverse populations.

Setting guidelines and national standards for the role of television, radio and written media in preparing families, children and adolescents at all stages of the crisis.

Determining unit cost of effective evidence-based mental health interventions in all school, community and health care settings.

Formulating and implementing insurance coverage mandates by state and federal agencies to guarantee that all affected children receive mental health coverage, even if uninsured.

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