

NATIONAL COMMISSION ON CHILDREN AND DISASTERS
DRAFT INTERIM REPORT

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DRAFT

Commission Staff

Christopher J. Revere, Executive Director, Co-Editor

Victoria Johnson, Policy Director

Vinicia Mascarenhas, Communications Director

Jacqueline Haye, Executive Assistant

Randall Gnat, Policy Specialist

Matthew Seney, Communications Specialist

CAPT Roberta Lavin, USPHS, Designated Federal Official, Co-Editor

Carol Apelt, Alternate Designated Federal Official

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National Commission on Children and Disasters
Interim Report

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FOREWORD

Mr. President and Members of Congress:

We are pleased to deliver the *Interim Report of the National Commission on Children and Disasters*, which summarizes our work over the past twelve months.

Children comprise nearly 25 percent of the U.S. population. They represent the promise of our nation. We are confident most Americans in the face of a disaster would place the lives and well-being of children above all else. Yet it is sobering to inform you that when it comes to disaster planning and management across our great nation, children are not even placed on par with adults. In fact, State and local emergency managers are required by federal law to meet the needs of pets in their disaster plans, but not children.

Rather, children are considered an “at risk,” “vulnerable” or “special needs” population and subsequently grouped among the elderly, persons with disabilities, the medically-dependent, and persons with special transportation needs or limited English proficiency. In general, children do not fit into these broad categories. Among so many competing concerns, children are given less attention than necessary when disaster plans are written and exercised, equipment and supplies are purchased, and disaster response and recovery efforts are activated. Children, 74 million of them, simply are children. And while, for example, children with disabilities may require distinct planning and assistance in disasters, all children should be considered an integral part of, and many times an asset to, the general population.

Throughout this *Interim Report*, the Commission cites instances of what we characterize as “benign neglect” of children. The consequences of the benign neglect become magnified when children are disproportionately affected by disasters. For example, in April 2009, the H1N1 flu outbreak quickly illustrated this point when it was clear that children were disproportionately affected. Despite extensive planning for a much larger flu pandemic affecting the general population, the public health concerns of children created by the H1N1 outbreak prompted school and day care closings, creating challenges for accurate and timely communication to school administrators, child care operators, and parents, and economic consequences for families, small businesses and communities. H1N1 serves as a stark reminder of the central position children hold in the family and community.

Making children an immediate priority in disaster planning and management instills public confidence and creates greater stability to help families and communities recover faster. Federal Emergency Management Agency (FEMA) Administrator Craig Fugate invokes an ideal metaphor from his experiences in managing disasters in Florida, stating that there is no stronger indicator of hope and optimism to a disaster-affected community than to see a yellow school bus making its way down a neighborhood lane.

We recognize tangible examples of progress to prepare for and respond effectively to children, and we are encouraged by the enthusiasm of partners and stakeholders to engage the Commission in its work. Repeatedly, we have been told that yes, children should and must be a priority. However, much more needs to be done to bring about a sweeping change in disaster planning and management culture that currently favors able-bodied adults with better means to survive and fully recover from disasters.

This *Interim Report* is merely a prelude to a more extensive body of work that will be presented in the Commission's *Final Report*, due in October 2010. Over the next twelve months, we will dedicate our energies to closely monitoring the implementation of recommendations contained in the *Interim Report* and other initiatives, while simultaneously focusing our research more intensively on program evaluation, best practices, the examination of emerging issues, and development of clear, actionable recommendations.

Given the rise in the number of disasters over the past two decades and the emergence of H1N1, the work of this Commission is certainly as timely as it is essential. With your support and assistance, we must inspire a national movement that marks the beginning of the end to the cycle of benign neglect.

Thank you for the opportunity to serve. We look forward to working with you in this most important endeavor.

Respectfully submitted,

Mark. K. Shriver
Chairperson

Michael Anderson, M.D.
Vice-Chairperson

Ernest Allen
Merry Carlson
Hon. Sheila Leslie
Bruce Lockwood
Graydon Lord
Irwin Redlener, M.D.
David Schonfeld, M.D.
Lawrence Tan

ABBREVIATIONS

AHRQ Agency for Healthcare Research and Quality
ALS Advanced Life Support
ARC American Red Cross
BLS Basic Life Support
CBRNE Chemical, Biological, Radiological, Nuclear and Explosive
CCDBG Child Care and Development Block Grant Act of 1990
CDC Centers for Disease Control and Prevention
CONOPS Concept of Operations
DHS Department of Homeland Security
DMAT Disaster Medical Assistance Team
EMS Emergency Medical Services
EMSC Emergency Medical Services for Children
ESF Emergency Support Function
EUA Emergency Use Authorization
FDA Food and Drug Administration
FEMA Federal Emergency Management Agency
FETIG Federal Education and Training Interagency Group for Public Health and
Medical Disaster Preparedness and Response
GAO U.S. Government Accountability Office
HHS Department of Health and Human Services
IOM Institute of Medicine
LEA Local Education Agency
NDMS National Disaster Medical System
NIH National Institutes of Health
NRF National Response Framework
PHEMCE Public Health Emergency Medical Countermeasures Enterprise
PKEMRA Post Katrina Emergency Management Reform Act of 2006
PST Pediatric Subspecialty Team
REMS Readiness and Emergency Management for Schools
SEA State Education Agency
SNS Strategic National Stockpile

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BACKGROUND

The National Commission on Children and Disasters (“the Commission”) was established pursuant to the Kids in Disasters Well-being, Safety and Health Act of 2007 as provided in Division G, Title VI of the Consolidated Appropriations Act of 2008.¹ The Commission’s status as an independent Federal Advisory Committee was clarified in Division A, Section 157 (b) of the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009.²

The Commission shall conduct a comprehensive study to independently examine and assess the needs of children (0-18 years of age) in relation to the preparation for, response to and recovery from all emergencies, hazards and disasters, by building upon the evaluations of other entities and avoiding unnecessary duplication by reviewing the findings, conclusions and recommendations of these entities. In addition to this *Interim Report*, the Commission will submit a *Final Report* to the President and Congress no later than October 14, 2010.

The Commission shall report specific findings, conclusions and recommendations relating to: 1) child physical health, mental health, and trauma; 2) child care in all settings; child welfare; 3) elementary and secondary education; 4) sheltering, temporary housing and affordable housing; 5) transportation; 6) juvenile justice; 7) evacuation; 8) relevant activities in emergency management; and 9) the need for planning and establishing a national resource center on children and disasters. The Commission shall also report on coordination of resources and services, administrative actions, policies, regulations, and legislative changes as the Commission considers appropriate.³

The Commission is bipartisan, consisting of 10 members appointed by the President and Congressional leaders. Commission members represent a variety of disciplines, including pediatrics, state and local emergency management, emergency medical services, non-

¹ Public Law (P.L.) 110-161.

² P.L. 110-329.

³ P.L. 110-161.

governmental organizations dedicated to children, and state elected office. The Commission organized four subcommittees comprised of Commissioners and subject matter experts: 1) Education, Child Welfare and Juvenile Justice; 2) Evacuation, Transportation and Housing; 3) Human Services Recovery; and 4) Pediatric Medical Care. The Commission meets publicly on a quarterly basis and subcommittees meet monthly to address their specific focus areas.

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EXECUTIVE SUMMARY

The National Commission on Children and Disasters was created by Congress to 1) conduct a comprehensive study that examines and assesses the needs of children as they relate to preparation for, response to, and recovery from all hazards, including major disasters and emergencies; and 2) submit a report to the President and Congress on the Commission's specific findings, conclusions, and recommendations.

The recommendations contained in this *Interim Report* fall within the following categories: 1) Emergency Management; 2) Mental Health; 3) Child Physical Health and Trauma; 4) Emergency Medical Services and Pediatric Transport; 5) Disaster Case Management; 6) Child Care; 7) Elementary and Secondary Education; 8) Child Welfare and Juvenile Justice; 9) Sheltering Standards, Services and Supplies; 10) Housing; and 11) Evacuation.

1. Emergency Management

1.1: Distinguish and comprehensively integrate the needs of children across all inter and intra-governmental disaster planning activities and operations.

- *Establish a permanent focus on children and disasters within the Federal Emergency Management Agency and the White House, supported by policy and operational expertise from across the Federal government, non-federal partners and relevant non-governmental organizations.*
- *Incorporate meeting the needs of children as a distinct priority throughout base disaster planning documents and relevant grant programs.*

1.2: Accelerate the development of a National Disaster Recovery Strategy with an explicit emphasis addressing the immediate and long-term health, mental health, educational, housing and human services recovery needs of children.

2. Mental Health

2.1: Integrate mental and behavioral health for children into public and medical preparedness and response activities.

2.2: Enhance the research agenda for children's disaster mental and behavioral health.

2.3: Enhance pediatric disaster mental and behavioral health training for professionals and paraprofessionals.

2.4: Promote psychological resilience for individuals, families and communities.

3. Child Physical Health and Trauma

3.1: Ensure availability and access to pediatric medical countermeasures at the federal, state and local level for chemical, biological, radiological, nuclear and explosive threats.

3.2: Expand the capabilities of all federally-funded medical response teams through the comprehensive integration of pediatric-specific training, guidance, exercises, supplies and personnel.

- *Designate or establish a Pediatric Health Care Coordinator on each federally-funded medical response team and develop strategies to recruit and retain team members with pediatric medical expertise.*
- *Establish an Associate Chief Medical Officer for Pediatric Care in the office of National Disaster Medical System (NDMS).*
- *Form regional NDMS Pediatric Subspecialty Teams, to ensure robust pediatric disaster response and enhanced surge capacity.*

3.3: Ensure all health care professionals who may treat children during an emergency have adequate pediatric disaster medicine training specific to their role.

- *Form a Pediatric Disaster Medicine Education and Training Working Group to establish core competencies and a standard, modular pediatric disaster medicine training curriculum.*

3.4: Provide funding for a formal, regionalized pediatric system of care, prepared for disasters.

- *Ensure all hospital emergency departments stand ready to care for ill or injured children of all ages through the adoption of disaster preparedness guidelines jointly developed by the American Academy of Pediatrics, American College of Emergency Physicians and the Emergency Nurses Association.*

3.5: Ensure access to physical and mental health services for all children during recovery from disaster.

4. Emergency Medical Services and Pediatric Transport

4.1: Improve the capability of Emergency Medical Services (EMS) to transport pediatric patients and provide comprehensive pre-hospital pediatric care during daily operations and disasters.

- *Establish a dedicated federal grant program for pre-hospital EMS.*
- *Provide additional funding to the Emergency Medical Services for Children (EMSC) program to ensure all states and Territories meet targets and achieve progress in the EMSC performance measures for grantees, and to support development of a robust research portfolio.*

- *As an eligibility guideline for Centers for Medicare & Medicaid Services reimbursement, require first response and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies in accordance with the national guidelines for equipment for Basic Life Support and Advanced Life Support vehicles.*

5. Disaster Case Management

5.1: Establish a permanent, holistic Federal disaster case management program, with an emphasis on achieving tangible positive outcomes for children.

6. Child Care

6.1: Increase disaster planning capabilities of child care providers.

- *Require state child care regulatory agencies to include disaster planning, training and exercising requirements within the scope of the state's minimum health and safety standards for child care licensure or registration.*
- *Require state child care administrators to develop statewide child care plans in coordination with state and local emergency managers, child care regulatory agencies and child care resource and referral agencies.*

6.2: Improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster.

- *Include the provision of child care as a human service activity within the National Response Framework.*
- *Provide reimbursement under the Stafford Act, amending the Act as necessary, to support child care services to displaced families, establishment of temporary disaster child care, and the repair or reconstruction of child care facilities.*

7. Elementary and Secondary Education

7.1: Improve disaster planning for state education agencies (SEAs) and school districts and support integration of schools into state and local disaster planning, training, and exercises.

- *Provide federal funding to SEAs to support coordination and development of disaster planning, training, exercising, and guidance for school districts.*
- *Develop national disaster planning standards for school districts and performance measures to assess progress and accountability for funding.*

8. Child Welfare and Juvenile Justice

8.1: Provide guidance, technical assistance and model plans to assist state and local child welfare agencies in meeting current applicable disaster planning requirements; and further requiring collaboration with state and local emergency management, dependency courts, and other key stakeholders.

8.2: Create an advisory committee to guide a comprehensive national assessment of disaster planning and preparedness amongst state and local juvenile justice systems.

9. Sheltering Standards, Services, and Supplies

9.1: Provide a safe and secure mass care shelter environment for children, including appropriate access to essential services and supplies.

- *Develop and implement permanent national standards and indicators for mass care shelters that are specific and responsive to children.*
- *Develop a list of essential age-appropriate shelter supplies for infants and children and fund creation of caches to support shelter operations.*
- *Ensure the implementation of standards and training to mitigate risks unique to children in shelters including child abduction and sex offenders.*
- *Ensure all shelter operators have access to a fast, accurate and low-cost system for conducting national, fingerprint-based criminal history background checks for shelter workers and volunteers before they enter a shelter containing children.*

10. Housing

10.1: Prioritize families with school-age children, especially those families with children having special health, mental health or educational needs, for disaster housing assistance and permanent housing.

- *Establish within the Implementation Plan of the National Disaster Housing Strategy an emphasis on the delivery of social services and improvement of the living environment for children throughout all phases of disaster housing assistance.*

11. Evacuation

11.1: Develop an effective national evacuee tracking and family reunification system that ensures the safety and well-being of children.

INTRODUCTION

Children constitute nearly 25 percent of our population⁴ and in most cases their needs occupy the center of family and community. Logically, then, disaster planning would place an immediate priority on addressing the needs of children. In reality, children are given a passing mention in disaster plans and strategies or relegated to separate annexes in the back of planning documents, which emergency managers may not have the time or resources to address. In reality, the needs of children are often overlooked and misunderstood.

The consequences of such “benign neglect” may be devastating for children affected by disasters, given their unique health, behavioral and psychosocial needs. Terrorist events such as the 1995 Oklahoma City bombing and the unprecedented nature of the September 11, 2001 attacks signaled a new era in global and domestic terrorism, which deeply affected children.^{5 6 7 8 9} In the wake of Hurricanes Katrina and Rita, thousands of children were separated from their families, and some went unaccounted for months. Mental health distress and disability remain prevalent in Gulf Coast children who experienced displacement, long after the storms passed through.¹⁰ Wildfires in California,

⁴ U.S. Census Bureau, “USA QuickFacts from the US Census Bureau,” <http://quickfacts.census.gov/qfd/states/00000.html>.

⁵ Robin H. Gurwitch, Michelle Kees, Steven M. Becker, Merritt Schreiber, Betty Pfefferbaum, and Dickson Diamond, "When Disaster Strikes: Responding to the Needs of Children." *Prehospital and Disaster Medicine* 19, no. 1 (2004): 22, <http://pdm.medicine.wisc.edu/19-1%20pdfs/Gurwitch.pdf>.

⁶ Betty Pfefferbaum, Sara J. Nixon, Ronald S. Krug, Rick D. Tivis, Vern L. Moore, Janice M. Brown, Robert S. Pynoos, David Foy, and Robin H. Gurwitch, "Clinical Needs Assessment of Middle and High School Students Following the 1995 Oklahoma City Bombing." *American Journal of Psychiatry* 156, no. 7 (1999): 1069-74, <http://ajp.psychiatryonline.org/cgi/reprint/156/7/1069>.

⁷ Gerry Fairbrother, Jennifer Stuber, Sandro Galea, Betty Pfefferbaum, and Alan R. Fleischman, "Unmet Need for Counseling Services by Children in New York City Following the September 11th Attacks on the World Trade Center: Implications for Pediatricians," *Pediatrics* 113, no. 5 (2004), 1367-74, <http://pediatrics.aappublications.org/cgi/reprint/113/5/1367>.

⁸ David J. Schonfeld, "Are We Ready and Willing to Address the Mental Health Needs of Children? Implications from September 11th," *Pediatrics* 113, no. 5 (2004): 1400, <http://pediatrics.aappublications.org/cgi/reprint/113/5/1400>.

⁹ Mark A. Schuster, Bradley D. Stein, Lisa H. Jaycox, Rebecca L. Collins, Grant N. Marshall, Marc N. Elliott, Annie J. Zhou, David E. Kanouse, Janina L. Morrison, and Sandra H. Berry, "A National Survey of Stress Reactions after the September 11, 2001, Terrorist Attacks," *New England Journal of Medicine* 345, no. 20 (2001): 1507-12, <http://content.nejm.org/cgi/reprint/345/20/1507.pdf>.

¹⁰ David Abramson, Tasha Stehling-Ariza, Richard Garfield, and Irwin Redlener, "Prevalence and Predictors of Mental Health Distress Post-Katrina: Findings from the Gulf Coast Child and Family Health

flooding in the Midwest, and tornadoes touch the lives of children with increasing frequency,¹¹ challenging the capability and capacity to respond to everyday events, let alone an event of catastrophic proportions.

Catastrophic or “mega” disasters, whether acts of terror or acts of nature, magnify the weaknesses of our nation’s daily disaster “state of readiness” for children, whether in schools, child care centers, pre-hospital Emergency Medical Services (EMS), hospitals, juvenile detention facilities or in families.¹² Moreover, inadequacies for children exist in: emergency equipment and medications; essential supplies and services in mass care shelters; reunification systems; pediatric training of first responders; capacity among EMS and hospital systems to provide acute care; and mental health services across the continuum of disaster management.

In disasters, children should neither be grouped with “at-risk,” “special needs” or “vulnerable” adult populations nor considered “little adults.” Children are unique, especially when prescribing disaster health and mental health interventions and purchasing equipment and supplies. Children with disabilities and chronic health needs become even further marginalized in planning when their needs are not distinguished and prioritized.

In order to achieve a more knowledgeable and integrated consideration of children in disaster planning and management across our nation, a significant shift in philosophy, culture and attitude must occur, which elevates children into an immediate priority.

Institutional change is neither easy nor swift, but in this instance, it is critical. The road to ending the cycle of benign neglect began twelve months ago when the Commission held

Study," *Disaster Medicine and Public Health Preparedness* 2, no. 2 (2008): 77-86.
<http://www.dmphp.org/cgi/rapidpdf/DMP.0b013e318173a8e7v1>.

¹¹ Federal Emergency Management Agency, Annual Major Disaster Declaration Totals,
http://www.fema.gov/news/disaster_totals_annual.fema.

¹² Andrew L. Garrett, Roy Grant, Paula Madrid, Aarturo Brito, David Abramson, and Irwin Redlener, "Children and Megadisasters: Lessons Learned in the New Millennium," *Advances in Pediatrics* 54, no. 1 (2007): 209-10.

its first public meeting and continues with this Interim Report and its formidable, yet actionable, recommendations.

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FINDINGS AND RECOMMENDATIONS

1. Emergency Management

Recommendation 1.1: Distinguish and comprehensively integrate the needs of children across all inter and intra-governmental disaster planning activities and operations.

- *Establish a permanent focus on children and disasters within the Federal Emergency Management Agency (FEMA) and the White House, supported by policy and operational expertise from across the Federal government, non-federal partners and relevant non-governmental organizations.*
- *Incorporate meeting the needs of children as a distinct priority throughout base disaster planning documents and relevant grant programs.*

In disaster planning, children are considered “at risk,” “vulnerable” or “special needs” populations, along with the elderly, persons with disabilities, the medically-dependent and persons with limited fluency in English, to name a few. In general, children do not fit into these broad categories, which often are addressed in annexes at the back of planning documents. Among so many competing concerns, and limited time and resources, children are given far less attention than necessary.

FEMA plays a central leadership and coordinating role in supporting disaster planning and management for partners, communities and citizens.¹³ Responding to concerns expressed by the Commission, on August 3, 2009, FEMA Administrator Craig Fugate announced the creation of a “Children’s Working Group,” which will serve as a centralized platform across all FEMA directorates to ensure that the unique needs of children are incorporated into all disaster plans.¹⁴ The Working Group is tasked not only with identifying and facilitating how best to integrate children into all FEMA planning efforts, but also with improving FEMA’s capacity to work collaboratively with its

¹³ FEMA lists as “partners” state and local emergency management agencies, 27 federal agencies and the American Red Cross. U.S. Federal Emergency Management Agency, “About FEMA,” <http://www.fema.gov/about/#1>.

¹⁴ Craig Fugate, Testimony before the U.S. Senate, Committee on Homeland Security and Governmental Affairs, Ad Hoc Subcommittee on Disaster Recovery, “Focus on Children in Disasters: Evacuation Planning and Mental Health Recovery,” Washington D.C., August 4, 2009. http://hsgac.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=ac143d9a-c760-47d6-bc46-0a9845b74116.

partners and other key non-governmental stakeholders. Representatives from virtually all aspects of the agency will serve on the Children's Working Group, including subject matter experts from outside the agency. Upon issuing its *Final Report*, the Commission will evaluate the effectiveness of the Children's Working Group and recommend whether it, or an alternative model, should be permanently established in the agency.

The Commission further recognizes the central leadership and coordinating role of the White House in advising the President on matters affecting national security, including disasters. In order to encourage cooperation among partners and a clearer understanding of roles and responsibilities in meeting the needs of children affected by disasters, a coordinating council composed of senior White House staff, collaborating with the National Security Staff¹⁵ and relevant subject matter experts from within and outside the federal government, should be formed to serve as a focal point of Presidential policy development specific to children and disasters.

Disaster planning must clearly incorporate specific strategies for children into base planning documents, such as Comprehensive Preparedness Guide (CPG) 101, rather than separate documents, such as CPG 301 (Special Needs Planning) or annexes. Disaster planning must include collaboration with administrators, regulators, parents and parent organizations and providers of services to children, such as: education, child care, child welfare and juvenile justice. National disaster planning documents, such as the National Response Framework (NRF), including the Emergency Support Functions (ESFs), must elevate children as a distinct priority.¹⁶

Further, relevant target capabilities and preparedness training and exercises, with specific target outcomes and performance measures must include children. The Commission is

¹⁵ President Obama established a "National Security Staff", which will function under the direction of the National Security Advisor, to support all White House policymaking activities related to both national security and homeland security issues. President Barack Obama, Statement by the President on the White House Organization for Homeland Security and Counterterrorism, (Washington, DC: The White House, May 26, 2009), http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-the-White-House-Organization-for-Homeland-Security-and-Counterterrorism/.

¹⁶ Federal Emergency Management Agency, "National Response Framework, Resource Center," <http://www.fema.gov/emergency/nrf/>.

monitoring draft revisions to the Target Capabilities List, particularly sections related to Mass Care and Weapons of Mass Destruction and Hazardous Materials Rescue to ensure incorporation of measurable target outcomes and resource elements for children, based upon the percentage of children in the community.¹⁷ For example, if a target capability is to treat a general population of 1,000 people, and children make up 25 percent of the community, the target capability should include treatment of 250 children. The Commission recommends exercises include objectives that test capacities including, but not limited to, pediatric triage, pre-hospital treatment, surge capacity, transport of children and coordination with schools, child care providers, and child welfare and juvenile justice systems.

The Commission is collaborating with the Department of Homeland Security (DHS) Grants Directorate to strengthen community preparedness planning by make children a priority in grants awarded through the Homeland Security Grant Program (HSGP). In addition, the Commission recommends critical supply lists and allowable costs and expenses include program activities, planning, training, exercising, equipment, food and basic medical supplies for children.^{18 19} The Commission recommends that DHS encourage grantees to make pediatric capabilities integral to base plans rather than as a subset of special needs populations. The Commission further recommends that HSGP grant guidance enhance and expand capabilities for improved preparedness of child congregate care systems, providers and facilities, especially school districts and child care providers.

¹⁷ The Target Capabilities List (TCL) provides a guide for development of a national network of capabilities that will be available when and where they are needed to prevent, protect against, respond to, and recover from major events. The TCL comprises 37 capabilities that address response capabilities, immediate recovery, selected prevention and protection mission capabilities, as well as common capabilities such as planning and communications that support all missions. They provide the basis for assessing preparedness and improving decisions related to preparedness investments and strategies. For these capabilities, local jurisdictions and States are the lead in conjunction with Federal and private sector support. U.S. Department of Homeland Security, "Target Capabilities List: A Companion to the National Preparedness Guidelines," ed. DHS (Washington DC: 2007), iv, <http://www.fema.gov/pdf/government/training/tcl.pdf>.

¹⁸ Specifically, grants within the Homeland Security Grant Program (HSGP) including the Urban Areas Security Initiative (UASI) and the Metropolitan Medical Response System (MMRS); the Emergency Management Performance Grants (EMPG); the State Homeland Security Program Tribal; and the UASI Nonprofit Security Grant Program.

¹⁹ U.S. Department of Homeland Security, Office of Grants & Training, "Goals," U.S. Department of Justice, Office of Justice Programs, http://www.ojp.usdoj.gov/odp/grants_goals.htm.

In addition to DHS, the Commission initiated discussions with the Centers for Disease Control and Prevention's (CDC) Coordinating Office for Terrorism Preparedness and Emergency Response to discuss the provision of input to the Public Health Emergency Preparedness cooperative agreement to states and local public health departments,²⁰ as well as the Office of the Assistant Secretary for Preparedness and Response to discuss the integration of children's unique needs into the Hospital Preparedness Program.²¹ The Commission found that both grant programs require a more focused effort to improve the capacities of health departments and hospitals to meet the unique needs of children, particularly in light of the current global H1N1 pandemic. Public health departments and hospitals will need to improve their abilities to handle a surge of pediatric patients due to influenza, provide appropriate risk communication and community mitigation guidance to schools, child care providers and other child congregate care facilities, and potentially execute mass vaccinations and mass prophylaxis, with special considerations to safely and effectively administer medications and interventions to children. Going forward, the Commission will explore opportunities to engage the CDC-funded Advanced Practice Centers²² and the Centers for Public Health Preparedness²³ to develop child-centric preparedness guidance and planning tools for state and local health departments and hospitals.

Recommendation 1.2: Accelerate the development of a National Disaster Recovery Strategy with an explicit emphasis addressing the immediate and long-term health, mental health, educational, housing and human services recovery needs of children.

The absence of a National Disaster Recovery Strategy, combined with the absence of effective support programs in communities, places children in persistent jeopardy.

Recent reports regarding children affected by Hurricane Katrina reflect conditions of

²⁰ Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER), "Funding Guidance and Technical Assistance to States," Centers for Disease Control and Prevention, <http://www.bt.cdc.gov/cotper/coopagreement/>.

²¹ Office of the Assistant Secretary for Preparedness and Response, "The Hospital Preparedness Program (HPP)," U.S. Department of Health and Human Services, <http://www.hhs.gov/aspr/opeo/hpp/>.

²² National Association of County and City Health Officials, "Advanced Practice Centers," <http://www.naccho.org/topics/emergency/APC/index.cfm>.

²³ Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER), "Centers for Public Health Preparedness (CPHP)," Centers for Disease Control and Prevention, <http://www.bt.cdc.gov/cotper/cphp/>.

serious housing instability, poor access to health care, and lack of available and adequate educational opportunities.²⁴

The Post Katrina Emergency Management Reform Act of 2006 (PKEMRA)²⁵ requires the development of a National Disaster Recovery Strategy to coordinate long-term recovery resources following major disasters. Tangible progress is slow in the development of the Strategy.²⁶ The Commission strongly urges that FEMA aggressively intensify efforts to develop the Strategy by the close of 2009, with the assistance of governmental and non-governmental stakeholders who provide health, educational, and social services to children.

A National Disaster Recovery Strategy that benefits children would ensure:

- The immediate availability and continuity of disaster case management services to families;
- Continuous access to a medical home;
- Federal disaster assistance through grants for all medical facilities damaged or destroyed by a disaster, such as primary medical, dental and mental health care practices and clinics;
- Access to appropriate crisis, bereavement and mental health services;
- Academic continuity and immediate educational access by enrolling and placing disaster-affected children in educational and related services in compliance with the McKinney-Vento Homeless Education Assistance Improvements Act;²⁷

²⁴ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), <http://www.gao.gov/new.items/d09561.pdf>.

²⁵ P.L. 109-295; 120 Stat. 1394 (2006).

²⁶ "Actions Taken to Implement the Post-Katrina Emergency Management Reform Act of 2006," GAO-09-59R, ed. Government Accountability Office (Washington, DC: GAO, 2008), <http://www.gao.gov/products/GAO-09-59R>.

²⁷ As part of Title X, Part C of the No Child Left Behind Act: P.L. 107-110; 42 U.S.C. §11431 et. seq (2001).

- Priority for families with school-aged children, especially for those families with children having special health, mental health or educational needs, for disaster housing assistance and permanent housing; and
- The provision of developmental and age-appropriate play and recreation options, particularly quality day care and after-school services.

The overarching principle for recovery from disasters must be to create self-sufficient families and a “new and improved normalcy” for all children, especially children who are socially and economically disadvantaged. The development of a National Disaster Recovery Strategy would specify guiding principles for services that must be provided to children affected by disasters: safe, stable living environments; health care, mental health and oral health; academic continuity and supervised after school activities; child care; and disaster case management. The guiding principles would govern the request for and provision of federal disaster and recovery funding for these services, to ensure the economic recovery of communities as a whole. Strategies, roles, and responsibilities for recovery must be established and emphasized as critical components of federal, state and local disaster plans, and should include the roles and contributions of systems responsible for the education, care and welfare of children.

2. Mental Health

Recommendation 2.1: Integrate mental and behavioral health for children into public and medical preparedness and response activities.

All disasters have a high likelihood of negatively impacting mental and behavioral health, both immediately and long-term. The mental and behavioral health effects undermine the efficacy of response efforts, the ability of citizens to comply with public health recommendations, and the capacity of the communities and states to ensure effective recovery. Yet, mental and behavioral health impacts are rarely considered until long after the event when it is too late to inform and affect optimal response or even recovery efforts. Therefore, mental and behavioral health should be a core component of the planning and response efforts for all disasters, requiring its integration within the unified concept of operations (CONOPS).

Children are particularly vulnerable to the mental health impact of disasters and lack the experience, skills, and resources to independently meet their mental and behavioral health needs.²⁸ It is therefore both surprising and concerning that children's mental and behavioral health needs are virtually absent across federal and state disaster planning efforts, and training exercises neglect to test for pediatric mental health response capacity.

A broad range of pediatric mental health services, including long-term interventions when indicated, must become part of disaster mental health response and recovery. The Commission supports the recommendations proposed within the report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board, with the addition of the prioritization of the mental and behavioral needs of children.²⁹ Disaster mental and behavioral health response for children can be strengthened from a common operational picture, enabling triggers for mutual aid requests, resource allocation,

²⁸ David J. Schonfeld, "Are We Ready and Willing to Address the Mental Health Needs of Children? Implications from September 11th," *Pediatrics* 113, no. 5 (2004): 1400.

²⁹ *Disaster Mental Health Recommendations: Report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board*, ed. National Biodefense Science Board U.S. Department of Health and Human Services, Disaster Mental Health Subcommittee, (Washington, DC: HHS, 2008), 6-20, <http://www.hhs.gov/aspr/conferences/nbsb/dmhreport-final.pdf>.

targeted monitoring of population health and the recovery environment, and the provision of appropriate interventions such as psychological first aid, bereavement counseling and support, and cognitive-behavioral treatments.

The Commission recommends that at the federal level, coordination of mental and behavioral health service efforts for children can be accomplished through a unified CONOPS that addresses all phases of disaster planning and includes representation of pediatric mental and behavioral health functions, within operational frameworks across local, State, and national levels aligned with the National Incident Management System. In addition, states can incorporate disaster mental and behavioral health planning and operations for children by including language on children's mental and behavioral health in all appropriate legislation, regulations, and grants.

Recommendation 2.2: Enhance the research agenda for children's disaster mental and behavioral health.

A small amount of research exists evaluating the effectiveness of services and interventions to address the full spectrum of children's mental health needs in the aftermath of a disaster, especially outside the area of trauma-related syndromes and symptoms and trauma-focused treatments.³⁰ Evidence suggests that some commonly used interventions, such as critical incident stress debriefing or management, are not effective, especially when used with children, and may instead be detrimental.^{31 32} A new, expanded national agenda for disaster mental health research that is broad in its scope would prioritize and facilitate exploration of a full spectrum of mental health services for children and families that would be necessary for recovery after a disaster,

³⁰ *Disaster Mental Health Recommendations: Report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board*, ed. National Biodefense Science Board U.S. Department of Health and Human Services, Disaster Mental Health Subcommittee, (Washington, DC: HHS, 2008), 8-10, <http://www.hhs.gov/aspr/conferences/nbsb/dmhreport-final.pdf>.

³¹ *Disaster Mental Health Recommendations: Report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board*, ed. National Biodefense Science Board U.S. Department of Health and Human Services, Disaster Mental Health Subcommittee, (Washington, DC: HHS, 2008), 9, <http://www.hhs.gov/aspr/conferences/nbsb/dmhreport-final.pdf>.

³² *Pediatric Terrorism and Disaster Preparedness: A Resource for Pediatricians*, ed. George L. Foltin, David J. Schonfeld and Michael W. Shannon, Bioterrorism and Other Public Health Emergencies, (Rockville, MD: American Academy of Pediatrics, 2006), 279, <http://www.ahrq.gov/RESEARCH/PEDPREP/pedresource.pdf>.

including but not limited to trauma-related syndromes and symptoms, and cognitive-behavioral interventions.

The Commission recommends that a working group of children's disaster mental health and pediatric experts be convened to review the research portfolios of relevant agencies that fund Federal research across the U.S. government to identify gaps in knowledge, areas of recent progress, and priorities for research in disaster mental and behavioral health program evaluation, early intervention, treatment for disaster-related problems, and dissemination of training in disaster mental and behavioral health interventions. The working group would also recommend a national research agenda for Federal agencies that fund research initiatives across the full spectrum of disaster mental health services for children and families, including trauma-related syndromes and symptoms, psychological first aid, cognitive-behavioral interventions, social support interventions, and bereavement counseling and support.

Recommendation 2.3: Enhance pediatric disaster mental and behavioral health training for professionals and paraprofessionals.

Limited numbers of pediatric mental health professionals coupled with the limited insurance reimbursement for mental and behavioral health services has resulted in a critical gap in our ability to provide the necessary mental health care to those that most need it, especially if we rely on traditional mental health providers. Children's limited access to mental health services is further exacerbated during and after disasters by issues such as lack of transportation, competing family recovery needs, and concerns about stigmatization when utilizing these services.^{33 34} In order to accommodate the surge of demand for mental health services and ameliorate the mental health and behavioral health effects that are caused by or exacerbated by a disaster, adequate resources for immediate and long-term interventions must be appropriate and available to children. Mental health

³³David J. Schonfeld, "Are We Ready and Willing to Address the Mental Health Needs of Children? Implications from September 11th," *Pediatrics* 113, no. 5 (2004): 1400.

³⁴"Hurricane Katrina: Barriers to Mental Health Services for Children Persist in Greater New Orleans, Although Federal Grants Are Helping to Address Them," GAO-09-563, ed. Government Accountability Office (Washington, DC: GAO, 2009), <http://www.gao.gov/new.items/d09935t.pdf>.

professionals, including those that are school-based, need to have adequate training related to disaster mental health care for children.

Communities rely upon a cadre of non-mental health professionals, persons who routinely interact with children, such as school staff, child care providers, and pediatric healthcare providers,³⁵ to provide basic mental health and bereavement support services and brief interventions. Therefore, it is essential that these individuals receive adequate training and are knowledgeable about how to identify children who require more advanced care and can provide information to their guardians on existing resources.³⁶

Most children who receive mental health services receive them in schools³⁷ and mental health professionals working in schools constitute the largest cadre of primary providers of mental health services for children.^{38 39} According to the National Center for School Crisis and Bereavement, teachers and school administrators receive little, if any, training at the pre- or post- service level around how to support children and staff during and in the aftermath of a disaster to promote adjustment and coping.

³⁵ “The primary medical care system has become the de facto mental health care system for children in the United States. Children are most likely to be evaluated for mental and behavioral health problems and to receive treatment, including psychotropic drugs, from pediatricians for symptoms associated with mental disorders.” David J. Schonfeld, "Are We Ready and Willing to Address the Mental Health Needs of Children? Implications from September 11th," *Pediatrics* 113, no. 5 (2004): 1400.

³⁶ Lisa H. Jaycox, Lindsey K. Morse, Terri Tanielian, and Bradley D. Stein, *How Schools Can Help Students Recover from Traumatic Experiences: A Tool Kit for Supporting Long-Term Recovery*, (Santa Monica, CA: RAND, 2006), 6-12.

³⁷ Mark D. Weist, Marcia Rubin, Elizabeth Moore, Steven Adelsheim, and Gordon Wrobel, "Mental Health Screening in Schools," *Journal of School Health* 77, no. 2 (2007): 53-8.

³⁸ Bradley D. Stein, Terri L. Tanielian, Mary E Vaiana, Hilary J. Rhodes, and M. Audrey Burnam, "The Role of Schools in Meeting Community Needs During Bioterrorism," *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 1, no. 4 (2003), 274, <http://www.liebertonline.com/doi/pdf/10.1089/153871303771861487?>

³⁹ In New York City, more than half of the students who received counseling in the months following the attacks of September 11, 2001, received it through services provided at schools. Yet, most children with mental health needs related to the events of September 11th were not identified and the vast majority never received any services. Gerry Fairbrother, Jennifer Stuber, Sandro Galea, Betty Pfefferbaum, and Alan R. Fleischman, "Unmet Need for Counseling Services by Children in New York City Following the September 11th Attacks on the World Trade Center: Implications for Pediatricians," *Pediatrics* 113, no. 5 (2004), 1369; David J. Schonfeld, "Are We Ready and Willing to Address the Mental Health Needs of Children? Implications from September 11th," *Pediatrics* 113, no. 5 (2004): 1400.

In many disasters, children will experience deaths of family members and friends. Such losses may have long-term effects on learning and emotional adjustment. Schools provide much-needed stability for children following a disaster and are a natural place for children to receive information and support after such events.⁴⁰ Basic disaster mental health and psychological support training specific to the unique needs of children should be extended beyond the traditional mental health disciplines (e.g., psychiatry, psychology, counseling, social work, and marriage and family therapy) and health care professionals (e.g., medicine, pediatrics, nursing and epidemiology) to include the full range of emergency responders (e.g., law enforcement, fire service, emergency medical responders), faith-based professionals, disaster response leaders (e.g., incident commanders, emergency managers, and civil service and elected government leaders), and educators.

Disaster mental health training, including traditional and just-in-time training, for the various professional groups may include psychological first aid, cognitive-behavioral interventions, social support interventions, and bereavement counseling and support. Minimum training standards should be identified, and disaster mental health training should be a requirement for professional accreditation and licensure where applicable.

Recommendation 2.4: Promote psychological resilience for individuals, families and communities.

Funding to develop a national strategy to promote psychological resilience in children and families should be provided to build mental health capacity through the establishment of community networks of individuals prepared to respond to the mental and behavioral health and bereavement support and counseling needs of children. “Psychological first aid” is psychological support that can be provided by non-mental health professionals to children, family, friends and neighbors.⁴¹ It incorporates education on issues related to

⁴⁰ Andrew L. Garrett, Roy Grant, Paula Madrid, Aarturo Brito, David Abramson, and Irwin Redlener, "Children and Megadisasters: Lessons Learned in the New Millennium," *Advances in Pediatrics* 54, no. 1 (2007): 207-208.

⁴¹ *Disaster Mental Health Recommendations: Report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board*, ed. National Biodefense Science Board U.S. Department of Health and Human Services, Disaster Mental Health Subcommittee, (Washington, DC: HHS, 2008), 12, <http://www.hhs.gov/aspr/conferences/nbsb/dmhreport-final.pdf>.

trauma and active listening, and should be part of the plan to help children experiencing emotional stress following a disaster enhance their sense of self and collective efficacy, and provide a sense of connectedness, and hope. Community-based networks of individuals who have received appropriate training can increase our capacity to rapidly respond and meet the unique mental health needs of children.⁴²

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⁴² *Disaster Mental Health Recommendations: Report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board*, ed. National Biodefense Science Board U.S. Department of Health and Human Services, Disaster Mental Health Subcommittee, (Washington, DC: HHS, 2008), 12, <http://www.hhs.gov/aspr/conferences/nbsb/dmhreport-final.pdf>.

3. Child Physical Health and Trauma

Recommendation 3.1: Ensure availability and access to pediatric medical countermeasures at the federal, state and local level for chemical, biological, radiological, nuclear and explosive (CBRNE) threats.

- *Provide funding for the development, acquisition and stockpiling of medical countermeasures specifically for children for inclusion in the Strategic National Stockpile (SNS) and all Federally-funded caches.*
- *Form a standing advisory body of federal partners and external experts to advise the Department of Health and Human Services (HHS) Secretary on issues pertaining specifically to pediatric emergency medical countermeasures.*
- *Include pediatric expertise on all relevant committees and working groups addressing issues pertaining to medical countermeasures.*

Children are known to be at *greater* risk of: 1) exposure to community-dispersed chemical, biological, radiological and nuclear terrorist agents; 2) absorption of comparable doses of these agents; and 3) mortality and morbidity from comparable doses of the agents that are absorbed.⁴³

However, while medical countermeasures⁴⁴ for several CBRNE agents are available for use in adults and included in the SNS,⁴⁵ comparable agents for use in children have not yet been approved by the Food and Drug Administration (FDA), and therefore are not present in the SNS.⁴⁶ Currently, 50-75% of all medications administered to children have

⁴³ Committee on Environmental Health and Committee on Infectious Diseases American Academy of Pediatrics, "Chemical-Biological Terrorism and Its Impact on Children," *Pediatrics* 118, no. 3 (2006): 1271, <http://pediatrics.aappublications.org/cgi/content/abstract/118/3/1267>.

⁴⁴ Medical countermeasures refer to drugs, biological products, or devices that treat, identify, or prevent harm due to chemical, biological, radiological, nuclear and explosive agents.

⁴⁵ CDC's SNS has large quantities of medicine and medical supplies to protect the American public if there is a public health emergency severe enough to cause local supplies to run out. Once Federal and local authorities agree that the SNS is needed, medicines will be delivered to any state in the U.S. within 12 hours. Each state has a plan to receive and distribute SNS medications and medical supplies to local health departments as soon as possible. Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER), "Strategic National Stockpile (SNS)," Centers for Disease Control and Prevention, <http://www.bt.cdc.gov/stockpile>.

⁴⁶ Obstetric and Pediatric Pharmacology Branch, Center for Research for Mothers and Children, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health, and U.S. Department of Health and Human Services (HHS), "Meeting Minutes," BPCA Biodefense Meeting, Rockville, MD, September 8-9 2008, <http://bpca.nichd.nih.gov/outreach/upload/Biodefense-09-08.pdf>.

not been tested on pediatric populations and are being used off-label,⁴⁷ which hinders legal stockpiling and deployment of these pediatric medications. However, many unapproved or off-label products may be the very best preventative, diagnostic or therapeutic options available.⁴⁸ Moreover, key Federal working groups and committees⁴⁹ across the National Institutes of Health (NIH), Public Health Emergency Medical Countermeasures Enterprise (PHEMCE), and CDC are establishing research and development priorities for high-risk CBRNE threats and the medical countermeasures to combat them and would benefit greatly from the inclusion of pediatric subject-matter expertise from outside the federal government.

In certain instances where the HHS Secretary declares an emergency, FDA may issue an Emergency Use Authorization (EUA). EUA permits the FDA to approve the emergency use of drugs, devices, and medical products (including diagnostics) that were not previously approved, cleared, or licensed by FDA, or the off-label use of approved products in certain well defined emergency situations.⁵⁰ Based on the circumstances of the emergency, the EUA process may take hours or days. Without pre-existing, consensus-derived guidance from experts for off-label use of existing drugs, there may not be enough time to develop such consensus in the immediate aftermath of an incident.

Taking into account the small number of FDA-approved medications for children in the SNS and other emergency caches, and the challenges associated with developing and approving medical countermeasures for children and authorizing off-label use under an EUA, the Commission recommends the formation of a standing advisory body consisting

⁴⁷ Cori Vanchieri, Adrienne Stith Butler, and Andrea Knutsen, *Addressing the Barriers to Pediatric Drug Development: Workshop Summary*, (Washington, DC: Institute of Medicine, 2008), 1.

⁴⁸ Stuart L. Nightingale, Joanna M. Prasher, and Stewart Simonson, "Emergency Use Authorization (EUA) to Enable Use of Needed Products in Civilian and Military Emergencies, United States," *Emerging Infectious Diseases* 13, no. 7 (2007): 1046.

⁴⁹ Obstetric and Pediatric Pharmacology Branch, Center for Research for Mothers and Children, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health, and U.S. Department of Health and Human Services (HHS), "Meeting Minutes," BPCA Biodefense Meeting, Rockville, MD, September 8-9 2008, <http://bpca.nichd.nih.gov/outreach/upload/Biodefense-09-08.pdf>.

⁵⁰ Stuart L. Nightingale, Joanna M. Prasher, and Stewart Simonson, "Emergency Use Authorization (EUA) to Enable Use of Needed Products in Civilian and Military Emergencies, United States," *Emerging Infectious Diseases* 13, no. 7 (2007): 1046.

of federal and non-federal partners and experts, to advise the HHS Secretary on issues pertaining specifically to pediatric emergency medical countermeasures. Liaisons of this body will represent children on all relevant NIH, PHEMCE, and CDC committees and working groups addressing issues pertaining to medical countermeasures.

The advisory body would:

- Assemble and study available data on therapies used as medical countermeasures in the pediatric population for high risk CBRNE;
- Develop formal consensus-driven recommendations on the emergency use of medications or interventions to pre-authorize the use of specific medical countermeasures;
- Develop a proposed research agenda supported by sufficient funding; and
- Rapidly and efficiently approve and disseminate updated treatment guidelines to state and local jurisdictions.

In 2006, Congress passed the Pandemic and All-Hazards Preparedness Act⁵¹, which provided authority for a number of programs related to the development and acquisition of medical countermeasures. Chief among these was the establishment of the Office of the Biomedical Advance Research and Development Authority, which manages the PHEMCE. The PHEMCE is a coordinated, inter-agency effort to bring about the development and purchase of necessary vaccines, drugs, therapies and diagnostic tools for public health emergencies. Responsibilities include coordinating research, development, and procurement of emergency medical countermeasures; and setting deployment and use strategies for the countermeasures held in the SNS.⁵²

Current PHEMCE policies do not prioritize children in the research and development of medical countermeasures. The most recent published version of the PHEMCE Plan (2007) states that “priority will be given to those medical countermeasures that will

⁵¹ P.L. 109-417; 120 Stat. 2831 (2006).

⁵² Office of the Assistant Secretary for Preparedness and Response, “Public Health Emergency Medical Countermeasures (PHEMC) Enterprise,” U.S. Department of Health and Human Services, <http://www.hhs.gov/aspr/barda/phemce/index.html>.

prevent and treat adverse health effects for the greatest number of individuals.”⁵³ Unfortunately for children, pediatric indications of medications and their delivery mechanisms tend to be more difficult and expensive to test, develop, and acquire compared to adults. Pediatric studies involve special considerations relative to adult studies, such as stricter safety and quality control measures, and may require the product to be developed in an alternative form from the adult dose, such as oral suspension.⁵⁴

The PHEMCE must address these inherent disadvantages and develop strategies to achieve parity for children in the research, development and acquisition of medical countermeasures. Incentives and requirements should be developed for the conduct of pediatric research by pharmaceutical companies that receive federal awards.⁵⁵ All procurements of countermeasures for the SNS under Project Bioshield⁵⁶ must provide options and significant incentives to study and potentially license the countermeasures for pediatric populations. Incentives are also needed to encourage testing of older, off-patent drugs.⁵⁷ A reprioritization of funding also is necessary to facilitate the development, acquisition and stockpiling of medical countermeasures specifically for children for inclusion in the SNS and other caches.

The public’s will to prioritize the protection of children when faced with resource constraints was made clear in the federal government’s public engagement meetings on

⁵³ Office of the Assistant Secretary for Preparedness and Response, "HHS Public Health Emergency Medical Countermeasures Enterprise Strategy for Chemical, Biological, Radiological and Nuclear Threats," *Federal Register* 72, no. 53 (2007), 13112, http://www.hhs.gov/aspr/barda/documents/federalreg_vol72no53_032007notices.pdf.

⁵⁴ Cori Vanchieri, Adrienne Stith Butler, and Andrea Knutsen, *Addressing the Barriers to Pediatric Drug Development: Workshop Summary*, (Washington, DC: Institute of Medicine, 2008), 4.

⁵⁵ Cori Vanchieri, Adrienne Stith Butler, and Andrea Knutsen, *Addressing the Barriers to Pediatric Drug Development: Workshop Summary*, (Washington, DC: Institute of Medicine, 2008), 8.

⁵⁶ On July 21, 2004, President George W. Bush signed the Project BioShield Act of 2004 (Project BioShield) into law as part of a broader strategy to defend America against the threat of weapons of mass destruction. The purpose of Project BioShield is to accelerate the research, development, purchase, and availability of effective medical countermeasures against biological, chemical, radiological, and nuclear (CBRN) agents. P.L. 108-276, 118 Stat. 852 (2004). <http://www.hhs.gov/aspr/barda/bioshield/index.html>.

⁵⁷ Cori Vanchieri, Adrienne Stith Butler, and Andrea Knutsen, *Addressing the Barriers to Pediatric Drug Development: Workshop Summary*, (Washington, DC: Institute of Medicine, 2008), 9.

the prioritization of pandemic influenza vaccines.⁵⁸ Federal agencies and working groups should consider public expectations, population demographics, and the difference in benefit when using “life-years saved” vs. “lives saved” in any cost-benefit analysis⁵⁹ for decisions concerning the use of limited funding and resources.

Recommendation 3.2: Expand the capabilities of all federally-funded medical response teams through the comprehensive integration of pediatric-specific training, guidance, exercises, supplies and personnel.

- *Designate or establish a Pediatric Health Care Coordinator on each federally-funded medical response team and develop strategies to recruit and retain team members with pediatric medical expertise.*
- *Establish an Associate Chief Medical Officer for Pediatric Care in the office of National Disaster Medical System (NDMS).*
- *Form regional NDMS PSTs, to ensure robust pediatric disaster response and enhanced surge capacity.*

The capability of Disaster Medical Assistance Teams (DMATs)^{60 61} to meet the care requirements of pediatric disaster survivors is limited by deficiencies in the training,

⁵⁸ U.S. Department of Health and Human Services, and U.S. Department of Homeland Security, *Guidance on Allocating and Targeting Pandemic Influenza Vaccine*, (Washington, DC: HHS and DHS, 2008), <http://www.flu.gov/vaccine/allocationguidance.pdf>.

⁵⁹ There is long-standing debate whether to count “lives saved” or “life-years saved” when evaluating policies to reduce mortality risk. Historically, the two approaches have been applied in different domains. Environmental and transportation policies have often been evaluated using lives saved, while life-years saved has been the preferred metric in other areas of public health including medicine, vaccination, and disease screening. For benefit-cost analysis, the monetary value of risk reductions can be calculated either by multiplying expected lives saved by the “value per statistical life” (VSL) or by multiplying expected life-years saved by the “value per statistical life-year” (VSLY). James K. Hammitt, "Valuing 'Lives Saved' Vs. 'Life-Years Saved'," *Risk in Perspective* 16, no. 1 (2008), 1, http://www.hcra.harvard.edu/rip/rip_Mar_2008.pdf.

⁶⁰ DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved. National Disaster Medical System, Office of the Assistant Secretary for Preparedness and Response, “What Is a Disaster Medical Assistance Team (DMAT)?,” U.S. Department of Health and Human Services, <http://www.hhs.gov/aspr/opeo/ndms/teams/dmat.html>.

⁶¹ DMATs are managed by the National Disaster Medical System, otherwise known as NDMS, is the primary Federal program that supports care and transfer during evacuation of patients. NDMS is a component of ASPR comprised of over 1500 volunteer hospitals and over 6,000 intermittent Federal employees assigned to approximately 90 general disaster and specialty teams geographically dispersed across the United States. The over all purpose of NDMS is to establish a single integrated national medical response capability or assisting State and local authorities with the medical impacts of peacetime disasters and to provide support to the military. Office of the Assistant Secretary for Preparedness and Response, “National Disaster Medical System (NDMS),” U.S. Department of Health and Human Services, <http://www.hhs.gov/aspr/opeo/ndms/index.html>.

clinical practice experience, on-going continuing education and composition of DMAT members, and their deployed resources.^{62 63 64} Pediatric patients can comprise a significant percentage of disaster survivors treated at DMAT field clinics.⁶⁵ While 68 percent of the clinical practitioners comprising DMATs have pediatric-specific training, only 5.6 percent have formal subspecialty training in pediatrics (e.g. pediatricians, pediatric nurse practitioners, pediatric emergency medicine and pediatric critical care), and 47 percent have formal training specific to pregnant women.^{66 67} DMAT members who routinely practice in emergency care settings such as hospital emergency departments likely have limited exposure to ill and injured children: approximately 50 percent of emergency departments in the United States serve less than ten children a day.⁶⁸ Additionally, there are only two PSTs in the U.S.⁶⁹

The Commission recommends that NDMS increase its pediatric capacity by forming regional PSTs to ensure robust surge capacity and flexible and scalable pediatric disaster response. These teams can provide additional support to hospital providers once the pre-

⁶² Sharon E. Mace, and Andrew I. Bern, "Needs Assessment: Are Disaster Medical Assistance Teams up for the Challenge of a Pediatric Disaster?," *The American Journal of Emergency Medicine* 25, no. 7 (2007): 762-9.

⁶³ Katherine A. Gnauck, Kevin E. Nufer, Jonathon M. LaValley, Cameron S. Crandall, Frances W. Craig, and Gina B. Wilson-Ramirez, "Do Pediatric and Adult Disaster Victims Differ? A Descriptive Analysis of Clinical Encounters from Four Natural Disaster DMAT Deployments," *Prehospital and Disaster Medicine* 22, no. 1 (2007): 67-73.

⁶⁴ Allen Dobbs, Chief Medical Officer, National Disaster Medical System, Letter to Michael Anderson, Commissioner, May 31, 2009.

⁶⁵ Katherine A. Gnauck, Kevin E. Nufer, Jonathon M. LaValley, Cameron S. Crandall, Frances W. Craig, and Gina B. Wilson-Ramirez, "Do Pediatric and Adult Disaster Victims Differ? A Descriptive Analysis of Clinical Encounters from Four Natural Disaster DMAT Deployments," *Prehospital and Disaster Medicine* 22, no. 1 (2007): 67.

⁶⁶ Nicole Laurie, Testimony before the U.S. Senate, Committee on Homeland Security and Governmental Affairs, Ad Hoc Subcommittee on Disaster Recovery, "Children and Disasters: The Role of HHS in Evacuation Planning and Mental Health Recovery," Washington, DC, August 4, 2009, <http://www.hhs.gov/asl/testify/2009/08/t20090804a.html>.

⁶⁷ "Pediatric-specific training" refers to the number of boarded or licensed providers who have received formalized training in pediatric care that also includes training for other age groups (e.g. Emergency Medicine and Family Medicine). Physician Assistant training programs also have pediatric-specific training as part of their curriculum. These groups also receive formalized training in managing the medical care of pregnant women. "Subspecialty training in pediatrics" refers to physicians and nurse practitioners who have received formalized training limited to pediatrics. Allen Dobbs, Chief Medical Officer, National Disaster Medical System, E-mail to Christopher Revere, August 19, 2009.

⁶⁸ Marianne Gausche-Hill, Charles Schmitz, and Roger J. Lewis, "Pediatric Preparedness of US Emergency Departments: A 2003 Survey," *Pediatrics* 120, no. 6 (2007): 1232.

⁶⁹ Marianne Gausche-Hill, Charles Schmitz, and Roger J. Lewis, "Pediatric Preparedness of US Emergency Departments: A 2003 Survey," *Pediatrics* 120, no. 6 (2007): 1275.

hospital management phase of the disaster has passed. To initiate this effort, two existing PSTs in Boston and Atlanta could be tested as a pilot for a regional DMAT response capability, through exercising as an adjunct to other DMAT teams within their regions. System planning must include provision of pediatric education for DMAT team members, and appropriate equipping of the DMAT team to ensure that children's needs are met prior to deployment. Training can be added to core competencies in pediatric clinical care, evacuation, triage, decontamination and administration of pediatric medical countermeasures in NDMS' national credentialing standards now in development

All federally-funded medical response teams (including, but not limited to, DMATs, Public Health Service Commissioned Corps teams, FEMA teams, Department of Defense teams, and Medical Reserve Corps) should increase the pediatric capabilities, capacities and assets of all deployed teams to meet the demand for pediatric care. First, a Pediatric Health Care Coordinator should be designated on each federally-funded medical response team, and an Associate Chief Medical Officer for Pediatric Care should be established in the office of NDMS. Strategies must be developed to recruit and retain members with pediatric medical expertise. In addition, development of standards for federally-funded medical response teams is necessary in relation to stockpiling of pediatric equipment and supplies; protocols for the delivery of care and use of pediatric equipment and supplies; and continuing education and training for response team members. Pediatric response capabilities could also be increased through the development of new strike teams that can respond to catastrophic events involving pediatric mass casualties, such as Pediatric Intensive Care Unit (ICU) and Neonatal Intensive Care Unit (NICU) Teams, General Pediatric Teams, Pediatric Surgical Teams, Pediatric Transport Teams, and Pediatric Mental Health Teams.

Recommendation 3.3: Ensure all health care professionals who may treat children during an emergency have adequate pediatric disaster medicine training specific to their role.

- *Form a Pediatric Disaster Medicine Education and Training Working Group to establish core competencies and a standard, modular pediatric disaster medicine training curriculum.*

Currently, national standards for pediatric disaster education do not exist, and a set of core competencies for pediatric responders has yet to be identified.⁷⁰ In the event of a large-scale disaster or pandemic, the appropriate training and utilization of both pediatric and non-pediatric health care resources will be crucial to minimize the morbidity and mortality of the pediatric population. The formation of a Pediatric Disaster Medicine Education and Training Working Group would serve as an oversight body that would establish a national curriculum and provide appropriate peer review and quality control over the development and distribution of competency-based pediatric disaster training materials.

The working group would establish core competencies and guidelines for a standard, modular pediatric disaster medicine training curriculum. The curriculum would be applied across a spectrum of professions from basic training of non-medical emergency responders and volunteers to advanced training for DMAT members, pre-hospital and hospital-based EMS providers, and Medical Reserve Corps volunteers, among others. The scope of practice capabilities for pediatric response must be defined for each discipline specific responder including the identification of core competencies and the articulation of a minimum task specific skill-set for pediatric response. Continuing education becomes critically important for EMS providers for example, as they rarely treat a sufficient number of pediatric patients to develop and maintain skills. The Commission supports the adoption of requirements by states and territories for pediatric emergency education for the licensure/certification renewal of Basic Life Support (BLS) and Advanced Life Support (ALS) providers.⁷¹

During a disaster response some professionals will require basic education and training (e.g. emergency medical technicians) while other responders, such as DMAT members

⁷⁰ Elizabeth Ablah, Annie M. Tinius, and Kurt Konda, "Pediatric Emergency Preparedness Training: Are We on a Path toward National Dissemination?," *The Journal of Trauma* 67, no. 2 (2009), S156, http://journals.lww.com/jtrauma/Fulltext/2009/08001/Pediatric_Emergency_Preparedness_Training__Are_We.21.aspx.

⁷¹ EMSC National Resource Center, *EMSC Performance Measures: Implementation Manual for State Partnership Grantees (Draft Edition)*, (Washington, DC: EMSC National Resource Center, Child Health Advocacy Institute, Children's National Medical Center, 2009), http://childrensnational.org/files/PDF/EMSC/ForGrantees/Implementation_Manual_2009-2010_Draft.pdf.

will require advanced training. Key elements of standardized curriculum and training program would include the development of core competencies, pediatric-specific severity criteria and treatment guidelines, clinical practice guidelines for triage and treatment, and guidance for Emergency Medical Services, hospitals, emergency management, fire and law enforcement, on the incorporation of pediatric-related objectives into routine drills and exercises.

The objectives of the working group are separate from, yet complimentary to, the Federal Education and Training Interagency Group for Public Health and Medical Disaster Preparedness and Response (FETIG). The expertise and scope of the FETIG is very broad⁷², therefore a federally funded pediatrics-focused working group is necessary that includes external stakeholders to ensure adequate pediatric professional and academic expertise for the task of developing core competencies. This working group would collaborate with and have representation on the FETIG.

Efforts to develop consensus-based guidelines for altered standards of care and interventions for use in disasters⁷³ must include pediatric medical experts, as children have different standards of care than adults. While altering care for any patient is challenging, it may prove nearly impossible to do so for children during a disaster without clear recommendations and methodologies. This is the result of multiple factors, including “the societal expectation for care of children, the emotional burden of potentially limiting or withholding care from a child, and the unique barriers faced when trying to provide care for children.”⁷⁴

⁷² Federal Education and Training Interagency Group for Public Health and Medical Disaster Preparedness and Response, “Charter,” U.S. Department of Health and Human Services, <http://www.hhs.gov/aspr/conferences/nbsb/nbsb-fetig-080328.pdf>.

⁷³ The HHS Office of the Assistant Secretary for Preparedness and Response recently sponsored a one-day workshop with the Institute of Medicine on establishing standards of care in emergency situations. No pediatricians or pediatric-specific topics were included in the panel presentations. Workshop on Guidance for Establishing Standards of Care for Use in Disaster Situations, Washington, DC, September 2, 2009, <http://www.iom.edu/CMS/3740/72417/72451.aspx>.

⁷⁴ David Markenson, "Developing Consensus on Appropriate Standards of Hospital Disaster Care: Ensuring That the Needs of Children Are Addressed," *Disaster Medicine and Public Health Preparedness* 3, no. 1 (2009): 5.

Recommendation 3.4: Provide funding for a formal, regionalized pediatric system of care, prepared for disasters.

- *Ensure all hospital emergency departments stand ready to care for ill or injured children of all ages through the adoption of disaster preparedness guidelines jointly developed by the American Academy of Pediatrics, American College of Emergency Physicians and the Emergency Nurses Association.*

Pediatric surge capacity and capability must be assessed beyond the scope of individual institutions and in a coordinated manner on local, regional and national levels. Additional funding for the HHS Hospital Preparedness Program can assist states in developing and implementing comprehensive state and regional plans for pediatric patient surge capacity in conjunction with hospitals, EMS and emergency management agencies. In addition, local, regional and national disaster response plans must anticipate need and fully integrate trauma systems, children's hospitals, EMS, and other institutions with pediatric critical care and pediatric medical and surgical sub-specialty care capabilities.

All health care facilities, not simply children's hospitals, must be prepared for a surge of critically ill children. Although EMS field efforts will attempt to match the survivors' needs with the nearest appropriate hospital, the most recent disaster literature suggest that up to 50 percent of survivors arriving at a hospital under a surge (mass casualty) scenario will arrive by other means. To accommodate a surge of pediatric patients, all hospitals should ensure that adequate, up-to-date stocks of pediatric supplies are on site. Pediatric hospital preparedness can be optimized by accommodating pediatric considerations in planning and in utilizing the guidelines outlined by the American Academy of Pediatrics, American College of Emergency Physicians and Emergency Nurses Association.⁷⁵ All hospitals should diligently practice disaster drills that include scenarios with sufficient

⁷⁵ Committee on Pediatric Emergency Medicine American Academy of Pediatrics, Pediatric Committee American College of Emergency Physicians, and Emergency Nurses Association, Pediatric Committee , "Joint Policy Statement: Guidelines for Care in the Emergency Department.," *Pediatrics* 124, no. 4 (2009): in press.

pediatric survivors to test their pediatric surge capacity. These activities should also include all staff that may be called on to deliver care to children.

Currently, the United States has fewer than 300 children’s hospitals, a fraction of all hospitals (five percent), and only 40 percent of emergency department hospitals have procedures regarding pediatric transfers. A surge of ill children may present considerable staffing challenges to non-pediatric designated hospitals. These hospitals should develop databases with the contact information of locally available pediatricians, pediatric nurses and other personnel with pediatric experience who can provide assistance in the event of a surge.⁷⁶ During a biological event, children may not be well-suited for transfer and may therefore have to remain in the receiving facility.⁷⁷ The transfer of children to a local or regional pediatric referral center may be impaired by factors limiting patient transport (e.g. disaster conditions, weather, transport system availability), or the availability, level of function or capacity of the tertiary center (e.g. facility operations, patient saturation). All hospitals must be prepared to provide care for children under such circumstances.

Recommendation 3.5: Ensure access to physical and mental health services for all children during recovery from disaster.

Access to comprehensive primary care, including vaccines, health, dental, and mental health screening following a disaster, is essential for children. A “medical home,” defined as a source of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective,⁷⁸ is vital resource for children and families recovering from disasters.

The Commission recommends the development of programs based on a model of care consistent with the “medical home” that consists of preventive care, health education, timely diagnosis and treatment of acute illness, management of chronic conditions, coordination of specialty care

⁷⁶ Edward W. Boyer, James Fitch, and Michael Shannon, *Pediatric Hospital Surge Capacity in Public Health Emergencies*. (Prepared under Contract No. 290-00-0020), ed. Agency for Healthcare Research and Quality. (Rockville, MD: AHRQ, 2009), 16.

⁷⁷ Edward W. Boyer, James Fitch, and Michael Shannon, *Pediatric Hospital Surge Capacity in Public Health Emergencies* (Prepared under Contract No. 290-00-0020, AHRQ Publication No. 09-0014) (Rockville, MD: Agency for Healthcare Research and Quality, 2009), 16-17.

⁷⁸ Stephen E. Edwards, “Foreword,” *Pediatrics: Supplement: The Medical Home* 113, no. 5 (2004), 1471.

needs, and availability of urgent and emergent response. Ideally, following a disaster, each child would be assigned to a “medical home provider,” who would provide comprehensive physical, mental and oral health care and assessments consistent with the model as described above. Access to medications, specialty health care services and other special needs would be assured, and comprehensive medical records, preferably on an electronic health record system, would be maintained for every child receiving care under this program.

The ability of health and mental health care entities, such as clinics and providers, to recover from a disaster quickly is essential to assisting children in their recovery. The Commission recommends an examination of disaster assistance provided under the Robert T. Stafford Disaster Relief and Emergency Assistance Act⁷⁹ (“Stafford Act”) amending the Act as necessary, to support the re-establishment of these vital entities in disaster-affected communities.

⁷⁹ P.L. 93-288, as amended, 42 U.S.C. 5121-5207 (1988).

4. Emergency Medical Services and Pediatric Transport

Recommendation 4.1: Improve the capability of EMS to transport pediatric patients and provide comprehensive pre-hospital pediatric care during daily operations and disasters.

- *Establish a dedicated federal grant program for pre-hospital EMS.*
- *Provide additional funding to the EMSC program to ensure all states and Territories meet targets and achieve progress in the EMSC performance measures for grantees, and to support development of a robust research portfolio.*
- *As an eligibility guideline for Centers for Medicare & Medicaid Services reimbursement, require first response and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies in accordance with the national guidelines for equipment for BLS and ALS vehicles.⁸⁰*

The majority of EMS systems in the nation do not receive federal support for disaster preparedness and response, like other first responder agencies including emergency management, public health and hospitals.⁸¹ The DHS Homeland Security Grant Program requires states and local governments to include EMS in their homeland security plans, however, "...if no State or local funding is provided to EMS, the State should be prepared to demonstrate that related target capabilities have been met or identify more significant priorities."⁸² A dedicated federal grant program for EMS would support state-level coordination and disaster planning, field-level staffing, pediatric supply and equipment needs, and pediatric-specific training and exercises. In addition, the grant deliverables of a dedicated federal grant program could help ensure that EMS systems are meeting the pediatric-specific performance measures established by the EMSC program.

⁸⁰ American College of Emergency Physicians American College of Surgeons Committee on Trauma, National Association of EMS Physicians, Pediatric Equipment Guidelines Committee- Emergency Medical Services for Children (EMSC Partnership for Children Stakeholder Group, and American Academy of Pediatrics, *Equipment for Ambulances*, (Washington, DC: Children's National Medical Center, 2009), http://www.childrensnational.org/files/PDF/EMSC/PubRes/Equipment_for_ambulances_FINAL.pdf.

⁸¹ National Association of State Emergency Medical Services Officials, *State EMS Office Involvement in Domestic Preparedness Efforts: NASEMSO 2008 Addendum*, (Falls Church, VA: NASEMSO, 2008), 5, <http://www.nasemso.org/Projects/DomesticPreparedness/documents/08DPAddendumReport-2.pdf>.

⁸² This is problematic because states are not assessed by DHS on their performance in meeting Target Capabilities; this work is self-reported. "Fiscal Year 2009 Homeland Security Grant Program Guidance and Application Kit," ed. U.S. Department of Homeland Security (Washington, DC: FEMA, 2008), 11, http://www.fema.gov/pdf/government/grant/hsgp/fy09_hsgp_guidance.pdf.

EMSC provides limited resources to states to improve day-to-day readiness of emergency care for children. In 2007, an Institute of Medicine (IOM) report supported the EMSC program citing its many accomplishments including the delivery of thousands of hours of pediatric-specific training for emergency medical providers, the implementation of injury prevention programs and the establishment of a pediatric research network, despite limited funding growth over the history of the program.⁸³ IOM recommended that funding for the EMSC program be increased to \$37.5 million per year for 5 years. Forty-eight stakeholder organizations signed a July 14, 2009 letter to the Chairmen of the House and Senate Appropriations Subcommittees on Labor, Health and Human Services, Education & Related Agencies advocating for an increase above the current \$20 million appropriation to the EMSC program, citing the fact that death rates due to pediatric injury have dropped by 40 percent since the EMSC program was established.⁸⁴ ⁸⁵ Despite this progress, the gap between adult emergency and pediatric emergency care on not only a day-to-day, but also a disaster basis, is sufficiently large as to require substantial increases in funding for EMSC. A significant amount of improvement must still be made to ensure that the emergency care system is prepared for the care of children in both every-day emergencies and in disasters, and the work of the EMSC is instrumental in achieving a higher level of preparedness.

The Commission recommends that additional funding be provided to the EMSC program as a means to boost pediatric preparedness in EMS systems throughout the nation. With additional funding, the EMSC program would support the establishment and/or maintenance of a full-time EMSC administrator in every state and territory to ensure the ongoing needs of children are met in state disaster planning and response. Assurance of pediatric needs in the pre-hospital system is an ongoing process that requires a state-level

⁸³ Board on Health Care Services Committee on the Future of Emergency Care in the United States Health System, *Emergency Care for Children: Growing Pains. Executive Summary*, ed. Institute of Medicine, (Washington, DC: National Academies Press, 2007), 13-14, http://www.nap.edu/nap-cgi/report.cgi?record_id=11655&type=pdfxsum.

⁸⁴ Coalition for American Trauma Care Advisory Council et al., Letter to Representative David Obey, July 14, 2009, <http://www.nasemsd.org/Advocacy/PositionsResolutions/documents/07-14-09EMSCAppropsltrObey.pdf>.

⁸⁵ Coalition for American Trauma Care Advisory Council et al., Letter to Senator Tom Harkin, July 14, 2009, <http://www.nasemsd.org/Advocacy/PositionsResolutions/documents/07-14-09EMSCAppropsltrHarkin.pdf>.

champion who is solely dedicated to ensuring that children are not forgotten during disaster planning and response. EMSC would provide additional funding for research to build an evidence base for the development of standard pre-hospital pediatric disaster care practices and protocols. Lastly, additional funding would support the inclusion of pediatric-specific supplies, equipment and medications in proportion to the pediatric population within all federally-funded multi-casualty incident caches.

The EMSC State Partnership Grant Program has a set of comprehensive performance measures that serve to establish an ongoing, systematic process for tracking progress towards meeting the goals of the EMSC Program and allow for continuous monitoring of the effectiveness of key EMSC Program activities.⁸⁶ The Commission supports the use of these performance measures in determining the extent to which grantees are meeting established targets and recommends that the proposed federal funding stream for EMS provide sufficient support to ensure all states integrate the EMSC priorities⁸⁷ into existing state and territory requirements by 2014.⁸⁸ With additional funding, EMSC could publish an annual report card on each state's performance in providing EMS to children, which would provide incentives for progress and public transparency in the use of the funds.

⁸⁶ EMSC National Resource Center, *EMSC Performance Measures: Implementation Manual for State Partnership Grantees (Draft Edition)*, (Washington, DC: EMSC National Resource Center, Child Health Advocacy Institute, Children's National Medical Center, 2009), 3, http://childrensnational.org/files/PDF/EMSC/ForGrantees/Implementation_Manual_2009-2010_Draft.pdf.

⁸⁷ The priorities summarized are:

1. Prehospital provider agencies have on-line and off-line pediatric medical direction at the scene of an emergency for BLS and ALS providers.
2. BLS and ALS patient care units in the State/Territory have the essential pediatric equipment and supplies.
3. The existence of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.
4. Hospitals in the State/Territory have written pediatric inter-facility transfer guidelines with specific components.
5. Hospitals in the State/Territory have written pediatric inter-facility transfer agreements.
6. The adoption of requirements by the State/Territory for pediatric emergency education for the licensure/certification renewal of BLS and ALS providers.
7. A full time EMSC manager within the State system to ensure and maintain the operational infrastructure to provide optimal prehospital care to children.

⁸⁸ EMSC National Resource Center, *EMSC Performance Measures: Implementation Manual for State Partnership Grantees (Draft Edition)*, (Washington, DC: EMSC National Resource Center, Child Health Advocacy Institute, Children's National Medical Center, 2009), 102-4, http://childrensnational.org/files/PDF/EMSC/ForGrantees/Implementation_Manual_2009-2010_Draft.pdf.

Over the next year, the Commission will be closely reviewing issues concerning the lack of surge capacity for critical care transport of children. One of EMSC's prioritized performance measures is the establishment of statewide, territorial, or regional standardized systems in each state/territory that recognize hospitals that are able to stabilize or manage pediatric medical emergencies and trauma. The existence of a statewide recognition system has been shown to increase the number of hospital emergency departments that are capable of providing pediatric emergency care.⁸⁹ Another priority is the establishment of written pediatric inter-facility transfer agreements. A categorization process and inter-facility transfer guidelines help facilitate EMS transfer of children to appropriate levels of resources. Although 19 states have such a system in place for trauma, only eight states have a categorization system for medical emergencies.

Since pre-hospital EMS providers generally do not treat a sufficient number of pediatric patients to develop and maintain clinical skills,⁹⁰ continuing education is critically important. The Commission supports the adoption of requirements by states and territories for pediatric emergency education for the licensure and certification renewal of BLS and ALS providers.

The Commission also recommends that eligibility guidelines for CMS reimbursement should, at a minimum, require first response and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies in accordance with the national guidelines for equipment for BLS and ALS vehicles.⁹¹ This would provide a strong

⁸⁹ EMSC National Resource Center, *EMSC Performance Measures: Implementation Manual for State Partnership Grantees (Draft Edition)*, (Washington, DC: EMSC National Resource Center, Child Health Advocacy Institute, Children's National Medical Center, 2009), 42-4, http://childrensnational.org/files/PDF/EMSC/ForGrantees/Implementation_Manual_2009-2010_Draft.pdf.

⁹⁰ EMSC National Resource Center, *EMSC Performance Measures: Implementation Manual for State Partnership Grantees (Draft Edition)*, (Washington, DC: EMSC National Resource Center, Child Health Advocacy Institute, Children's National Medical Center, 2009), 71, http://childrensnational.org/files/PDF/EMSC/ForGrantees/Implementation_Manual_2009-2010_Draft.pdf.

⁹¹ American College of Emergency Physicians American College of Surgeons Committee on Trauma, National Association of EMS Physicians, Pediatric Equipment Guidelines Committee- Emergency Medical Services for Children (EMSC Partnership for Children Stakeholder Group, and American Academy of

incentive to help ensure that all BLS and ALS vehicles meet a baseline level of pediatric preparedness.

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5. Disaster Case Management

Recommendation 5.1: Establish a permanent, holistic Federal disaster case management program, with an emphasis on achieving tangible positive outcomes for children.

Following Hurricanes Katrina and Rita, the federal government provided at least \$209 million for disaster case management⁹² services to assist survivors in coping with the devastation and rebuilding their lives, yet deficiencies existed that resulted in poor outcomes for these programs and illuminated the need for greater coordination and program evaluation in the provision of disaster case management services.⁹³

Confusion regarding roles and responsibilities across federal agencies compounded by the expiration of federally funded disaster case management programs initiated after the storms led to breaks in funding that adversely affected case management agencies and may have left survivors most in need of assistance without access to case management services.^{94 95} For example, as the first federally-funded case management program Katrina Aid Today drew to a close in March 2008, some case management providers shut down their operations and cases were closed, not because the client's needs had been met,

⁹² Disaster case management is the process of organizing and providing a timely, coordinated approach to assess disaster-related needs as well as existing healthcare, mental health and human services needs that may adversely impact a individual's recovery if not addressed. The objective of disaster case management is to rapidly return children and families who have survived a disaster to a state of self-sufficiency. This is accomplished by ensuring that each child/family has access to a case manager who will capture information about the child/family's situation and then serve as their advocate and help them organize and access disaster-related resources. "Disaster Case Management Implementation Guide," ed. U.S. Department of health and Human Services Administration for Children and Families (Washington, DC: HHS, 2008), 62.

⁹³ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 7.

⁹⁴ The federal role for funding and coordinating disaster case management was not explicitly defined until the passage of PKEMRA. The Stafford Act, as amended, is the primary authority under which the federal government provides major disaster and emergency assistance to states, local governments, tribal nations, individuals, and qualified private, nonprofit organizations. FEMA is responsible for administering the provisions of the Stafford Act. At the time of Hurricanes Katrina and Rita, the Stafford Act contained no explicit authority to fund disaster case management services. The Post-Katrina Act amended the Stafford Act and, among other things, granted the President the authority to provide financial assistance for case management services to victims of major disasters. Pub. L. No. 109-295, title VI, §689f, codified at 42 U.S.C. §5189d. The Post-Katrina Act was passed in October 2006.

⁹⁵ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 13.

but simply because the funding for the program was coming to an end. FEMA provided funds for additional services, but due to budget negotiations, the program's continuation in Mississippi was delayed several months while the program in Louisiana was never implemented.⁹⁶

Currently, FEMA is evaluating four pilot disaster case management programs authorized following hurricanes Gustav and Ike in 2008. The Commission recommends that FEMA move aggressively to establish a permanent program, with specific parameters and elements as indicated below.

The Commission supports the U.S. Government Accountability Office (GAO) reports' recommendation for the development of a federal disaster case management program⁹⁷ and suggests that it be holistic in scope, flexible and sensitive to cultural and economic differences in communities, while placing a priority on serving the needs of families with children. Disaster case management should be led by a single Federal agency which will coordinate, among all relevant agencies and organizations, disaster case management and ensure there is a) adequate understanding of the health, education and human services needs of children and families, b) involvement of voluntary agencies that provide disaster case management, and c) access to funding that supports all aspects of disaster case management, including direct services. Disaster preparedness funding must be provided for infrastructure and capacity building to support a disaster case management program, in advance of a disaster, and to contract for the rapid deployment of case managers into disaster affected areas.

The purpose of disaster case management is to rapidly return children and families who have survived a disaster to a state of self-sufficiency. The program should develop a consistent set of comprehensive program evaluation tools that regularly measure and

⁹⁶ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 13.

⁹⁷ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 36.

monitor success based upon tangible positive outcomes for families (especially those most in need), rather than case managers simply making referrals. The program evaluation should also include guidelines for assessing and monitoring recovery milestones for children. All individuals within a Presidentially-declared disaster area should be eligible to receive disaster case management services.

The Commission further recommends a national contract to ensure rapid deployment of case managers, funding, and transition to service providers in the local community. The contractor would be required to pre-identify state and local subcontracting agencies and pre-roster disaster case managers from professional organizations that can provide surge capacity following a disaster.

Difficulties in coordination resulted in limited monitoring and program oversight and a lack of accurate and timely information sharing between federal agencies and case management providers.⁹⁸ These difficulties, in conjunction with current privacy policies, created barriers to the provision of disaster case management services.⁹⁹ According to the GAO report, state and local agencies responsible for providing federally-funded disaster case management services following the hurricanes faced consistent difficulty obtaining timely and accurate information from the federal agencies overseeing the programs.¹⁰⁰ As a result of FEMA's interpretation of information sharing and privacy requirements under the Privacy Act,¹⁰¹ some case management providers in Louisiana and Mississippi were unable to obtain critical information that inhibited the coordination of service delivery and prevented eligible hurricane survivors from receiving services.¹⁰² The

⁹⁸ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 15-20.

⁹⁹ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 19-20.

¹⁰⁰ "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 19-20.

¹⁰¹ P.L. 93-579; 5 U.S.C. § 552a (1974).

¹⁰² "Disaster Assistance: Greater Coordination and an Evaluation of Programs' Outcomes Could Improve Disaster Case Management," GAO-09-561, ed. United States Government Accountability Office (Washington, DC: GAO, 2009), 19-20.

Commission recommends a review and modification of current privacy policies and laws, as is necessary to permit the timely sharing of relevant disaster victim information among Federal, state, local, tribal and non-governmental agencies and organizations engaged in supporting children and families affected by disasters.

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6. Child Care

Recommendation 6.1: Increase disaster planning capabilities of child care providers.

- *Require state child care regulatory agencies to include disaster planning, training and exercising requirements within the scope of the state’s minimum health and safety standards for child care licensure or registration.*
- *Require state child care administrators to develop statewide child care plans in coordination with state and local emergency managers, child care regulatory agencies and child care resource and referral agencies.*

Disaster planning for child care providers is crucial because young children – many of whom are immobile and unable to communicate basic identifying information to a rescuer – are particularly vulnerable in the face of danger when away from their families.¹⁰³ There are nearly 12 million children under the age of five in child care each week.¹⁰⁴ Child care providers must be prepared for disasters, not only to ensure children’s safety and mental well-being in the face of danger, but also to facilitate recovery by providing support services to parents, employees, and employers in the aftermath of a disaster.¹⁰⁵

However, a lack of basic disaster preparedness requirements for child care providers is commonplace in states throughout our nation.¹⁰⁶ In June 2009, Save the Children released a report, “The Disaster Decade,” which contained a report card on child care disaster planning requirements across fifty states and the District of Columbia. Among the key findings:

¹⁰³ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRRA, 2008), 3.

¹⁰⁴ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRRA, 2008), 3.

¹⁰⁵ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRRA, 2008), 9.

¹⁰⁶ Save the Children, *The Disaster Decade: Lessons Unlearned for the U.S.*, (Westport, CT: Save the Children U.S. Programs, 2009), 4, <http://www.savethechildren.org/publications/usa/disaster-decade-lessons.pdf>.

- Only seven states have laws or regulations requiring licensed child care providers to have basic written emergency plans in place addressing evacuation, reunification, and accommodating children with special needs;
- Only 21 states require licensed child-care facilities to have a designated site and evacuation route in the event of a disaster; and
- Only 15 states require licensed child care facilities to have a reunification plan for children and families in the event they become separated during an emergency.¹⁰⁷

State child care regulatory agencies should include disaster planning, training and exercising requirements within the scope of the state's minimum health and safety standards for child care licensure or registration. Disaster plans for child care providers must, at a minimum, incorporate specific capabilities for shelter-in-place, evacuation, relocation, family reunification, staff training, continuity of operations, and accommodation of children with special needs. State and local emergency management planning activities must be expanded to include participation of child care administrators, regulatory agencies, and child care resource and referral agencies. Similarly, state child care administrators must develop statewide child care disaster plans in coordination with emergency managers, child care regulatory agencies and child care resource and referral agencies. Model plans, guidance and technical assistance will aid disaster planning, training, and exercising efforts of individual child care providers and encourage state and local planning collaborations.

Moreover, state plans must adequately ensure the provision and sustainability of child care services following a disaster. Child care is a critical component of recovery efforts.¹⁰⁸ ¹⁰⁹ Provision of child care services to accommodate families who need

¹⁰⁷ Save the Children, *The Disaster Decade: Lessons Unlearned for the U.S.*, (Westport, CT: Save the Children U.S. Programs, 2009), 4, <http://www.savethechildren.org/publications/usa/disaster-decade-lessons.pdf>.

¹⁰⁸ "ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance," ed. U.S. Department of Health and Human Services, Administration for Children and Families (Washington, DC: HHS, 2007), 1.

¹⁰⁹ Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 9.

temporary relief during recovery efforts can mitigate a wide variety of economic, mental health, and social problems after a disaster.^{110 111} Child care is also essential to first responders, emergency managers, and critical personnel who work around the clock. Accordingly, states must develop child care disaster plans that establish guidelines for recovery after a disaster addressing the continuation of child care services and provision of temporary child care services.

In the aftermath of a disaster, temporary child care facilities may be set up near large employers and temporary housing sites to support parents, employees and employers and provide children with appropriate care and recreational opportunities.¹¹² However, those providing temporary child care services in non-permanent facilities often encounter regulatory hurdles that can obstruct their efforts to serve children and families.¹¹³ While it is critical that providers of temporary disaster child care services preserve the highest possible standards of care, states must appreciate the difficulties associated with providing care in a potentially devastated post-disaster environment and must be prepared to accommodate the provision of temporary child care in a variety of settings including shelters and non-permanent facilities.¹¹⁴ Establishing temporary child care services in the aftermath of a disaster may require exemptions from certain ordinary state child care licensing requirements that best serve needs of children in normal times.¹¹⁵ Accordingly, states must develop temporary disaster child care operating standards that permit the provision of disaster child care in non-traditional settings and waive requirements that

¹¹⁰ "ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance," ed. U.S. Department of Health and Human Services, Administration for Children and Families (Washington, DC: HHS, 2007), 1.

¹¹¹ Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 9.

¹¹² Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 15.

¹¹³ Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 18.

¹¹⁴ Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 18.

¹¹⁵ Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 18.

may become onerous or impracticable in the aftermath of a disaster, while continuing to ensure the health, safety, and well-being of children.¹¹⁶

The pending reauthorization of the Child Care and Development Block Grant Act of 1990 (CCDBG)¹¹⁷ provides Congress the opportunity to improve the disaster planning capabilities of child care providers. The CCDBG, which provides formula grants to States, Territories, and Tribes to assist low-income families in the purchase of child care services, also requires states to establish baseline health and safety standards for child care providers.^{118 119} For example, in the CCDBG's reauthorization, Congress could require state child care regulatory agencies to include disaster planning, training and exercising for child care providers and state-wide child care disaster plans that include guidelines for recovery, including temporary operating standards to be used in the aftermath of disasters.

Recommendation 6.2: Improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster.

- *Include the provision of child care as a human service activity within the NRF.*
- *Provide reimbursement under the Stafford Act, amending the Act as necessary, to support child care services to displaced families, establishment of temporary disaster child care, and the repair or reconstruction of child care facilities.*

Following a disaster, child care is an essential human service necessary to protect the safety of children and support the stabilization of families.¹²⁰ Child care helps expedite recovery efforts by ensuring that children are safe while parents visit damaged property, access public benefits, search for employment and housing, and make other efforts to

¹¹⁶ Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 18.

¹¹⁷ P.L. 101-58, as amended; 42 U.S.C. 9859, et seq.

¹¹⁸ P.L. 101-58, as amended; 42 U.S.C. 9859, et seq.

¹¹⁹ "ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance," ed. U.S. Department of Health and Human Services, Administration for Children and Families (Washington, DC: HHS, 2007), 2-3.

¹²⁰ "ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance," ed. U.S. Department of Health and Human Services, Administration for Children and Families (Washington, DC: HHS, 2007), 1.

rebuild their lives.^{121 122} Moreover, child care recovery supports a community's economic recovery - if a community does not have access to child care for its youngest children, families can not return to work and the community can not recover economically.¹²³ Finally, research indicates that consistent, high-quality early education and child care improve the health and promote the cognitive development of young children,¹²⁴ both of which can be negatively affected by a disaster.¹²⁵

The need for child care as a “supportive service” to survivors is clear when states and localities experience an overwhelming demand for child care assistance, including assistance through the CCDBG program.¹²⁶ The addition of child care as an essential service along with a definition of “emergency child care” to the NRF under ESF 6 and in the development of a National Disaster Recovery Strategy, will serve to formalize child care as a necessary component of disaster preparedness and recovery across all levels of government.

Following a disaster, states and localities may be faced with a surge of families with young children seeking child care assistance without resources to meet the increased demand.¹²⁷ After Hurricane Katrina, Mississippi funded the provision of child care services for displaced families (many of whom would not have otherwise been eligible for benefits due to residency, income, or work requirements) with the expectation that

¹²¹ "ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance," ed. U.S. Department of Health and Human Services, Administration for Children and Families (Washington, DC: HHS, 2007), 1.

¹²² National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRRA, 2008), 9.

¹²³ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRRA, 2008), 9.

¹²⁴ American Academy of Pediatrics, "Policy Statement," *Pediatrics* 115, no. 1 (2005), 187, <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;115/1/187.pdf>.

¹²⁵ Lori Peek, "Children and Disasters: Understanding Vulnerability, Developing Capacities, and Promoting Resilience - an Introduction," *Children, Youth and Environments* 18, no. 1 (2008), 4.

¹²⁶ "ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance," ed. U.S. Department of Health and Human Services, Administration for Children and Families (Washington, DC: HHS, 2007), 2-3.

¹²⁷ "ESF-6 Disaster Response Recommendation to FEMA: Reimbursement for Child Care Assistance," ed. U.S. Department of Health and Human Services, Administration for Children and Families (Washington, DC: HHS, 2007), 2.

they could be reimbursed.¹²⁸ Mississippi's Office of Children and Youth provided 60-day emergency child care certificates to displaced families without regard to income or employment, waiving the co-payment fee for parents.¹²⁹ Mississippi served approximately 2,789 evacuee children at an approximate cost of \$1.65 million.¹³⁰ However, it was denied reimbursement from FEMA which determined that emergency child care services did not qualify as an eligible Category B Emergency Protective Measure.¹³¹

The CCDBG program is not suited to accommodate increased demand for child care services resulting from a disaster since the program's finite resources are allocated to states based on statutorily required formulas and cannot be awarded to states impacted by a disaster on a targeted basis.¹³² FEMA could act preemptively to ensure that States that support child care services for disaster survivors have a mechanism to receive reimbursement under the Stafford Act for the expenses they incur in serving these families. Additionally, the creation of an emergency contingency fund through the CCDBG program to support states on a targeted basis after a federally-declared disaster, would allow states to receive reimbursement when subsidizing child care services for displaced families. States would be able to serve disaster survivors without depleting their already committed CCDBG funds that provide needed child care services to working, low-income families.

Funding and support for the repair and reconstruction of child care infrastructure is crucial so that child care services can be restored as quickly as possible. In New Orleans before Hurricanes Katrina and Rita, the city had 15,731 day care slots at 266 licensed

¹²⁸ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRA, 2008), 1.

¹²⁹ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRA, 2008), 1.

¹³⁰ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRA, 2008), 1.

¹³¹ National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRA, 2008), 1.

¹³² National Association of Child Care Resource & Referral Agencies, *Keeping Children Safe: A Policy Agenda for Child Care in Emergencies*, (Arlington, VA: NACCRRA, 2008), 2.

centers.¹³³ Nearly a year after the storms, 80 percent of those centers and 75 percent of the slots were still gone.¹³⁴ In St. Bernard Parish in Louisiana, the number of child care centers dropped from 26 before Katrina to only two by 2007.¹³⁵ Between 62 to 94 percent of the licensed child care slots were “lost or potentially lost” in the three coastal Mississippi counties hit hardest by Hurricanes Katrina and Rita.¹³⁶ Without repairing, rebuilding and reopening child care facilities that are damaged in disasters, communities may lose their capacity to provide child care services, which can stymie recovery by limiting the ability of parents to return to work and the ability of families to return to communities. Furthermore, research indicates that investment in the child care sector is effective in spurring economic development in both the short and long term.^{137 138}

Although certain private non-profit child care facilities may be eligible for reimbursement for repairs and reconstruction under the Stafford Act if they fail to qualify for disaster loans administered by the U.S. Small Business Administration, most child care services are provided by private businesses that operate for profit, thus precluding them from receiving Stafford funds.¹³⁹ Child care providers, regardless of their tax status, should be eligible to receive federal reimbursement for the repair and reconstruction of their facilities.

¹³³ Elizabeth F. Shores, Cathy Grace, Erin Barbaro, Michael Barbaro, and Jenifer Moore, *Orleans Parish, Louisiana, Child Care Assessment; Executive Summary*, (Mississippi State: Mississippi State University Early Childhood Institute, 2006), 3, <http://www.earlychildhood.msstate.edu/orleans-summary/orleans-exec-summ.pdf>.

¹³⁴ Elizabeth F. Shores, Cathy Grace, Erin Barbaro, Michael Barbaro, and Jenifer Moore, *Orleans Parish, Louisiana, Child Care Assessment; Executive Summary*, (Mississippi State: Mississippi State University Early Childhood Institute, 2006), 3, <http://www.earlychildhood.msstate.edu/orleans-summary/orleans-exec-summ.pdf>.

¹³⁵ U.S. Senator Mary L. Landrieu, Committee on Homeland Security and Governmental Affairs, Ad Hoc Subcommittee on Disaster Recovery, *Focusing on Children in Disasters: Evacuation Planning and Mental Health Recovery*, August 4, 2009, <http://www.senate.gov/fplayers/l2009/urlPlayer.cfm?fn=govtaff080409&st=0&dur=6090>.

¹³⁶ Mississippi State University Early Childhood Institute, *After Katrina: Rebuilding Mississippi's Early Childhood Infrastructure; the First Six Months*, Early Childhood Report no. 1, (Mississippi State, MS: Mississippi State University Early Childhood Institute, 2006), 5, <http://www.earlychildhood.msstate.edu/katrina-report.pdf>.

¹³⁷ Mildred E. Warner, and Zhilin Liu, "Economic Development Policy and Local Services: The Case of Child Care," *International Journal of Economic Development* Vol. 7, no. 1 (2005): 25-64.

¹³⁸ Mildred E. Warner, "Putting Child Care in the Regional Economy: Empirical and Conceptual Challenges and Economic Development Prospects," *Community Development: Journal of the Community Development Society* 37, no. 2 (2006): 7, <http://government.cce.cornell.edu/doc/pdf/7-22%20warner.pdf>.

¹³⁹ P.L. 93-288, as amended; 42 U.S.C. 5121-5207 (1988).

7. Elementary and Secondary Education

Recommendation 7.1: Improve disaster planning for state education agencies (SEAs) and school districts and support integration of schools into state and local disaster planning, training, and exercises.

- *Provide need based federal funding to local education agencies (LEAs) distributed by SEAs to support coordination and development of disaster planning, training, exercising, and guidance for school districts.*
- *Develop national disaster planning standards for school districts and performance measures to assess progress and accountability for funding.*

Most schools and school districts have developed all-hazards emergency management plans, however, very few of these plans are comprehensive enough to address disasters such as pandemics and radiological events.¹⁴⁰ School districts currently lack integration with the planning efforts of SEAs and would benefit from community-wide coordination with local heads of government, local public health and emergency response officials, and parents.¹⁴¹ In a 2007 GAO report, school officials from 62 percent of all school districts included in the study identified challenges to implementing emergency management programs, including lack of equipment, training for staff, and lack of personnel with expertise in the area of emergency planning.¹⁴² While most school districts practice their emergency management plans annually within the school community, the GAO estimates “over one quarter of school districts have never trained with first responders and over two thirds of school districts do not regularly train with community partners on how to implement their school district emergency management plans.”¹⁴³

¹⁴⁰ "Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance," GAO-07-609, ed. Government Accountability Office (Washington, DC: GAO, 2007), 5, <http://www.gao.gov/new.items/d07609.pdf>.

¹⁴¹ "Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance," GAO-07-609, ed. Government Accountability Office (Washington, DC: GAO, 2007), 5, <http://www.gao.gov/new.items/d07609.pdf>.

¹⁴² "Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance," GAO-07-609, ed. Government Accountability Office (Washington, DC: GAO, 2007), 6, <http://www.gao.gov/new.items/d07609.pdf>.

¹⁴³ "Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance," GAO-07-609, ed. Government Accountability Office (Washington, DC: GAO, 2007), 6, <http://www.gao.gov/new.items/d07609.pdf>.

A current and comprehensive national assessment of the disaster plans of school districts is needed to update and expand upon findings from the 2007 GAO report “Status of School Districts’ Planning and Preparedness.” A new assessment would provide a more accurate snapshot of the current state of readiness within schools and school districts, including information regarding their capacity to respond to children with special needs, and would also serve to identify continuing gaps requiring targeted federal and state guidance and technical assistance. An assessment is also needed to inform the development of realistic performance measures and benchmarks that would allow school districts to show progress in disaster preparedness.

The Commission further recommends legislation and appropriations for a dedicated federal funding stream to SEAs for state and district-level school disaster response planning and evaluation. Existing federal funding mechanisms for school districts, such as the U.S. Department of Education’s Readiness and Emergency Management for Schools (REMS) program, have provided much-needed support to help a number of school districts revise emergency management plans, provide training and develop systems to sustain project activities. Building upon the work of the REMS Technical Assistance Center, REMS should receive continued support since it is a mechanism that can yield model programs and test various cost- and time-effective approaches to improving school preparedness. However, REMS is a competitive grant program with a very limited budget that is able to fund a select number of school districts, thus leaving the majority of school districts in this country less than optimally prepared.¹⁴⁴ The establishment of a federal funding stream to all SEAs would facilitate coordinated disaster planning and exercising activities in school districts throughout the country. For example, federal funding would support:

- Direct need-based funding to LEAs at the discretion of the SEA that would support the development of comprehensive school district disaster plans

¹⁴⁴ Since 2003, the REMS program has distributed 714 grants to 661 Local Education Agencies, serving a small proportion of the 14,200 public school districts nationwide. Readiness and Emergency Management for Schools Technical Assistance Center, “FY2009 REMS Grantees,” U.S. Department of Education, <http://rems.ed.gov/index.cfm?event=grantees2009>.

- Coordination with existing school-based programs and networks for disaster-displaced children, specifically the McKinney-Vento Act's Education for Homeless Children and Youth program;
- Provision of in-service trainings to teachers and school staff in all phases of emergency management on topics including emergency management and disaster mental health;
- Execution of regular disaster preparedness exercises and drills that involve local emergency management, school personnel, and other stakeholders;
- Development of state, regional and local school district continuity of operations plans to ensure academic continuity for all students affected by a disaster; and
- Effective dissemination of guidance, best practices and technical assistance provided at the federal and state level.

DHS provides funding to state emergency management agencies for emergency preparedness initiatives, with grant guidance that allows the inclusion of school-related activities, such as security training for school bus drivers and physical hardening of school buildings.¹⁴⁵ Yet very few states provide DHS funding directly to school districts even though school districts are eligible to receive the funds.¹⁴⁶

Guidance from a new dedicated funding stream to LEAs via SEAs could require state-level collaboration among SEAs and state emergency management agencies to better leverage federal emergency management funds. State and school district performance measures and benchmarks must be established and disseminated with federal funding for emergency preparedness activities, and regular evaluations should be conducted to assess

¹⁴⁵ U.S. Department of Homeland Security, "School Safety," http://www.dhs.gov/files/programs/gc_1183486267373.shtm.

¹⁴⁶ GAO reported "Five states—Florida, Hawaii, Michigan, Mississippi, and Wyoming—reported that they provided approximately \$14 million in DHS funding directly to school districts in these states during fiscal years 2003–2006." "Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance," GAO-07-609, ed. Government Accountability Office (Washington, DC: GAO, 2007), 60, <http://www.gao.gov/new.items/d07609.pdf>.

progress and accountability for federal funding to both SEAs and state emergency management agencies.

Federal and state guidance must also enhance school professionals' abilities to support children who are traumatized, grieving or recovering from a disaster. Most children who receive mental health services receive them in schools.¹⁴⁷ However, without proper planning and training, school personnel can be unsure about their role with children following a disaster.¹⁴⁸ Teachers and other school personnel should be trained to provide psychological first aid and basic bereavement support following a disaster. According to school personnel interviewed following Hurricanes Katrina and Rita, the greatest barriers to helping students following the storms were not knowing what mental health programs they should use and shortage of trained staff to implement these types of programs.¹⁴⁹

Initiatives that both support and promote training for teachers should be encouraged through requirements for accreditation and licensure. The National Center for School Crisis and Bereavement has recommended that concerted efforts be made to ensure that basic knowledge about the impact of bereavement and crisis on children is covered within pre-service training of teachers and basic skills in providing support to grieving students and students in crisis is assessed in licensure and/or accreditation examinations of new teachers, consistent with recent recommendations by the Mental Health Subcommittee of the National Biodefense Science Board.¹⁵⁰

¹⁴⁷ Mark D. Weist, Marcia Rubin, Elizabeth Moore, Steven Adelsheim, and Gordon Wrobel, "Mental Health Screening in Schools," *Journal of School Health* 77, no. 2 (2007): 54.

¹⁴⁸ Claude M. Chemtob, Joanne P. Nakashima, and Roger S. Hamada, "Psychosocial Intervention for Postdisaster Trauma Symptoms in Elementary School Children: A Controlled Community Field Study," *Archives of Pediatric and Adolescent Medicine* 156, no. 3 (2002): 211-16, <http://archpedi.ama-assn.org/cgi/content/abstract/156/3/211>.

¹⁴⁹ Lisa H. Jaycox, Lindsey K. Morse, Terri Tanielian, and Bradley D. Stein, *How Schools Can Help Students Recover from Traumatic Experiences: A Tool Kit for Supporting Long-Term Recovery*, (Santa Monica, CA: RAND, 2006), 10-12.

¹⁵⁰ *Disaster Mental Health Recommendations: Report of the Disaster Mental Health Subcommittee of the National Biodefense Science Board*, ed. National Biodefense Science Board U.S. Department of Health and Human Services, Disaster Mental Health Subcommittee, (Washington, DC: HHS, 2008), 11-14, <http://www.hhs.gov/aspr/conferences/nbsb/dmhreport-final.pdf>.

The pandemic outbreak of H1N1 influenza is an on-going concern for schools and communities. A January 2009 report to the Homeland Security Council found that many state governments deferred pandemic influenza planning responsibilities, such as school closure decisions, to their local educational or governing entities.¹⁵¹ The report noted “it is neither likely that [LEAs] would have the capacity to operate with equal levels of ability, nor is it likely that the [SEA] would be comfortable deferring all responsibility to LEAs with no oversight or coordination. Furthermore, a lack of coordinated State response could potentially compromise the State’s ability to successfully mitigate the virus’ transmission.”¹⁵² A dedicated funding stream to SEAs could improve state and regional coordination of schools closures, dissemination of federal and state guidance and emergency information to LEAs, and improve disaster planning and response efforts at the local level.

¹⁵¹ "Assessment of States' Operating Plans to Combat Pandemic Influenza: Report to Homeland Security Council," ed. U.S. Department of Health and Human Services (Washington, DC: HHS, 2009), http://pandemicflu.gov/professional/states/state_assessment.html.

¹⁵² "Assessment of States' Operating Plans to Combat Pandemic Influenza: Report to Homeland Security Council," ed. U.S. Department of Health and Human Services (Washington, DC: HHS, 2009), 25, http://pandemicflu.gov/professional/states/state_assessment.html.

8. Child Welfare and Juvenile Justice

Recommendation 8.1: Provide guidance, technical assistance and model plans to assist state and local child welfare agencies in meeting current applicable disaster planning requirements; and further requiring collaboration with state and local emergency management, dependency courts, and other key stakeholders.

Although state child welfare agencies are required to have disaster plans, additional measures may be required to enable child welfare programs to maintain services and adequately respond to disasters. In addition to challenging a child welfare agency's ability to handle existing cases, a disaster may also create a higher level of demand on referrals for children in need of child welfare services, including children who are separated from their parents, injured, or orphaned.

In 2006, Congress passed the Child and Family Services Improvement Act, adding a requirement that state plans have procedures in place to do the following:

- Identify, locate and continue availability of services for children under State care or supervision who are displaced or adversely affected by a disaster;
- Respond to new child welfare cases in areas adversely affected by a disaster, and provide services;
- Remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster;
- Preserve essential program records;
- Coordinate services and share information with other States.¹⁵³

Prior to the passage of the Act, the majority of states did not have written child welfare disaster plans, and the plans that were in place failed to adequately address tracking children and families and managing the ongoing needs of the system in the wake of a

¹⁵³ P.L. 109-288; 120 Stat. 1233.

disaster.¹⁵⁴ In 2006, the GAO surveyed the states' foster care disaster planning to evaluate their plans to continue an operational foster care system during a disaster and found that only three states had comprehensive child welfare plans addressing all of the vital components of planning included when the Act became law in 2006.¹⁵⁵

Although plans had to be submitted to HHS by September 28, 2007, the requirement was not tied to any additional funding to aid states in creating or implementing a plan and states may have had inadequate funding or guidance to engage in comprehensive, meaningful planning activities. Additionally, the Act neither requires states to coordinate their child welfare plans with other disaster relief efforts in the state nor utilize the expertise of emergency management agencies to help them develop better plans. Furthermore, the plans do not require training, exercises or the identification of personnel to implement the plans at the local level.¹⁵⁶ Consequently, many of the state plans, which were deficient or nonexistent prior to the Act, may still be lacking.¹⁵⁷

In addition, the Act does not require state child welfare agencies to collaborate with juvenile dependency courts and other key stakeholders within the child welfare arena in the formulation of plans. Today's child welfare system is a "large and interconnected web" that is the product of contributions from various stakeholders from the judicial branch, the executive branch, and the public and private sectors.¹⁵⁸ In a disaster, in order

¹⁵⁴ "Child Welfare: Federal Action Needed to Ensure States Have Plans to Safeguard Children in the Child Welfare System Displaced by Disasters," GAO-06-944, ed. Government Accountability Office (Washington, DC: GAO, 2006), 3, <http://www.gao.gov/new.items/d06944.pdf>.

¹⁵⁵ "Child Welfare: Federal Action Needed to Ensure States Have Plans to Safeguard Children in the Child Welfare System Displaced by Disasters," GAO-06-944, ed. Government Accountability Office (Washington, DC: GAO, 2006), 16, <http://www.gao.gov/new.items/d06944.pdf>.

¹⁵⁶ Gerald F. Glynn, "Foster Care: Disasters Complicate an Already Bad Situation " In *Children, Law and Disasters: What We Have Learned from Katrina and the Hurricanes of 2005*, ed. American Bar Association Center on Children and the Law, University of Houston Law Center and Center for Children Law and Policy (Houston: ABA Center on Children and the Law, 2009), 33.

¹⁵⁷ Gerald F. Glynn, "Foster Care: Disasters Complicate an Already Bad Situation " In *Children, Law and Disasters: What We Have Learned from Katrina and the Hurricanes of 2005*, ed. American Bar Association Center on Children and the Law, University of Houston Law Center and Center for Children Law and Policy (Houston: ABA Center on Children and the Law, 2009), 34.

¹⁵⁸ Karen Gottlieb and Susan Jennen Larson, "How Should the Best Interests of the Child Be Balanced against the Need for Confidentiality of Records in Times of Emergency?," In *Emergency Preparedness in Dependency Courts: Ten Questions That Courts Serving Abused and Neglected Children Must Address*, ed. Victor E. Flango (Williamsburg, VA: National Center for State Courts, Chapter 7, <http://www.icmeducation.org/katrina/chapter7.html>).

to identify, locate and continue available services to families who have children under state care or supervision who are displaced or adversely affected by a disaster, the child welfare agency, juvenile dependency courts, and other stakeholders such as lawyers, advocates for foster children, youth and parents, public and private providers of services such as health, mental health, developmental and substance abuse services, and foster and biological families must all work together in a collaborative effort.¹⁵⁹

In a recent review of specific state child welfare plans, the National Council of Juvenile and Family Court Judges found that state plans often contained only general statements addressing the five areas of planning required by the Child and Family Services Improvement Act, and had no directives concerning how information would be shared with the juvenile dependency courts that make vital decisions affecting the lives of children and families in the child welfare system.¹⁶⁰ To the extent that a court has a duty to ensure that children in the state's custody are receiving proper care, it is imperative for that court to know whether the children under its jurisdiction are physically and emotionally healthy.¹⁶¹ In addition to having their own continuity of operations plans, dependency courts must be involved in the planning efforts of state and local child welfare agencies so that a coordinated effort can be planned for reuniting separated foster families, attorneys, social workers, court appointed special advocates, children's relatives and parents for timely processing of open cases.

If a disaster forces a mass evacuation, biological parents may have difficulty reuniting with their children in foster care at the time of the evacuation, resulting in children

¹⁵⁹ Karen Gottlieb and Susan Jennen Larson, "How Should the Best Interests of the Child Be Balanced against the Need for Confidentiality of Records in Times of Emergency?," In *Emergency Preparedness in Dependency Courts: Ten Questions That Courts Serving Abused and Neglected Children Must Address*, ed. Victor E. Flango (Williamsburg, VA: National Center for State Courts), Chapter 7, <http://www.icmeducation.org/katrina/chapter7.html>.

¹⁶⁰ Lisa Portune, and Sophia I. Gatowski, *Ensuring the Unique Needs of Dependency Courts Are Met in Disaster Planning Efforts: Dependency Court Planning Templates for Continuity of Operations Plans*, (Reno, NV: National Council of Juvenile and Family Court Judges, Permanency Planning for Children Department, 2008), 67.

¹⁶¹ Victor E. Flango, "Why Must the Needs of Children Come First" In *Emergency Preparedness in Dependency Courts: Ten Questions That Courts Serving Abused and Neglected Children Must Address* ed. Victor E. Flango (Williamsburg, VA: National Center for State Courts), Chapter 1, <http://www.icmeducation.org/katrina/chapter1.html>.

remaining in foster care for extended time periods. Without proper procedures to locate children and families in their systems, preserve essential program records, and remain in communication with caseworkers, courts, and other key personnel and stakeholders, states will be unable to continue processing cases and providing much needed services. In addition, child welfare systems and courts in areas that were not directly affected by a disaster should be prepared to effectively respond to an influx of new child welfare cases emanating from the disaster area or emerging as a result of the disaster itself.

Along with dependency courts, all other juvenile courts including those presiding over juvenile delinquency cases, need comprehensive disaster plans to protect the constitutional and civil rights of children. Courts presiding over juvenile delinquency cases and other juvenile matters must have comprehensive disaster plans in place that address procedures for continuity of operations, including maintaining records, processing cases and holding hearings in the aftermath of a disaster.

The Commission recommends that the planning activities of state and local child welfare and juvenile justice agencies include juvenile and dependency courts, and will issue additional recommendations regarding juvenile and dependency court preparedness upon engaging in more extensive work in this arena over the next year.

Recommendation 8.2: Create an advisory committee to guide a comprehensive national assessment of disaster planning and preparedness amongst state and local juvenile justice systems.

Each year, more than 140,000 juveniles are placed in residential, correctional, and detention facilities, foster homes and group homes nationwide.¹⁶² The experience of approximately 150 residents of juvenile detention centers run by the City of New Orleans during Hurricane Katrina provides an illustration of the importance of having and effectively implementing such plans in a disaster.¹⁶³

¹⁶² Charles Puzzanchera, and Melissa Sickmund, *Juvenile Court Statistics*, (Pittsburgh, PA: National Center for Juvenile Justice, 2008), 50, <http://www.ncjrs.gov/pdffiles1/ojjdp/224619.pdf>.

¹⁶³ Juvenile Justice Project of Louisiana (JJPL), *Treated Like Trash: Juvenile Detention in New Orleans before, during, and after Hurricane Katrina*, (New Orleans, LA: JJPL, 2006), 3, http://www.jjpl.org/PDF/treated_like_trash.pdf.

While state-run juvenile facilities in New Orleans evacuated inmates to Baton Rouge in advance of the hurricane, the residents of city-operated juvenile detention centers remained trapped in their facilities until shortly before the storm's landfall when they were moved to Orleans Parish Prison, which predominantly housed adult male inmates, for several days following the storm.¹⁶⁴ While floodwaters inundated the city and the prison itself, "these children – a substantial percentage of whom had only just been arrested and not adjudicated of any crime – would endure flooding, exposure to toxins, food deprivation, water deprivation, medical care deprivation, heat exposure, violence and significant psychological stress."¹⁶⁵ Once the juveniles were finally evacuated to a Baton Rouge facility several days after the storm, officials had difficulty locating families of several of the New Orleans youths.¹⁶⁶ In addition, the juvenile records of the detainees were left behind in the flood ravaged city, which stalled officials' efforts to determine who could be released to family and who needed to remain in custody.¹⁶⁷ About 50 youths had been admitted to detention centers shortly before the storm, and had to wait weeks for their initial court hearings.¹⁶⁸

The Orleans Parish Juvenile Court, which moved operations to Baton Rouge and recruited public defenders and assistant district attorneys to hold hearings and conduct trials, was able to hold its first post-storm hearing just over three weeks after the storm.¹⁶⁹ Within two months, every eligible juvenile inmate had been released, placed on probation

¹⁶⁴ Juvenile Justice Project of Louisiana (JJPL), *Treated Like Trash: Juvenile Detention in New Orleans before, during, and after Hurricane Katrina*, (New Orleans, LA: JJPL, 2006), 5, http://www.jjpl.org/PDF/treated_like_trash.pdf.

¹⁶⁵ Juvenile Justice Project of Louisiana (JJPL), *Treated Like Trash: Juvenile Detention in New Orleans before, during, and after Hurricane Katrina*, (New Orleans, LA: JJPL, 2006), 5, http://www.jjpl.org/PDF/treated_like_trash.pdf.

¹⁶⁶ Allen Powell II, "State Searching for Families of Some Youth Detention Center Residents," *Times-Picayune*, September 15, 2005, Hurricane Katrina: Special Coverage Section.

¹⁶⁷ Allen Powell II, "State Searching for Families of Some Youth Detention Center Residents," *Times-Picayune*, September 15, 2005, Hurricane Katrina: Special Coverage Section.

¹⁶⁸ Allen Powell II, "State Searching for Families of Some Youth Detention Center Residents," *Times-Picayune*, September 15, 2005, Hurricane Katrina: Special Coverage Section.

¹⁶⁹ Richard A. Webster, "Not Child's Play," *New Orleans CityBusiness*, May 8, 2006, <http://www.neworleanscitybusiness.com/viewStory.cfm?recID=15477>.

or sentenced.¹⁷⁰ While the Court's effort in reestablishing operations in the storm's aftermath is commendable, the horrors experienced by the juveniles while detained at Orleans Parish Prison, along with some of the difficulties they encountered thereafter, could have been avoided with better planning and preparation. It is therefore critical that state juvenile justice systems ensure that all residential treatment, correctional, and detention facilities that house juveniles via court-ordered placements have comprehensive disaster plans.

Although a baseline level of disaster planning is required for state child welfare agencies, there is currently no parallel federal law requiring state juvenile justice systems to have comprehensive disaster plans in place. In addition, little information is available regarding the level of disaster preparedness among state juvenile justice systems and residential, correctional and detention facilities.

Accordingly, the Commission recommends that an advisory committee be formed to include members from relevant federal, state, and local agencies and nongovernmental stakeholders with expertise in managing and providing services within juvenile justice systems, including juvenile courts, as well as members with disaster management experience. The advisory committee would:

- Identify common gaps and shortcomings in state disaster planning, best practices, and develop and disseminate guidance and model disaster plans for state juvenile justice systems;
- Provide technical assistance and training to states; and
- Encourage state juvenile justice systems to develop or update disaster plans in coordination with state emergency management and key stakeholders including juvenile courts, residential treatment, correctional, and detention facilities that house juveniles via court-ordered placements, and social services agencies.

¹⁷⁰ Richard A. Webster, "Not Child's Play," *New Orleans CityBusiness*, May 8, 2006, <http://www.neworleanscitybusiness.com/viewStory.cfm?recID=15477>.

The Commission met with the Office of Juvenile Justice and Delinquency Prevention (OJJDP), within the U.S. Department of Justice, to discuss creative ways to support state planning activities and bring state juvenile justice disaster planning to the forefront of the agenda. The Commission will collaborate with the OJJDP to identify mechanisms to support the efforts of state agencies and to elevate the importance of juvenile justice disaster planning. The Commission envisions the recommended advisory committee playing an integral role in facilitating this effort and increasing the disaster preparedness of juvenile justice systems across the nation. An ultimate goal of this partnership is to support the development and implementation of disaster plans that minimize long-term displacement of children housed in residential, correctional and detention facilities from their families and support networks.

DRAFT

9. Sheltering Standards, Services, and Supplies

Recommendation 9.1: Provide a safe and secure mass care shelter environment for children, including appropriate access to essential services and supplies.

- *Develop and implement permanent national standards and indicators for mass care shelters that are specific and responsive to children.*
- *Develop a list of essential age-appropriate shelter supplies for infants and children and fund creation of caches to support shelter operations.*
- *Ensure the implementation of standards and training to mitigate risks unique to children in shelters including child abduction and sex offenders.*
- *Ensure all shelter operators have access to a fast, accurate and low-cost system for conducting national, fingerprint-based criminal history background checks for shelter workers and volunteers before they enter a shelter containing children.*

Sheltering services in disasters typically are provided by a core group of National Voluntary Organizations Active in Disasters. These core agencies operate under agreed upon standards and protocols, including basic care of children. The Commission determined that a more comprehensive body of information is necessary to provide guidance about children to local emergency planners, shelter managers and staff.

The Commission facilitated the development and dissemination of a draft document, *Standards and Indicators for Disaster Shelter Care for Children* (Annex B). The document is being piloted in the field by the American Red Cross (ARC) and selected state and local emergency agencies during the 2009 hurricane season. The availability of services and supplies relevant to infants and children would be included in Federal shelter assessment tools in the field. The standards and indicators will be evaluated and revised, as necessary, and incorporated into comprehensive documents that provide general shelter guidelines and training for shelter managers and staff.¹⁷¹ In addition, the Commission has engaged the Department of Justice to address the needs of children with disabilities and chronic medical needs in shelters, including the needs of children who have parents with disabilities or chronic medical needs.

¹⁷¹ For example, they can be incorporated into the Common Standards of Care for Domestic Disaster Response in development by the coalition group National Voluntary Organizations Active in Disasters.

The Commission also facilitated the development of a list of age-appropriate shelter supplies for infants and toddlers. Based upon this list, federal, state and local disaster supply caches can be created to support shelter managers with essential and cost-reimbursable supplies (i.e. formula, food, diapers, etc.) prior to the opening of shelters.

The Commission recommends that all shelter operators establish protocols to ensure the safety and security of children. A fast, accurate and low-cost system for conducting national, fingerprint-based criminal history background checks for shelter workers and volunteers would help prevent sex offenders from entering shelters and coming in contact with children. In addition, all shelter workers and volunteers should be trained to identify and address suspicious and inappropriate activity.

Systems must also be in place to allow for appropriate tracking of children and families in shelters and to share appropriate information for the purpose of family unification. Protocols should prevent families from being separated during evacuations and ensure they are sheltered together. Staff must be aware of protocols to handle unaccompanied minors, homeless youth or self-evacuated youth that present at shelters, and to pre-plan for children with special needs. Additional protocols may be required to ensure the rapid reunification of children separated from their families.

Development of an electronic database and records management system would facilitate an accurate daily count of children in shelters, grouped by age and needs, and assist in the location of children residing in shelters. Demographic information would be useful to shelter managers in responding to the medical, behavioral, academic, mental health and basic daily needs of children in a timely manner. The current version of the National Shelter System is owned and maintained by the ARC and does not collect demographic information on children. The system relies upon self-reported aggregate information from shelter managers based on the daily number of

occupied beds. FEMA has also developed its own version of the National Shelter System¹⁷² and is working with the ARC to achieve integration of the two systems via automatic electronic updates by early 2010.¹⁷³ The Commission recommends that integration include demographic and needs data on children.

Recognizing the strong bonds between children and their pets, the Commission also recommends guidance and planning be provided for the location of pet shelters in close proximity to shelters, whenever possible.

¹⁷² The National Shelter System (NSS) is a comprehensive web-based, data system created to support agencies (government and non-government) responsible for elements of shelter management. The NSS allows users to identify, track, analyze, and report on shelter data in a consistent and reliable manner. The NSS supports Emergency Support Function (ESF 6) - Mass Care, Housing, and Human Services. U.S. Department of Homeland Security, "National Shelter System," Federal Emergency Management Agency, <http://www.fema.gov/about/regions/regioni/bridge8-3.shtm>.

¹⁷³ Personal communication to Tener Veenema from Scott Richardson, FEMA National Shelter System Point of Contact, August 20, 2009.

10. Housing

Recommendation 10.1: Prioritize families with school-age children, especially those families with children having special health, mental health or educational needs, for disaster housing assistance and permanent housing.

- *Establish within the Implementation Plan of the National Disaster Housing Strategy an emphasis on the delivery of social services and improvement of the living environment for children throughout all phases of disaster housing assistance.*

When forced to move several times or relocate to unfamiliar communities or temporary housing following a disaster, children may suffer emotional stress as a result of separation from family, friends and social networks, and exposure to unfamiliar geographic and cultural environments.¹⁷⁴ Children displaced following Hurricane Katrina experienced an average of three moves per child.¹⁷⁵ Research indicates that it takes anywhere from four to six months to recover academically from a disruption like moving more than twice in one school year.¹⁷⁶ In addition, children living in FEMA trailer camps following Katrina and Rita faced a variety of medical, physical and social hazards,^{177 178} and six months after Hurricane Katrina, 34 percent of children in living in FEMA-subsidized community settings had at least one diagnosed chronic medical health condition.¹⁷⁹

¹⁷⁴ Lori Peek, "Children and Disasters: Understanding Vulnerability, Developing Capacities, and Promoting Resilience - an Introduction," *Children, Youth and Environments* 18, no. 1 (2008), 4-7.

¹⁷⁵ Anne Westbrook Lauten and Kimberly Leitz, "A Look at the Standards Gap: Comparing Child Protection Responses in the Aftermath of Hurricane Katrina and the Indian Ocean Tsunami," *Children, Youth and Environments* 18, no. 1 (2008), 187.

¹⁷⁶ Laurene M. Heyback and Patricia Nix-Hodes, "Reducing Mobility: Good for Kids, Good for Schools," *The Beam: The Newsletter for the National Association for the Education of Homeless Children and Youth* 9, no. 1 (1999), 5.

¹⁷⁷ Shane Townsend, and Nathalie Dajko, *Rapid Assessments of Temporary Housing Camps for Hurricane-Displaced Children and Families*, (Westport, CT: Save the Children, 2006), 1-2.

¹⁷⁸ David Abramson and Richard Garfield, *On the Edge: Children and Families Displaced by Hurricanes Katrina and Rita Face a Looming Medical and Mental Health Crisis*, (New York: National Center for Disaster Preparedness and Operation Assist, Mailman School of Public Health, Columbia University, 2006), 13-19,
http://www.preventionweb.net/files/2958_On20the20Edge20LCAFH20Final20ReportColumbia20University.pdf.

¹⁷⁹ David Abramson and Richard Garfield, *On the Edge: Children and Families Displaced by Hurricanes Katrina and Rita Face a Looming Medical and Mental Health Crisis*, (New York: National Center for Disaster Preparedness and Operation Assist, Mailman School of Public Health, Columbia University, 2006), 1,

Access to adequate housing is a precondition for many other elements of a family's recovery following a disaster, including returning children to schools and child care, returning parents to work, and reconnecting children with their medical care providers. To help create a stable environment and minimize the harmful effects that can occur when children's lives are disrupted by a disaster, housing recovery plans should facilitate quick and seamless transitions from emergency shelters to temporary housing to permanent housing. Lessons learned from previous disasters suggest that the goal for post-disaster housing should be to keep children and families linked to the support networks within their communities by enabling them to remain in or return to their homes as quickly as possible, reducing the need for shelters and temporary housing options, and preventing minor damage from developing into major damage.¹⁸⁰ Families who are unable to return to their own homes should be provided with safe, healthy, stable, adequate and affordable housing in their home communities whenever possible. Throughout the trajectory of emergency sheltering to interim and permanent housing, children's safety, and physical, mental and behavioral well-being must be prioritized.

In the aftermath of an event where the severity and magnitude warrants a declaration by the President, the 2009 National Disaster Housing Strategy articulates FEMA's initial actions that focus on supporting State efforts to ensure that all disaster survivors are sheltered safely and securely, with access to food and other necessary life-sustaining commodities and resources.¹⁸¹ The Commission supports the six goals for disaster housing assistance addressed in the National Disaster Housing Strategy¹⁸² and

http://www.preventionweb.net/files/2958_On20the20Edge20LCAFH20Final20ReportColumbia20University.pdf.

¹⁸⁰ Habitat for Humanity, Letter to the Commission, June 8, 2009.

¹⁸¹ "National Disaster Housing Strategy," ed. Federal Emergency Management Agency (Washington, DC: FEMA, 2009), 88-90, <http://www.fema.gov/pdf/emergency/disasterhousing/NDHS-core.pdf>.

¹⁸² National Goals: 1) Support individuals, households, and communities in returning to self-sufficiency as quickly as possible. 2) Affirm and fulfill fundamental disaster housing responsibilities and roles. 3) Increase our collective understanding and ability to meet the needs of disaster victims and affected communities. 4) Build capabilities to provide a broad range of flexible housing options, including sheltering, interim housing, and permanent housing. 5) Better integrate disaster housing assistance with related community support services and long-term recovery efforts. 6) Improve disaster housing planning to better recover from disasters, including catastrophic events. "National Disaster Housing Strategy," ed.

recommends integration of child-specific priorities throughout the forthcoming Implementation Plan.

In addition, the Commission recommends that representation on both the National Disaster Housing Taskforce, and its complimentary state taskforces, include persons with subject matter expertise related to children and the programs that serve their health, mental health, educational and social services needs, and a working group formed to specifically address these needs..

The Commission also supports FEMA's strategy that community sites of factory-built housing units ("trailers" or "temporary housing camps") be used only as "an option of last resort."¹⁸³ However, when community sites are erected in situations where all other options have been exhausted, it is essential that these sites be designed and built to better meet the needs of children and families. In the temporary housing camps constructed in the wake of Hurricane Katrina, "overcrowding, unsafe environments and alienation from surrounding communities put children at risk."¹⁸⁴ To improve community site operations that were deleterious to children's health, safety and well-being, PKEMRA required a plan for the operation of community sites, "including access to public services, site management, security, and site density."¹⁸⁵

FEMA recognizes that access to educational institutions, places of employment and essential social services such as public transportation, emergency services, and healthcare facilities, must be considered during the process of planning and designing a community site.¹⁸⁶ Although FEMA states that the availability of these and other wrap-around

Federal Emergency Management Agency (Washington, DC: FEMA, 2009), 4-5, <http://www.fema.gov/pdf/emergency/disasterhousing/NDHS-core.pdf>.

¹⁸³ "National Disaster Housing Strategy," ed. Federal Emergency Management Agency (Washington, DC: FEMA, 2009), 99, <http://www.fema.gov/pdf/emergency/disasterhousing/AnnexesAll.pdf>.

¹⁸⁴ Shane Townsend, and Nathalie Dajko, *Rapid Assessments of Temporary Housing Camps for Hurricane-Displaced Children and Families*, (Westport, CT: Save the Children, 2006), 3.

¹⁸⁵ P.L. 109-295; 120 Stat. 1394.

¹⁸⁶ "National Disaster Housing Strategy," ed. Federal Emergency Management Agency (Washington, DC: FEMA, 2009), 52, <http://www.fema.gov/pdf/emergency/disasterhousing/NDHS-core.pdf>.

services¹⁸⁷ “should be considered during the community site design process,” it also acknowledges that positioning a community site in close proximity to these services is not always possible and maintains that “the Stafford Act currently provides no specific authorities to FEMA for these temporary augmentations,” such as child care, playground facilities and/or other services for children, to community sites.¹⁸⁸

To address the social service needs of people living in interim housing, FEMA intends to rely on community groups, such as faith-based and volunteer organizations, and municipal organizations, such as local housing authorities.¹⁸⁹ In its forthcoming Implementation Plan, FEMA must clearly delineate the roles and responsibilities of all stakeholders involved in community site design and operations and establish a clear plan to better facilitate the delivery of social services and improve the living environment for children and families in community sites. As recommended in a 2006 Save the Children report, the Implementation Plan must address how FEMA will support its partner agencies in recovery to:

- Provide access to basic services including, but not limited to, transportation, emergency services, education, healthcare facilities, food shopping, laundry facilities, and child care;
- Link residents with state and local resources;
- Facilitate integration into local communities;
- Improve school integration;
- Improve the physical environment to include playgrounds, lighting, ramps, signage for children, etc.;
- Create a communal space for children and parents; and

¹⁸⁷ “The term ‘wrap-around services’ includes the delivery of infrastructure and additional social services to affected residents living on temporary housing sites that go beyond a physical need for housing.” “National Disaster Housing Strategy,” ed. Federal Emergency Management Agency (Washington, DC: FEMA, 2009), 109, <http://www.fema.gov/pdf/emergency/disasterhousing/AnnexesAll.pdf>.

¹⁸⁸ “National Disaster Housing Strategy,” ed. Federal Emergency Management Agency (Washington, DC: FEMA, 2009), 109-10, <http://www.fema.gov/pdf/emergency/disasterhousing/AnnexesAll.pdf>.

¹⁸⁹ “National Disaster Housing Strategy,” ed. Federal Emergency Management Agency (Washington, DC: FEMA, 2009), 52, <http://www.fema.gov/pdf/emergency/disasterhousing/NDHS-core.pdf>.

- Ensure the provision of basic activities such as child play and social activities.¹⁹⁰

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According to a recent report from the Ad Hoc Subcommittee on Disaster Recovery of the U. S. Senate Committee on Homeland Security and Governmental Affairs, FEMA's heavy reliance on trailers in recent disasters has "proved less healthy, cost effective, livable, or humane" for families than rental housing would have been for intermediate and long term housing recovery needs.¹⁹² PKEMRA established a rental repair pilot program, which was implemented in two disasters of different incident types until the program's expiration on December 31, 2008.¹⁹³ The pilot program provided adequate, cost-effective temporary housing to individuals and households by funding repairs to existing multi-family rental housing units. An expanded rental repair program has the potential not only to facilitate recovery by increasing rental stock and affordable housing in disaster stricken areas, but also to help prevent children and families from exposure to many of the well-documented dangers associated with living in manufactured housing and community sites. Furthermore, FEMA estimated that the cost of providing housing via its rental repair pilot program in one pilot site was 83 percent less than the cost of providing manufactured housing, and 66 percent less in the other.¹⁹⁴ Any pilot or permanent rental repair program established to expand affordable housing options in disaster-affected jurisdictions should prioritize assistance to families with children.

¹⁹⁰ Shane Townsend, and Nathalie Dajko, *Rapid Assessments of Temporary Housing Camps for Hurricane-Displaced Children and Families*, (Westport, CT: Save the Children, 2006), 3.

¹⁹¹ "Play is at the heart of what it means to be a kid," and is critical to their mental well-being. It is imperative that following a disaster, children are provided protective, restorative environments where they can return to being a kid as soon as possible. In this pursuit, Project K.I.D. established PlayCare disaster child care sites across coastal Mississippi, Alabama and Louisiana, and worked on-the-ground with over 5,000 children in storm devastated areas in the aftermath Hurricane Katrina. ¹⁹¹ Lenore T. Ealy, and Paige Ellison-Smith, *To Hold Safe: Framing a New Era of Disaster Child Care*, (Carmel, IN: Project K.I.D., 2007), 2.

¹⁹² "Far from Home: Deficiencies in Federal Disaster Housing Assistance after Hurricanes Katrina and Rita and Recommendations for Improvement," ed. U.S. Senate Committee on Homeland Security and Governmental Affairs (Washington, DC: U.S. Government Printing Office, 2009), 274, <http://www.gpoaccess.gov/congress/index.html>.

¹⁹³ "Individuals and Households Pilot Program: Fiscal Year 2009 Report to Congress," ed. US Department of Homeland Security (Washington DC: FEMA, 2009), 1-2.

¹⁹⁴ "Individuals and Households Pilot Program: Fiscal Year 2009 Report to Congress," ed. US Department of Homeland Security (Washington DC: FEMA, 2009), 4.

11. Evacuation

Recommendation 11.1: Develop an effective national evacuee tracking and family reunification system that ensures the safety and well-being of children.

Hurricane Katrina provided a graphic illustration of the challenges in our national disaster response capacity regarding evacuation, tracking and family reunification. Parents and guardians were separated from their children, as far as hundreds of miles apart. Downed communication lines, and lack of centralized record keeping and the absence of a tracking system logging evacuees' movements hampered survivors' abilities to locate family members.¹⁹⁵ Following Hurricanes Katrina and Rita, the National Center for Missing and Exploited Children received over 34,000 calls on the hotline they established and devoted specifically to reuniting children missing as a result of the two storms, with 5,192 children separated from their families.¹⁹⁶ Three months after the storms, 4,371 children had been reunited with their families, but 740 children remained separated from their parents or guardians.¹⁹⁷ After six months of separation, the last missing child was reunited with her family.¹⁹⁸

Depending on their stage of development, children may be unable to provide their name, address, or phone number, or may be too frightened to give any information to aid in reunification efforts.¹⁹⁹ The rapid identification, protection, and reunification of separated children with their guardians can help to minimize secondary injuries such as

¹⁹⁵ Daniel D. Broughton, Ernest E. Allen, Robert E. Hannemann, and Joshua E. Petrikin, "Getting 5000 Families Back Together: Reuniting Fractured Families after a Disaster: The Role of the National Center for Missing & Exploited Children," *Pediatrics* 117, no. 5 (2006): S442-5, <http://pediatrics.aappublications.org/cgi/reprint/117/5/S2/S442>.

¹⁹⁶ Sarita Chung, and Michael Shannon, "Reuniting Children with Their Families During Disasters: A Proposed Plan for Greater Success," *American Journal of Disaster Medicine* 2, no. 3 (2007): 114.

¹⁹⁷ Sarita Chung and Michael Shannon. "Reuniting Children with Their Families During Disasters: A Proposed Plan for Greater Success," *American Journal of Disaster Medicine* 2, no. 3 (2007): 114.

¹⁹⁸ Sarita Chung and Michael Shannon. "Reuniting Children with Their Families During Disasters: A Proposed Plan for Greater Success," *American Journal of Disaster Medicine* 2, no. 3 (2007): 114.

¹⁹⁹ Sarita Chung and Michael Shannon. "Reuniting Children with Their Families During Disasters: A Proposed Plan for Greater Success," *American Journal of Disaster Medicine* 2, no. 3 (2007): 116-7.

physical and sexual abuse, neglect, and abduction.²⁰⁰ The separation of children from their guardians also affects the psychological responses of children after a disaster, and places them at greater risk for injury.²⁰¹

Following the Indian Ocean tsunami in 2004, the World Health Organization issued Guiding Principles for tracking and reunification of families following a disaster. These principles state that “[u]naccompanied and separated children should be provided with services aimed at reuniting them with their parents or customary care-givers as quickly as possible.”²⁰² The principles also state that “[i]nterim care should be consistent with the aim of family reunification, and should ensure children’s protection and well-being... Identifying, registering and documenting unaccompanied and separated children are priorities in any emergency and should be carried out as quickly as possible.”²⁰³

PKEMRA authorized the creation of two mechanisms to help locate family members and displaced children after a major emergency or disaster. First, the Act established the National Emergency Child Locator Center within the National Center for Missing and Exploited Children to provide assistance in locating displaced children and reunifying missing children with their families. The Act also required the FEMA Administrator to establish the National Emergency Family Registry and Locator System to help reunify separated families.^{204 205}

²⁰⁰ Mark A. Brandenburg, Sue M. Watkins, Karin L. Brandenburg, and Christoph Schieche, "Operation Child-ID: Reunifying Children with Their Legal Guardians after Hurricane Katrina," *Disasters* 31, no. 3 (2007): 277-87.

²⁰¹ Mark A. Brandenburg, Sue M. Watkins, Karin L. Brandenburg, and Christoph Schieche, "Operation Child-ID: Reunifying Children with Their Legal Guardians after Hurricane Katrina," *Disasters* 31, no. 3 (2007): 277-87.

²⁰² World Health Organization, *Unaccompanied and Separated Children in the Tsunami-Affected Countries*, (Maldives: WHO, 2005), http://www.who.org.mv/EN/Section40/Section41_56.htm.

²⁰³ World Health Organization, *Unaccompanied and Separated Children in the Tsunami-Affected Countries*, (Maldives: WHO, 2005), http://www.who.org.mv/EN/Section40/Section41_56.htm.

²⁰⁴ William O. Jenkins Jr., "Emergency Management: Actions to Implement Select Provisions of the Post-Katrina Emergency Management Reform Act," GAO-09-433T, ed. Government Accountability Office (Washington, DC: GAO, 2009).

²⁰⁵ P.L. 109-295; 120 Stat. 1394 (2006).

To date, tracking and family reunification plans have not worked consistently during disasters.²⁰⁶ Although some tracking systems have been developed or are in varying stages of development, current systems are not interoperable and no central data repository exists.²⁰⁷ A November 2008 Congressional Research Service Report recommended that Congress consider expanding FEMA grants for the research and development of new technologies that could improve evacuation planning and operations.²⁰⁸ The American College of Emergency Physicians also recommended the investigation of the use of newer technology (such as digital identification) that can integrate information from multiple sites for identifying and tracking missing individuals, especially children, to assist in the reunification of families.²⁰⁹ While States such as Texas and Louisiana have initiated development of State-wide electronic tracking systems, the need for a national tracking system is buttressed by the fact that many major evacuations across the U.S. result in an average of 3.5 moves per household, often across state lines.²¹⁰

The Agency for Healthcare Research and Quality (AHRQ) developed recommendations for a National Mass Patient and Evacuee Movement, Regulating and Tracking System that could be used during a mass casualty or evacuation incident for the purposes of locating, tracking, and regulating²¹¹ patients and evacuees.²¹² The recommendations for

²⁰⁶ Nancy Blake, and Kathleen Stevenson, "Reunification: Keeping Families Together in Crisis," *Journal of Trauma: Injury, Infection, and Critical Care* 67, no. 2 (2009): S147.

²⁰⁷ Nancy Blake, and Kathleen Stevenson, "Reunification: Keeping Families Together in Crisis," *Journal of Trauma: Injury, Infection, and Critical Care* 67, no. 2 (2009): S147.

²⁰⁸ Bruce R. Lindsay, "Federal Evacuation Policy: Issues for Congress," RL34745, ed. Congressional Research Service (Washington, DC: The Library of Congress, 2008), <http://www.fas.org/sgp/crs/homesec/RL34745.pdf>.

²⁰⁹ American College of Emergency Physicians, Letter to the Commission, June 8, 2009.

²¹⁰ David Abramson and Richard Garfield, *On the Edge: Children and Families Displaced by Hurricanes Katrina and Rita Face a Looming Medical and Mental Health Crisis*, (New York: National Center for Disaster Preparedness and Operation Assist, Mailman School of Public Health, Columbia University, 2006), <http://www.ncdp.mailman.columbia.edu/files/LCAFH.pdf>.

²¹¹ "Regulating is a process that attempts to ensure that a patient or evacuee is transported on an appropriate vehicle to a location that has the staff, equipment, and other supplies that are needed to care for this person." Regulation of child victims could greatly enhance the success of a regional pediatric disaster response system. Tom Rich, Paul Biddinger, Richard Zane, Andrea Hassol, Lucy Savitz, and Margarita Warren, *Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System*, ed. Agency for Healthcare Research and Quality, (Rockville, MD: AHRQ, 2009), <http://www.ahrq.gov/prep/natlsystem/natlsys.pdf>.

²¹² Tom Rich, Paul Biddinger, Richard Zane, Andrea Hassol, Lucy Savitz, and Margarita Warren, *Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System*,

the proposed national system, which would also provide decision support to those with responsibility for patient and evacuee movement and care, health care and transportation resource allocation, and incident management, acknowledged various difficulties associated with implementation, including legal and privacy issues and challenges with interoperability of data management systems.²¹³ The AHRQ proposal recommends that the system obtain much of the data needed to track the location and health status of patients and evacuees electronically from existing systems at health care facilities, disaster shelters, and other locations.²¹⁴ However, the Privacy Act²¹⁵ and Health Insurance Portability and Accountability Act²¹⁶ may present barriers to the sharing of personal information of evacuees,²¹⁷ and thus to the effective implementation of the system for reunification purposes.

A consensus conference on pediatric reunification was hosted by the Pediatric Disaster Resource and Training Center, Los Angeles, in June 2008, and issued recommendations across a broad scope of issues.²¹⁸ The Commission will review and consider these recommendations in the coming year and will continue to investigate the feasibility of implementing a national evacuee tracking and family reunification system and the barriers associated therewith.

ed. Agency for Healthcare Research and Quality, (Rockville, MD: AHRQ, 2009), <http://www.ahrq.gov/prep/natlsystem/natlsys.pdf>.

²¹³ Tom Rich, Paul Biddinger, Richard Zane, Andrea Hassol, Lucy Savitz, and Margarita Warren, *Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System*, ed. Agency for Healthcare Research and Quality, (Rockville, MD: AHRQ, 2009), <http://www.ahrq.gov/prep/natlsystem/natlsys.pdf>.

²¹⁴ Tom Rich, Paul Biddinger, Richard Zane, Andrea Hassol, Lucy Savitz, and Margarita Warren, *Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System*, ed. Agency for Healthcare Research and Quality, (Rockville, MD: AHRQ, 2009), 3, <http://www.ahrq.gov/prep/natlsystem/natlsys.pdf>.

²¹⁵ P.L. 93-579; 5 U.S.C. § 552a (1974).

²¹⁶ P.L. 104-191; 101 Stat. 1936 (1996).

²¹⁷ Tom Rich, Paul Biddinger, Richard Zane, Andrea Hassol, Lucy Savitz, and Margarita Warren, *Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System*, ed. Agency for Healthcare Research and Quality, (Rockville, MD: AHRQ, 2009), 32, 41-43, <http://www.ahrq.gov/prep/natlsystem/natlsys.pdf>.

²¹⁸ Nancy Blake, and Kathleen Stevenson, "Reunification: Keeping Families Together in Crisis," *Journal of Trauma: Injury, Infection, and Critical Care* 67, no. 2 (2009): S147-S51.

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Appendix A: Literature Collection Methodology

Commission staff explored academic databases and websites to identify existing research, reports, policy positions, guidelines, recommendations and identified gaps in the professional literature related to children and disasters using the terms/keywords “child*”, “pediatric”, “disaster”, “all-hazards”, “emergency”, “policy”, “recommendation” or “guidelines” in the title or abstract. These include PubMed, Google Scholar, the Health Services Research Library, and the National Child Resource Center, from the Child Welfare Information Gateway.

Federal government websites and related websites, including Thomas.gov, GAO.gov, OpenCRS.com, EBSCOhost.com, and GalleryWatch.com were searched for reports, findings and recommendation papers either cited in the above searches or containing specific wording on “child”, “disaster”, and “all-hazards.”

Websites of professional, advocacy and other non-governmental organizations related to children and disasters were reviewed for public documents discussing policy, guidelines, recommendations or gaps within the Commission’s scope.

Citations and sources of relevant articles and reports were reviewed to garner any additional papers and reports.

On April 1, 2009 the Commission sent letters requesting information, research articles, reports and policy recommendations to 73 non-governmental stakeholder organizations conducting policy or academic work relating to children’s health and mental health, emergency management, disaster response, human services, housing, children’s education, juvenile justice, and state and local government and legislatures (Appendix C). The Commission received 25 responses. Furthermore, documents from these stakeholder organizations and other various entities and individuals have also been submitted in meetings and by mail and email throughout the Commission’s tenure.

All documents meeting the Commission's scope, including abstracts where available, were entered into an EndNote® X2 database, which serves as the Commission's library. PDF copies of the documents when available were attached to the citations. All documents were scanned for relevant information and categorized when possible. Summary sections of documents were entered in as abstracts for reports. As of September 15, 2009, the database contained xxx documents.

DRAFT

Future Directions

(Placeholder)

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Appendix B: Standards and Indicators for Disaster Shelter Care for Children

Standards and Indicators for Disaster Shelter Care for Children

Purpose

To provide guidance to shelter managers and staff that ensures children have a safe, secure environment during and after a disaster – including appropriate support and access to essential resources.

Standards and Indicators for All Shelters

- Under most circumstances a parent, guardian or caregiver is expected to be the primary resource for their children, age 18 and younger.
- In cases where parents or guardians are not with their children, local law enforcement personnel and local child protective/child welfare services must be contacted to assist with reunification.
- Children are sheltered together with their families or caregivers.
- Every effort is made to designate an area for families away from the general shelter population.
- Family areas should have direct access to bathrooms.
- Parents, guardians, and caregivers are notified that they are expected to accompany their children when they use the bathrooms.
- Every effort is made to set aside space for family interaction:
 - This space is free from outside news sources thereby reducing a child's repeated exposure to coverage of the disaster.
 - If age-appropriate toys are available they will be in this space, with play supervised by parents, guardians or caregivers.
- Shared environmental surfaces in shelters that are frequently touched by children's hands or other body parts should be cleaned and disinfected on a regular basis. High contact areas may include diaper changing surfaces, communal toys, sinks, toilets, doorknobs and floors. These surfaces should be cleaned daily with a 1:10 bleach solution or a commercial equivalent disinfectant based on the manufacturer's cleaning instructions. Local health department authorities may be consulted for further infection control guidance.
- When children exhibit signs of illness, staff will refer children to on-site or local health services personnel for evaluation and will obtain consent from a parent, guardian or caretaker whenever possible.
- When children exhibit signs of emotional stress, staff will refer children to on-site or local disaster mental health personnel and will obtain consent from a parent, guardian or caretaker whenever possible.

- Children in the shelters come in all ages and with unique needs. Age appropriate and nutritious food (including baby formula and baby food) and snacks are available, as soon as possible after needs are identified.
- Diapers are available for infants and children as soon as possible after needs are identified. General guidelines suggest that infants and toddlers need up to 12 diapers a day.
- Blankets, for all appropriate ages, are also available.
- A safe space for breastfeeding women is provided so they may have privacy and a sense of security and support (this can include a curtained off area or providing blankets for privacy).
- Basins and supplies for bathing infants are provided as soon as possible after needs are identified.

Standards and Indicators for Temporary Respite Care for Children

Temporary Respite Care for Children provides temporary relief for children, parents, guardians or caregivers. It is a secure, supervised and supportive play experience for children in a Disaster Recovery Center, assistance center, shelter or other service delivery site. When placing their child or children in this area, parents, guardians or caregivers are required to stay on-site in the disaster recovery center, assistance center or shelter or designate a person to be responsible for their child or children, who shall also be required to stay on-site.

In cases where temporary respite care for children is provided in a Disaster Recovery Center, assistance center, shelter and other service delivery site, the following Standards and Indicators shall apply:

- Temporary respite care for children is provided in a safe, secure environment following a disaster.
- Temporary respite care for children is responsive and equitable. Location, hours of operation and other information about temporary respite care for children is provided and easy for parents, guardians and caregivers to understand.
- All local, state and federal laws, regulations and codes that relate to temporary respite care for children are followed.
- The temporary respite care for children area is free from significant physical hazards and/or architectural barriers and remains fully accessible to all children.
- The temporary respite care for children area has enclosures or dividers to protect children and ensure that children are supervised in a secure environment.
- The temporary respite care for children area is placed close to restrooms and a drinking water source; hand washing and or hand sanitizer stations are available in the temporary respite care for children area.
- Procedures are in place to sign children in and out of the temporary respite care for children area and to ensure children are only released to the parent(s), guardian(s), caregiver(s) or designee(s) listed on the registration form.

- All documents---such as attendance records and registration forms (which include identifying information, parent, guardian or caregiver names and contact information), information about allergies and other special needs, injury and/or incident report forms---are provided, maintained, and available to staff at all times.
- Toys and materials in the temporary respite area are safe and age appropriate.
- Prior to working in the temporary respite care for children area, all shelter staff members must receive training and orientation. In addition, such staff must successfully complete a criminal and sexual offender background check. Spontaneous volunteers are not permitted. When inside the temporary respite area, staff shall visibly display proper credentials above the waist at all times.
- When children are present, at least two adults are to be present at all times. No child should be left alone with one adult who is not their parent, guardian or caregiver.
- All staff members must be 18 years or older. Supervision of the temporary respite care for children area is provided by a staff person at least 21 years of age.
- An evacuation plan will be developed with a designated meeting place outside the center. The evacuation plan will be posted and communicated to parent(s), caregiver(s), and guardian(s) when registering their child.
- The child to staff ratio is appropriate to the space available and to the ages and needs of the children in the temporary respite care for children area at any time.

Appendix C: Stakeholder Outreach

To inform its work, The National Commission on Children and Disasters requested information, reports, research findings, and policy recommendations from the following non-governmental organizations:

American Academy of Family Physicians
American Academy of Pediatrics†*§
American Bar Association Center on Children and the Law†*
American Association of School Administrators
American College of Emergency Physicians†*
American College of Nurse Midwives
American Federation of Teachers*
American Medical Association
American Nurses Association†
American Public Health Association
American Red Cross†*
America's Promise
Annie E. Casey Foundation†
Association of Maternal and Child Health Programs*§
Association of State and Territorial Health Officials§
Association of the Schools of Public Health, Centers for Public Health Preparedness
Association of Women's Health, Obstetric & Neonatal Nurses
Brethren Disaster Ministries, Children's Disaster Services†
Catholic Charities U.S.A.†
Center for Education Reform
Children & Family Futures
Children's Defense Fund
Children's National Medical Center
Church World Service
CityMatch
Coalition for Global School Safety
Congressional Research Service§
Council of Juvenile Correctional Administrators†
Council of State Governments
Early Childhood and Family Learning Foundation†
Education Commission of the States
Emergency Management Assistance Compact Advisory Group§
Episcopal Diocese of Louisiana†
Families of September 11th †
Feeding America*
First Star
Food Research and Action Center§
Habitat for Humanity*
Health Care Centers in Schools†
Home Safety Council

Institute of Women's Policy Research
 International Association of Chiefs of Police
 International Association of Emergency Managers†*
 International Association of Fire Chiefs*
 International City/County Management Association
 LAUSD/RAND/UCLA Trauma Services Adaptation Center for Schools and
 Communities†
 Louisiana Family Recovery Corps†*
 March of Dimes
 Mississippi Coast Interfaith Disaster Task Force
 National Assembly on School-Based Health Care*
 National Association for the Education of Homeless Children & Youth†*
 National Association of Child Care Resource & Referral Agencies†*
 National Association of Children's Hospitals
 National Association of Children's Hospitals and Related Institutions†
 National Association of Counties§
 National Association of County and City Health Officials†*§
 National Association of Emergency Medical Technicians*
 National Association of Pediatric Nurse Practitioners†*
 National Association of School Nurses†
 National Association of School Psychologists
 National Association of State Boards of Education
 National Association of State EMS Officials§
 National Center for Child Traumatic Stress†
 National Center for Disaster Preparedness at Columbia University†
 National Center for Missing and Exploited Children†*
 National Center for School Crisis and Bereavement*
 National Child Traumatic Stress Network
 National Coalition of Children and Disasters§
 National Conference of State Legislatures§
 National Council of Juvenile and Family Court Judges†
 National Education Association*
 National Emergency Management Association†*§
 National Emergency Medical Services Association
 National Governor's Association§
 National Homeland Security Consortium§
 National League of Cities*§
 National School Boards Association†*
 National Voluntary Organizations Active in Disaster†
 Poverty & Race Research Action Council
 Project KID, Inc*
 Ready Communities Partnership
 Ready Moms Alliance*
 Rebuilding Together
 Salvation Army
 Save the Children†§

Southern Baptist Disaster Ministries†
The Children's Health Fund
Trust for America's Health*
United States Breastfeeding Committee§
U.S. Conference of Mayors
White Ribbon Alliance for Safe Motherhood*
Youth Law Center†

† Provided representation to one of the Commission's four subcommittees

* Provided a formal response to the Commission's April 1 outreach letter

§ Held an in-person meeting with the Commission

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