



**Disaster Planning After 9/11:
Is New York City Ready to Care for its Children?**

**A Children's Health Fund Issue Briefing
September 2003**

The Department of Defense defines terrorism as "the calculated use of violence or the threat of violence to inculcate fear; intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological."ⁱ Terrorism differs from other forms of violence in that one of its goals is psychological: creating fear. To be adequately prepared for future acts of terrorism, we must understand the nature of the anxiety associated with terrorism. In addition to having a plan and the necessary resources for psychological support and intervention, we must enhance individual and collective resilience to respond to traumatic events.

Since October 2001, the Children's Health Fund (CHF) has worked with the Marist Institute for Public Opinion to field a series of polls surveying child and family reactions to the events of September 11 and the resources on which families rely for support.ⁱⁱ Each poll focused on children's reactions as reported by their parents. Polls were conducted three weeks (October 2001), six weeks (November 2001)ⁱⁱⁱ, six months (March 2002), and one year (August 2002) after the terror attacks. The last two polls included questions about the adults' own reactions. In August 2003, CHF and the Mailman School of Public Health at Columbia University completed a larger poll that provided information about local and national perceptions of government preparedness to meet the challenges of terrorism.

Starting in November 2001, CHF has provided mental health counseling and support services to children and families throughout New York City through the *Crisis Response Program*. This unique model includes a mobile mental health unit to reach high-risk, medically underserved communities and provides state-of-the-art trauma interventions in both office and community settings. It also provides psycho-educational information and support services and has developed new curricula to build coping and resilience skills among high-risk children and to enhance identification and intervention skills among professionals who care for children and families. This program has now joined with *A Common Ground*, a clinical program of the Mailman School of Public Health, to form *The Resiliency Project*, which will focus on building child and family coping skills to deal with the possibility of future terrorism and trauma. The Resiliency Project is an integral part of the National Center for Disaster Preparedness at the Mailman School of Public Health.

The results of CHF’s clinical experience corroborate key findings of the CHF/Marist polls and provide important information about the impact of terrorism on children and families. These findings can be used to develop better mental health interventions as the need arises. This is especially relevant because many of the findings call into question the model that the Federal Emergency Management Agency (FEMA) implemented after September 11 to provide “crisis counseling” services in New York City.

- ◆ The psychological impact of terrorism is widespread geographically. It is not limited to Ground Zero, the physical location of the attacks;
- ◆ Vulnerable populations – people with prior exposure to violence, prior history of depression or anxiety disorders, and low income/medically underserved populations are disproportionately affected by new traumatic events;
- ◆ While the needs of many children and families can be met through a public health approach focusing on building resilience, those individuals who need mental health intervention cannot be adequately helped in only a few clinical sessions;
- ◆ Those who implement a public health model must be mental health professionals with specific expertise in trauma intervention, to ensure that individuals who need more intensive services are identified and their needs met;
- ◆ There are not enough mental health resources in New York City to meet needs;
- ◆ Schools can be used to a greater extent as the locus of intervention for children in need.

The following are some key findings from the CHF/Mailman School of Public Health/Marist survey data. For each question, parents were asked to report whether “with the events of September 11 and the continued threat of terrorism, has your child, in the past month” shown a specific feeling or behavior.

- ◆ Increased child concern about safety is ubiquitous, and has declined only slightly during the two years since September 11. As expected, the degree of concern is greater in New York City than nationally. Within New York City, the poorest borough, the Bronx, continues to have the highest level of concern.

FIGURE ONE:

New York City, child concern (%) about own and family safety, two years post-9/11

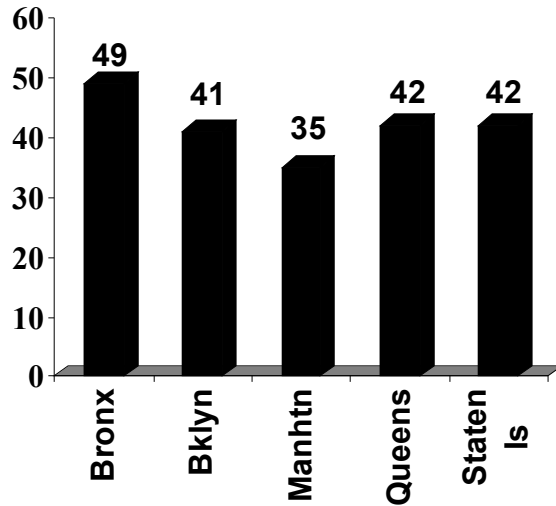


FIGURE TWO:

Trend data: New York City, child concern (%) about own and family safety post-9/11

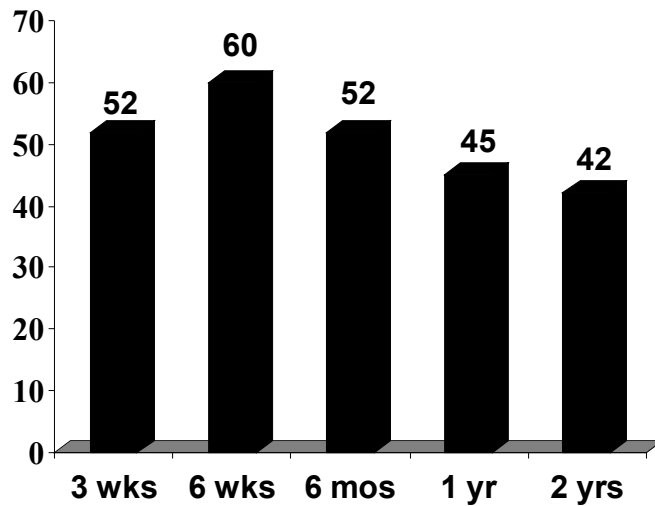
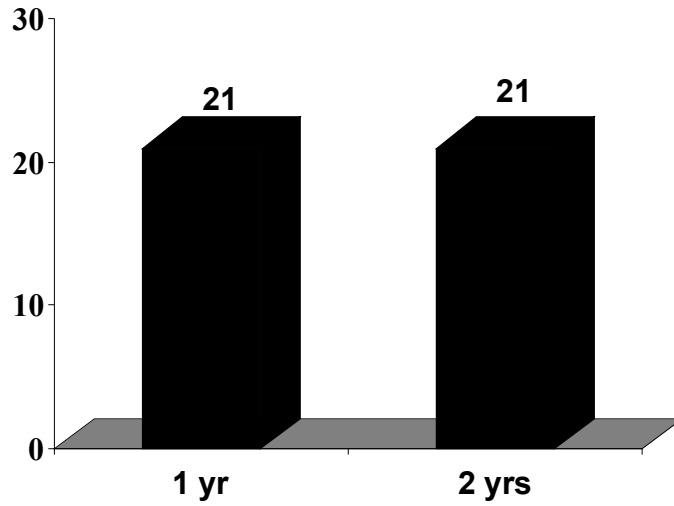


FIGURE THREE:

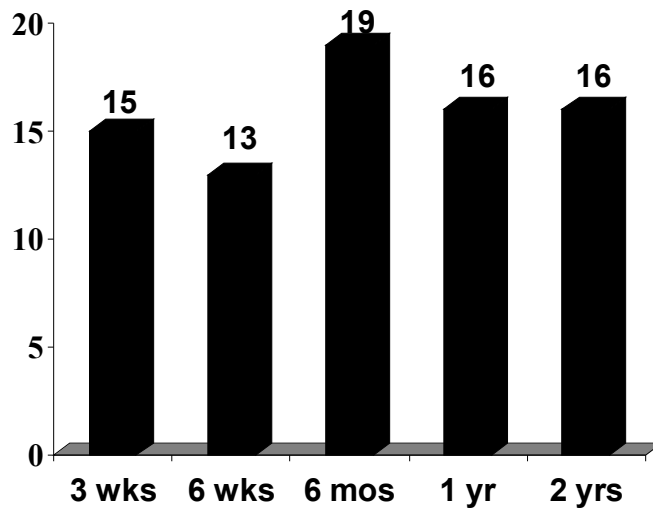
Trend data: USA, child concern (%) about own and family safety post-9/11



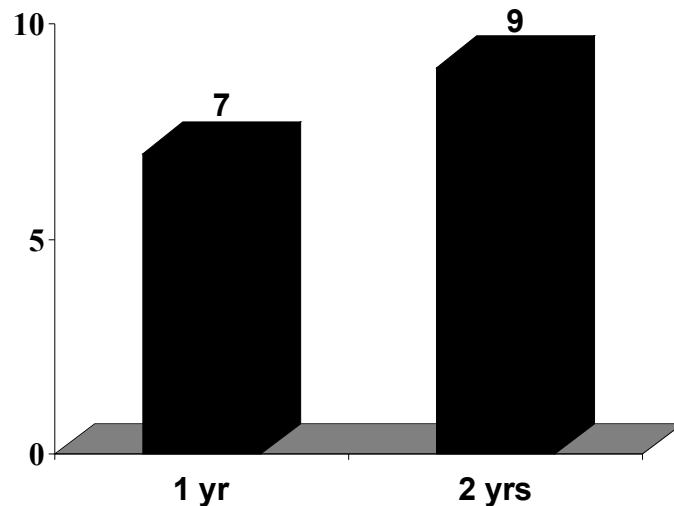
- ◆ A very consistent percent of children were reported to have somatic complaints such as headaches and stomach aches.

FIGURE FOUR:

Trend data: New York City children (%) reported with health complaint post-9/11



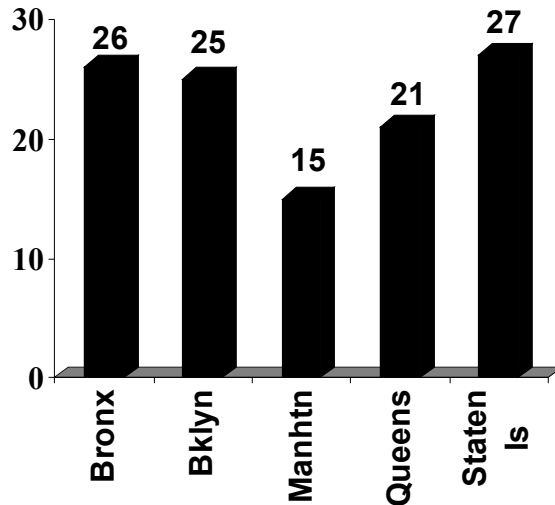
Trend data: USA children (%) reported with health complaint post-9/11



- ◆ While concern about safety in these uncertain times is widespread, there is a subset of children who have more serious concerns. Two years after September 11, when asked about specific signs and symptoms consistent with a mental health problem, some New York City parents reported that their child had generalized anxiety (24%), regressive behavior (24%), sadness or depression (12%), and sleep problems (11%).
- ◆ We combined the responses to this series of questions to get a percentage of children with multiple signs (four or more) of a mental health problem, which might indicate a more serious post-traumatic stress reaction. These children might need more intensive clinical or supportive services. There has been a consistently higher percentage of affected children in the city's poorest boroughs, the Bronx and Brooklyn, compared with Manhattan, the actual site of the World Trade Center attacks. In the most recent (August 2003) poll, a higher percentage figure emerged in Staten Island, which was home to many of the first responders who provided help and, in some cases, died in the attacks or their immediate aftermath.

FIGURE SIX:

New York City children with four or more reactions to the continued threat of terrorism, two years post-9/11



- ◆ When we compare children with four or more reactions, by borough, with children who received mental health services, by borough, the inadequate availability and mal-distribution of mental health resources in New York City becomes apparent. While 15% of children had multiple reactions in Manhattan, 10% received mental health help. By contrast, 26% of children in the Bronx had multiple reactions and 15% received help; in Brooklyn, 25% had multiple reactions and 12% received help. It is a special source of concern that only 12% of children in Staten Island were reported as having received mental health support, although 27% reported multiple reactions.
- ◆ Overall, when we asked whether parents had sought support from a mental health professional in the survey taken in August 2002, as many parents reported they wanted help but did not receive any as reported that they did receive mental health help for their child. Two years after the attacks, we found that the same percent had received mental health help as did one year after September 11. Child mental health needs were no better served in the second-year period. This is a grave concern, given that more than \$150 million was allocated by the federal government to New York State for “crisis counseling” services after September 11.

FIGURE SEVEN:

New York City: Mental health help wanted and received post-9/11



- ◆ We asked about services in schools on each poll. One year after September 11, 31% of New York City parents reported that their child received support from a special program at school. Two years after the attacks, this had only increased to 37%.

IMPLICATIONS FOR POLICY

- ◆ The “crisis counseling” model focuses initially on impact at the site of the disaster – but following an act of terrorism, there is no psychological ground zero. **Mental health support must be made available without the imposition of geographic eligibility restrictions.**
- ◆ Mental health services must be adequately available. Communities that lack an adequate mental health infrastructure should begin now to improve the availability of community-based services. **Adequate availability of mental health support is an integral component of comprehensive terrorism preparedness.**
- ◆ **Special outreach is required to reach vulnerable, high-risk populations** – especially since these communities may already be underserved for health and mental health care

- ◆ Because so many children are affected by an act of terrorism, a public health approach – as is integral to the “crisis counseling” model – is needed. **To facilitate identification of children who may need more intensive support, the public health model – helping children by helping their parents – should be implemented by mental health professionals expert in trauma intervention.**
 - ◆ **Pediatricians and others who care for children should receive the training and resources they need to become expert in identification of children who have difficult post-traumatic stress reactions.**
 - ◆ **Schools are a natural locus for services to help build child coping and resilience.**

- ◆ **Because heightened anxiety is a ubiquitous response to the threat of terrorism, comprehensive preparedness should include a specific focus on building resilience and coping skills.**

- ◆ The restrictions on mental health support services that were integral to the “crisis counseling” model as implemented in New York after September 11 are not required by either federal statute or applicable regulations. Therefore, it will not require legislative action to implement more effective mental health services following an act of terrorism. **We urge that the lessons learned following the World Trade Center attack – which corroborate the experience following the act of terrorism in Oklahoma City in 1995 – be used to develop more effective federal and local policies.**

ⁱ U.S. Army, Field Manual 100-20, *Stability and Support Operations*, (Final Draft), "Chapter 8: Combating Terrorism." The Terrorism Research Center, Internet: <http://www.terrorism.com> accessed 9/16/03.

ⁱⁱ Each of the first four polls had a sample size of approximately 460 parents of children four to eighteen years of age. Each was conducted by telephone, in English or Spanish as appropriate. Telephone numbers were selected based on a complete list of telephone exchanges from throughout the city. The exchanges were selected to ensure that each borough was represented in proportion to its population. In the August 2002 poll, 1,215 adults 18 years of age or older within the continental United States were interviewed by telephone, of which 363 were parents with children age four through eighteen living in their household. Telephone numbers were selected based upon a complete list of telephone exchanges from throughout the nation. The exchanges were selected to ensure that each region of the country was represented in proportion to its population. The margin of error for the polls ranges from 4.5% to 5%.

ⁱⁱⁱ The November 2001 New York City poll was conducted from October 29th through November 1st 2001, coincident with the first reports of anthrax attacks. There are spikes in degree of concern and fear attributable to the timing of the poll, which we believe demonstrate the reliability of the survey questions.