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# CHILDREN AND DISASTERS: A PROGRESS REPORT ON ADDRESSING NEEDS

## HEARING

BEFORE THE

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

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# CHILDREN AND DISASTERS: A PROGRESS REPORT ON ADDRESSING NEEDS

**THURSDAY, DECEMBER 10, 2009**

U.S. SENATE,
AD HOC SUBCOMMITTEE ON DISASTER RECOVERY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 2:30 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Mary L. Landrieu, Chairman of the Subcommittee, presiding.

Present: Senator Landrieu.

## OPENING STATEMENT OF SENATOR LANDRIEU

Senator LANDRIEU. Good afternoon, everyone. Thank you so much for being here today for this hearing of the Subcommittee on Disaster Recovery. We have had a series of hearings on the subject of how the National Government, with our partners at the State and local levels, as well as our nonprofit and private sector partners, can do a better job of preparing for, responding to, and recovering from catastrophic disasters, and I really appreciate all the support from those testifying and those listening in to this hearing today.

Today's hearing is entitled, "Children and Disasters: A Progress Report on Addressing Needs." The Subcommittee's overall objective today is to evaluate the special needs of children during the preparedness, response, and recovery phase of disasters and the extent to which current planning and programs address those needs.

This Subcommittee held a previous hearing on this subject on August 4, 2009. We have convened once again to evaluate the progress that has occurred in the 4 months since.

The National Commission on Children and Disasters was created as a result of the Kids in Disasters Well-Being, Safety, and Health Act, which was introduced in 2007 by Congresswoman Corrine Brown from Florida and Senators Chris Dodd from Connecticut and several of us in the Senate. I was proud to be a cosponsor, along with former Senator Kennedy and 31 other Members of Congress. I want to particularly thank Congresswoman Corrine Brown for her leadership in this area, having passed the bill in the House which established the Commission. We will be hearing from that Commission today.

We will begin by reviewing the recommendations of the Commission's interim report, which was issued on October 14. Next, we will hear from our Federal partners to learn what they have done

since that time to address some of the recommendations. And last, we will discuss the challenges that displaced families and host communities encountered following the Gulf Coast hurricanes in 2005, as they sought health care, day care, child care, and educational opportunities for children that had been displaced.

Let me just briefly start with a 5-minute opening statement and then I will go into introducing our first panel.

We are focused, in particular, on the needs of children because children are the focal point of a family, and parents who cannot find an open school or day care center after a disaster may be forced to relocate to a different community when we are calling on them to rebuild the one that was destroyed. Or parents, if they can't find adequate care for children, have to stay home or stay in a relative's home when we actually need them back at work, because these parents are nurses, doctors, teachers, first responders, construction workers that we depend on for the recovery.

There are 32.5 million families with children in the United States. Ninety percent of them include a parent who works. In 62 percent of the households that contain married couples and children, both parents are members of the workforce. If parents can't work after a disaster, the community, as I said, will have no nurses, teachers, first responders, grocery store owners, gas station operators, carpenters, bus drivers, just to name a few, and it will make the recovery even that much more difficult. So this is an essential component, in this Chairman's view, of recovery and I am pleased to know that I have many people here that share that view with me.

The provision of child care and reopening schools are essential elements to the recovery. We understand that child care facilities are both public and private. Some of them are not-for-profit and therefore eligible for FEMA assistance now. But many are privately owned and operated, mostly operating on very slim profit margins, doing good work in the community. Most of the times, at least in my neighborhood where I grew up, day care centers were run out of people's homes. If those homes have been destroyed by a flood, how do we establish new opportunities to get those day care centers restarted?

I want to show a chart on this issue because this has been a major focus of mine. The chart shows totals after Hurricanes Katrina, Rita, Ike, and Gustav. The chart shows the applications for small business loans for child care centers, so I think you can see there were 327 total applications. There were less than probably a third, 131, that were approved, 124 were declined, and 72 were withdrawn.[1]

When we show the other chart broken down by parish, if you want to show that, it is even more stark.[2] This is just a snapshot of what happened in Louisiana in the same metropolitan area, but different parishes, Orleans Parish, Jefferson Parish, and Saint Bernard. There were 275 day care centers in Orleans Parish in August 2005, and in June 2009, we had climbed, a very difficult climb back up to only 141.

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[1] The chart referenced by Senator Landrieu appears in the Appendix on page 36.
[2] The chart referenced by Senator Landrieu appears in the Appendix on page 37.

But if you look at Saint Bernard Parish that had 26, a smaller parish, they are just barely back up to 13. It will be 5 years this August—5 years. And again, if we can't find places for children, it is hard to find workers, since most parents are workers, and that is one of the main subjects of this hearing. We can't continue to neglect these facilities and families who rely on them nor can we continue to underestimate their importance to a full and robust recovery.

The other charts indicate the number of schools.[1] Do we have those charts up? If you see here, you can see the school situation is still—we are really struggling, and we have our superintendent here to talk about this. And although we have made good progress, you can see the difficulty of this recovery—222 schools post-Katrina. Orleans Parish now has 154. Jefferson Parish has slightly less. And then look at St. Bernard Parish, 22 schools, only 11 open today. And, of course, St. Tammany Parish, which was a hard-hit parish but also one that has recovered more quickly and was a host parish to Orleans Parish. We have three more schools there than we did before. But this is just to show you what the struggle still is.

Reopening schools and day care centers inside the disaster area is critical, but we must also look outside the disaster area and address the needs of displaced families in host communities. Hurricanes Katrina and Rita displaced over 370,000 children along the Gulf Coast, many of whom lost their homes and were unable to return for months. Families had to enroll their children in new schools, new child care centers, new State-run health care programs, and in many instances that was extremely challenging.

The Federal Government and several States established ad hoc programs to assist them. We are going to spend some time in this hearing talking about what worked and whether some of these programs should be made permanent.

Children have unique needs that require specialized planning. As our FEMA Administrator, who is here with us today, Craig Fugate, said, we must ensure that emergency planning accounts for citizens in the community, all citizens, not just able-bodied adults with ample resources. And children are just not small adults. They have special needs, and I agree with him.

Finally, let me mention mental health. As the Commission pointed out, children are disproportionately affected by disasters in comparison to adults when it comes to mental health. Children suffer higher rates of depression, post-traumatic stress disorder, and behavioral problems following a disaster. LSU's Department of Psychiatry screened 12,000 children in schools during the 2005 and 2006 school year. Eighteen percent of them had a family member who was killed in the storm—18 percent. Forty-nine percent, almost 50 percent of the children screened, met the threshold for mental health referral. And 1 year later, that referral rate was lower, but not that low. It was 30 percent.

So according to some good research from GAO that we have reviewed, we know that that is still a great challenge. The greatest

[1] The charts referenced by Senator Landrieu appears in the Appendix on page 38.

barriers to accessing mental health services are transportation, stigmatization, and financial problems.

School-based counseling—and then I will conclude—that same report emphasized an approach to service delivery that I would like to focus on today, which is a model of school-based counseling. Save the Children and RAND have also commended this approach. Schools that require psychological assessments after a disaster can help remove the stigma when all children are being addressed and spoken to. Placing providers in schools helps parents save money on treatment costs and avoid having to leave work and drive their children to the point of service, particularly when the point of service that they used to drive to no longer exists.

This is very important for people to understand. The hospital that was right around the corner is closed. The doctor's office that you used to visit is gone. The doctor has moved to Houston or to Atlanta. It is not the same after a disaster as before, getting your children to these points of service, which literally no longer exist, particularly after a catastrophic disaster.

School counselors also represent an existing workforce that can be trained in advance of a disaster, rather than relying exclusively on counselors only that deploy to the disaster area for a limited time. So hopefully we will hear some good suggestions about school-based counseling today.

And finally, millions of parents, educators, counselors, social workers, nonprofit innovators, and community leaders work hard every day to improve the lives of children in this Nation. Through the continued efforts of the Commission and State and Federal partners that are here today, we must provide strategic leadership and resources to move our children out of harm's way before disaster strikes, get them quickly back into school and to a day care support system that helps their parents get back to work, work that we depend on to rebuild our communities. We must invest in a smart, strategic, community-based support network. That is what this hearing is about today.

So I am pleased to begin this hearing and to introduce our first panel. We will be very happy to hear their remarks on this subject.

Our first witness is Mark Shriver, who Chairs the National Commission. As I said, this Commission was authorized by Congress and recently released its initial report. I really look forward to Mr. Shriver's testimony today as he discusses the interim report and ongoing efforts to address these and other needs.

Next we have Craig Fugate, Administrator of FEMA. This is his third time before this Subcommittee. We are honored to have him speak here again. He previously served as Director of the Florida Division of Emergency Management, so he brings a lot of State experience and, of course, some very well respected national leadership.

Rear Admiral Nicole Lurie is the Assistant Secretary for Preparedness and Response (ASPR) at the U.S. Department of Health and Human Services. The ASPR coordinates interagency activities between Homeland Security and other Federal agencies, State, and local officials to protect civilians from acts of bioterrorism and other public health emergencies. She also testified before this Subcommittee in August. We are pleased to have her here again.

And finally, Bill Modzeleski. He is the Associate Assistant Deputy, U.S. Department of Education, Office of Safe and Drug-Free Schools, where he is involved in the design and development of drug, alcohol, and violence programs. He has 25 years of experience at the local and Federal levels in the area of criminal and juvenile justice. Today, he will discuss Emergency Impact Aid programs created to address the needs of students displaced by Hurricanes Rita and Katrina.

So let us begin with our first panel. You have each been given 5 minutes to summarize your testimony. We are pleased to begin with you, Mr. Shriver and thank you for your leadership.

**TESTIMONY OF MARK K. SHRIVER,[1] CHAIRPERSON, NATIONAL COMMISSION ON CHILDREN AND DISASTERS**

Mr. SHRIVER. Thank you, Madam Chairman. I am very honored to be here once again with the opportunity to testify. The Commission is especially grateful to the Subcommittee and your leadership for your continued and diligent focus on the recovery needs of children affected by disasters.

The Commission's interim report, which you referenced earlier, Madam Chairman, has 21 primary recommendations and 25 supporting statements to help guide the implementation. For today's hearing, I will focus on just a few key areas.

When it comes to long-term recovery, the Commission strongly urged FEMA and the Obama Administration to aggressively intensify efforts to develop a National Disaster Recovery Framework. We are pleased that the President established a Long-Term Disaster Recovery Working Group, and the Commission intends to make meaningful contributions to the report that is due to the President in just a few months and the design framework, which is due in June 2010.

The overarching principle for recovery from disasters, as you have mentioned, Madam Chairman, 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 National Disaster Recovery Framework currently in development should specify services that must be provided to children affected by disasters, such as safe, stable housing; access to physical, mental health, and oral health services; child care; adequate nutrition; disaster case management; and other services.

A specific Federal entity should be designated with oversight, coordination, and guidance responsibilities, as the Commission's report indicates, to create awareness of all forms of Federal assistance to state and localities that address the needs of children and families affected by disasters.

Second, on the disaster case management services front, the Commission is very pleased that FEMA and the Administration for Children and Families have recently come to terms on an interagency agreement that was announced here in front of your Subcommittee a few weeks ago. The ACF model is comprehensive in scope and focused on achieving measurable, positive outcomes for

[1] The prepared statement of Mr. Shriver with attachments appears in the Appendix on page 39.

children and families. ACF's program was originally intended to transfer responsibilities to local agencies as quickly as possible. However, FEMA prefers that the disaster case management responsibilities transfer to the affected State.

Recognizing the difficulties encountered in State-led programs envisioned for Texas and Louisiana, as you know, following Hurricanes Gustav and Ike, which resulted in extensive delays in services being delivered to kids, the Commission has posed a number of questions to FEMA which are in the written testimony, so I won't go through them all, but I think there are a couple of key issues that we have actually spoken to the Administrator about and I think he will probably allude to them, and I think they have some good answers, but I think that bears making sure that we watch that going forward.

As far as child care, Madam Chairman, the charts that you showed behind you are incredibly revealing. Nearly 12 million children under the age of five are in child care each week. 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, guardians, employees, and employers in the aftermath of a disaster.

The Commission sees the reauthorization of the Child Care Development Block Grant program as a prime opportunity to address the lack of basic disaster preparedness among child care providers across the country. There is a report, from Save the Children, which shows that only seven States have child care facilities in schools that meet the basic minimum requirements for child care for disaster planning and response.

The Commission has been collaborating with FEMA to identify areas of potential disaster assistance for child care services. We are very pleased that FEMA, under Administrator Fugate's leadership, has committed to provide temporary facilities for child care providers that sustained damage beyond repair and to support States' efforts to stand up emergency child care facilities and provide emergency child care services for a very brief term in the immediate aftermath of a disaster.

However, the Commission recommends a change to the Stafford Act that would allow FEMA to continue supporting the provision of child care services for a longer duration in the recovery phase and to provide assistance to affected families for placement of children in child care. The major shortcoming of the Stafford Act is the inability to support the repair, restoration, or rebuilding of private, for-profit entities, such as child care facilities, that provide essential community services.

Madam Chairman, I know there is a lot of discussion in the Congress about the fact that there shouldn't be dollars out of the Stafford Act to support for-profit entities, but I think your charts really reveal in very vivid numbers that there has got to be something done. If folks are not in favor of using Federal dollars to assist for-profit entities that are providing essential services, then surely under your leadership we can come up with a creative solution. When you have that many entities not providing services to work-

ing families, it is really a disaster waiting to happen, and it is happening.

Madam Chairman, I know my time is up. There are other statements in the report. The only other thing I did want to say which is not in my testimony is the issue of medical countermeasures. I know Dr. Lurie has been appointed by Secretary Sebelius to look into this issue as a result of the H1N1 virus, and I think it is imperative for this Subcommittee and this Congress to make sure that children's needs are identified throughout that process and throughout the funding mechanisms that are put out to study this issue. The Institute of Medicine is revealing how to deal with issues to provide medical countermeasures in this country, as well. But once again, children's needs are overlooked on so many of these efforts. So I hope that the Subcommittee and your leadership will continue to look at the issue of medical countermeasures in children, which make up over 25 percent of the population not being addressed in those issues.

Thank you very much again for your leadership.

Senator LANDRIEU. Thank you very much. Administrator Fugate.

**TESTIMONY OF HON. W. CRAIG FUGATE,[1] ADMINISTRATOR, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY**

Mr. FUGATE. Good afternoon, Madam Chairman. In August, you asked us to address these issues and we are here today to give you a progress update of what we have been able to accomplish in the last 4 months.

At that time, we announced that we were going to create a Children's Working Group within FEMA to begin addressing the Commission's recommendations and looking at things in a more holistic approach versus developing one box, but really looking across our programs so that as we plan, prepare, respond, and recover from disasters, we incorporate the entire community and recognize that children are 25 percent or more of that community that we plan for.

The Commission's interim report and its steps have really tailored and driven what we have looked at, and working closely with Mark and others from the Commission, we have been trying to address these issues within the scope of authorities we currently have, but also identify issues that may require additional assistance. So I would like to share that progress with you today.

As was reported out by Mark Shriver, we have the interagency agreement with the Administration for Children and Families, and I think this is one of the things that is really important to us in FEMA. We try to explain to people, we are not the team, we are part of a team, and we need to really reach out in the Federal family where that expertise is and bring that in, and this contract and the ability to bring these services forward in this agreement will provide that initial response.

But as Mark pointed out, as well, at the point where this should now be devolved to a State program, where previously FEMA would look at grant requests and the grant for these services on

[1] The prepared statement of Mr. Fugate appears in the Appendix on page 52.

the technical means of the grant, we are partnering back with Administration for Children and Families to help us assess the quality of that grant to ensure that the services that are being proposed are going to be effective in delivery and use the expertise that HHS brings to this process to help us assess that grant versus merely looking at it from the standpoint of was the grant properly filled out.

And I think this gets back to some of the concerns about how effective we were able to bring these programs when they moved to the State and continue them. We are willing to work with States to encourage them to utilize this inter-local agreement and contract back to the service providers if their program is not ready to go.

Some of the other issues that were brought up by the Commission were looking at how we integrate children in all of our areas. So here are some of the steps we took. Yesterday, Secretary Napolitano announced over $2.7 billion in Homeland Security grants now available for the application. We were able to, through the Children's Working Group, develop specific language to go into the grant guidance to address children's issues. This is the first time, if you looked at these grants, that it really says that these activities are eligible. It was never denied they could do it, but we felt it was important to take the recommendations of the Commission and provide specific language in the grant guidance saying that, yes, these types of activities are not only allowable, they are desired in your grant applications.

We also had been working with the Commission over shelter supplies that children need, and Red Cross had taken a leadership role in this. We went back and met with our working group in Red Cross and the Commission to further refine the shelter list of supplies for disasters to incorporate the needs of children. We have taken and have consolidated that list now that the Red Cross is using with the Commission's input are in the process, through our Logistics Directorate, of actually going out and bidding out and building these packages.

Obviously, if a disaster strikes now, we are able to take those lists and go, but we want to incorporate, again, and stay away from sole sourcing or non-competitive bid products, so we are building that into our acquisition schedule. Logistics implies that we should be ready to go sometime in February, but we have the list now if something happens and we need to go.

The last part of it was in child care facilities and services. Again, the Commission made several recommendations, particularly in day care services. We were able to go back, and again, I give a lot of credit to Tracy Wareing and the folks that were leading the charge on the Children's Working Group, to really get with our public assistance folks and clearly get guidance on the fact that we consider providing day care services in the response phase an eligible activity, that we clearly consider, as Mark pointed out, facilities and other temporary facilities to provide those services should be eligible, and clearly indicate that not-for-profit day care centers will also be looked at as eligible if they did not qualify for SBA, for FEMA assistance to an eligible nonprofit for a critical function in the community.

So these are some of the things that we have gone back and made sure that, within our public assistance program under the Stafford Act, we are going to be able to deliver those services.

And so with that, Madam Chairman, we will conclude and appreciate further guidance and any questions you may have.

Senator LANDRIEU. Thank you. Admiral Lurie.

**TESTIMONY OF REAR ADMIRAL NICOLE LURIE, M.D., MSPH,[1] ASSISTANT SECRETARY FOR PREPAREDNESS, U.S. PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Admiral LURIE. Thank you, Madam Chairman. It is a privilege to testify again before you this afternoon. I want, first, also to commend this Subcommittee for its leadership on this critical issue and its focus on children as well as the critical work of the National Commission, and I am thrilled to be joined by my colleagues from FEMA and Education to create really a seamless system to support children in disasters.

I, too, would like to just provide a brief overview of the progress that HHS has made since we last met, and I am also prepared to discuss the action that we have taken to address the Commission's interim recommendations.

Beginning with my office, as you know, ASPR plays a pivotal role in coordinating emergency response efforts across the Department and among our Federal, State, and local partners. As we have done for our H1N1 and recent response to the tsunami in American Samoa, in those efforts, children's focused activities ranged from ensuring the availability of pediatric suspension of antivirals when it was in short supply to deploying emergency physicians trained in pediatric care as well as mental health teams.

We have been using tools such as HavBed and a recent ventilator survey to identify and monitor the surge capacity for children during H1N1. And we have been building on our web capability using mapping methods to be sure that we actually have enhanced awareness to identify where there are pockets of children, particularly disadvantaged children, before we send teams in to assist, including locations of schools and day care facilities, pediatric hospitals, and intensive care services. And we will be adding additional information over the next year on other special needs of children, in addition, language and other needs.

We have also been enhancing the National Disaster Medical System to focus on pediatric issues, and as you may know, we now have appointed a pediatrician as our Deputy Chief Medical Officer. We now have about two-thirds of NDMS clinicians trained in pediatric care and have been evaluating our equipment caches to be sure that they can be modified to meet the needs of children.

You have just heard from Administrator Fugate about the collaboration with the Agency for Children and Families, and we are really thrilled about the progress in that area, as well. As you know, ACF monitors the status of Head Start and child care facilities. During H1, ACF did the same, monitoring closures of all Head Start centers and child care centers. But importantly, also, it facili-

[1] The prepared statement of Admiral Lurie appears in the Appendix on page 56.

tated access to information about how parents and children could protect themselves during the pandemic and help people seek out vaccine and encourage vaccination among particularly vulnerable groups.

And you have just heard about the interagency agreement recently signed between FEMA and ACF, and so I don't feel like I need to go into that further, but we are really very pleased, also, about the ability to preposition contracts so they can be executed, as needed.

CMS has also been active, and as you know, in the aftermath of the hurricanes, CMS developed a model template that States could use to ensure the portability of benefits and really taking a hard look at issues related to enrollment, retention, portability, and coverage. CMS is currently consulting with State Medicaid and CHIP directors and many other stakeholders to make recommendations about how to enhance those efforts, and that work is, I believe, well underway, and we anticipate these efforts will continue to enhance knowledge and ultimately lead to some really solid recommendations about how to improve the coordination of care for displaced children.

With regard to mental health, we all know that effective disaster preparedness is an essential part of SAMHSA's mission. The number of programs they have, including the counseling, training, and assistance program, continue to be active. Since we last testified, our team has met with Commission staff to plan a coordinated response to the interim recommendations, as well as receive the recommendations of our Advisory Committee's Disaster Mental Health Subcommittee, with which there is a great deal of synergy with the Commission recommendations, and we are actively working those issues now.

With regard to the countermeasure issue just identified, we recently convened a pediatric preparedness and response workshop focused on many of these issues, and our recent PHEMCE stakeholders workshop really paid special attention to the development of countermeasures for children. And as we have just seen through the issues about H1N1 and even something as simple as pediatric antivirals, this is just a very critical issue for us moving forward.

Finally, we all know that what happens in early childhood often determines health over the life course, and particularly for those reasons, we remain fully committed to continually improving our efforts to address the recovery of children and look forward to continuing to work with the Subcommittee, colleagues across government, the Commission, and other partners.

I would be happy to answer further questions.

Senator LANDRIEU. Thank you very much. Mr. Modzeleski.

**TESTIMONY OF WILLIAM MODZELESKI,[1] ASSOCIATE ASSISTANT DEPUTY SECRETARY, OFFICE OF SAFE AND DRUG-FREE SCHOOLS, U.S. DEPARTMENT OF EDUCATION**

Mr. MODZELESKI. Thank you, Madam Chairman. Thank you for the opportunity to be here today to discuss how the Department of Education has responded to the needs of children affected by disas-

[1] The prepared statement of Mr. Modzeleski appears in the Appendix on page 72.

ters, including the role that we at the Department of Education played after Hurricanes Rita and Katrina, and to address the recommendations made by the National Commission on Children and Disasters in their October interim report.

I want to begin by providing a brief overview of the status of emergency management planning in elementary and secondary schools. In that regard, I am pleased to report that almost every school in the country has developed an emergency management plan. However, while most schools have these plans, we know from a variety of sources that a number of these plans have weaknesses.

To help schools address these weaknesses and to help ensure that they have the necessary resources to plan for, respond to, and recover from emergencies, we are implementing a variety of activities, including Project SERV, the Readiness Emergency Management for Schools, or REMS Program, the Readiness Emergency Management for Higher Education Program, and the School Counseling Program. Let me provide you a brief overview of each of these.

Project SERV was created by Congress and implemented by the Department of Education in 2001 to help schools restore the learning environment as quickly as possible after experiencing an event that disrupts teaching and learning. Events such as school shootings or natural disasters, including hurricanes, can have a traumatic effect on students, parents, and faculty, and Project SERV funds can be used for additional services that are often needed, such as mental health counseling, security assistance, or substitute teachers.

For example, shortly after Hurricane Katrina struck the Gulf Coast, we made grants totaling $7 million to each of the states that were directly impacted by the hurricane. SERV funds were used for a variety of efforts, including hiring additional counselors and social workers, providing supplemental educational services for students who had missed school, and offering teacher professional development on recovery-related topics.

In February 2008, after the shootings at Virginia Tech and Northern Illinois University, Project SERV was expanded so funds could be awarded to institutions of higher education. Since the inception of the program, we have made 74 awards, all except one to K-through-12 schools, totaling $26 million. The grants were made in response to a variety of traumatic incidents.

The Readiness Emergency Management for Schools initiative was created by Congress and implemented by the Department of Education in 2003. The program is designed to provide funds to districts to create, strengthen, or improve emergency management plans at the district and school building levels. Funds from this initiative can be used by LEAs to train school personnel in emergency management procedures, including training and recovery-related areas, to coordinate with local community partners, and to improve local capacity to sustain emergency management efforts. Since the inception of this program, we made 717 awards to school districts, including awards to Saint Bernard, Saint Tammany, and Jefferson Parishes.

Education also administers the program, Elementary and Secondary School Counseling Program. While not primarily a disaster

recovery program, the program supports enhanced access to mental health services for students and helps schools provide a comprehensive counseling program to meet students' needs, including recovery from a crisis.

Aside from these various programs, Education provides training and technical assistance focused on emergency management to assist schools in their efforts to plan for and recover from disasters. The framework for our emergency management guidance was published in 2003 and provides school officials with information on critical concepts and components of good crisis planning.

In addition to our broad and ongoing efforts to address emergency management in all schools, Education engaged in numerous activities designed specifically to support the recovery effort following Hurricanes Rita and Katrina. In the days, weeks, and months following the hurricanes, Education staff conducted numerous calls, meetings, and training sessions with State and local officials, and provided written guidances needed to respond to concerns. Education also granted waivers to various provisions of fiscal and Administration requirements of the Education Department requirements. Additional information about these programs can be found in my written testimony.

In its interim report, the National Commission on Children and Disasters made two recommendations related to elementary and secondary schools. In Recommendation 7.1, the Commission suggested the establishment of a School Disaster Preparedness Program, including the appropriation of funds to Education for a dedicated and sustained funding stream for all SEAs.

In Recommendation 7.2, the Commission suggested enhancing the ability of school personnel to support children who are traumatized, grieving, or otherwise recovering from a disaster.

We appreciate the Commission's work and believe that the many activities I have discussed here today have helped schools be better prepared to plan for, respond to, and recover from disasters. We are currently reviewing the recommendations to determine what additional actions we may take to provide schools with the most effective emergency management support possible.

Thank you very much.

Senator LANDRIEU. Thank you very much.

I just got a notice that they have just called a vote, but I am going to continue on and then take a brief recess and come back.

Mr. Shriver, let me begin with you. You have done, I guess, the most extensive general work on this subject. What would be the short version of your assessment of how well the Federal agencies are working together to keep children at the focus? Do you think that the agencies are appropriately focused on process or outcomes or a combination? And if you had to tell this Subcommittee about one or two areas of progress or lack thereof, what would those be at this point?

Mr. SHRIVER. It is a long question and I will give you a very short answer. I think that there are a lot of folks that care about this issue. I think the interim report has been received very well. But I think, really, the question is what actions are going to be taken that make a difference in kids' lives. I think there are a lot of folks in the Federal Government that have a lot of responsibility

over a bunch of different areas and it is hard to coordinate that and coordinate it across agencies, departments much less.

I think what has happened at FEMA under Administrator Fugate's leadership is very strong steps to make concrete changes to have a working group and a high-level person on that. That working group cuts across the agency or across FEMA and meets with him and we have, through the Commission, a monthly meeting with the Administrator which forces the issues on a monthly basis, and I think that type of structured, results-driven approach is critical.

I would say that if other agencies across the Federal Government were to do that, that would be fantastic. I think that is a concrete step that reports to a high-level person with strong staff support that makes a difference and is, again, on a monthly basis meeting with the Commission and Commission staff. So there is a lot of accountability on that.

The Administrator and I talked a while ago about the issue of child care, and child care regulations fall under the Child Care Bureau at HHS. They don't have the expertise to lay out plans for disaster preparedness response and recovery. FEMA has that. FEMA doesn't have the expertise to deal with kids and child care facilities. Getting them together to really work on that, where they can form a very strong team and come up with strong results that will help kids in child care facilities be prepared for disasters, that is some work. So I think, frankly——

Senator LANDRIEU. And I might mention on that that SBA has a responsibility to finance them. So they need to be at the table, as well, and I guess my question would be, since FEMA is at these meetings, or you are at the monthly meetings with FEMA, is the Department of Health and Human Services there? Is the Department of Education there? And if so, I would like to hear from you all. And if not, why not? Do you need a special invitation, or do you feel like it is not something that is a priority, or—if you want to start, Admiral.

Admiral LURIE. I will have to confess, I will need to consult with my colleagues at ACF about whether they are at these monthly meetings. I do know that ACF and FEMA have been working extremely actively together and I think this interagency agreement that was signed December 1 is really strong evidence of that and I think there is a full intent to continue to collaborate on the planning and taking advantage of the synergies for which there are.

I know that I meet regularly, as well, with my staff about children's issues now and to look at the kinds of things that we can do going forward, both through H1N1 and through this response, as well as the other opportunities that we have in the countermeasures area.

I am just informed, in fact, that ACF is at this regular meeting, so that is ongoing——

Senator LANDRIEU. Let me just be clear, and it may just be that I am not clear. Administrator Fugate, is it your idea or under your general framework that FEMA is going to enter into an agreement with each Federal agency as it relates to something in their jurisdiction relative to children? For instance, do you perceive that you will have an agreement with the SBA along certain lines, or an

agreement with Health and Human Services, an agreement with Education, so it is a series of interagency agreements between you and these agencies? Or is it going to be one interagency framework or understanding? Could you describe how we are building this, because it is a different kind of approach.

Mr. FUGATE. Yes, Madam Chairman. I think, to be fair to my fellow agencies here, the meetings that we have been having with Mark Shriver and the Commission have really been focused on their specific recommendations to FEMA's delivery of services. As we go through that process, we have been really working on the FEMA side and internal to FEMA to make sure we have gotten that right.

Again, what it does is it puts us in a position to then approach ACF on how do we provide counseling. You guys do this better than us. We need to leverage your expertise. Let us get this agreement in place. So we really, in this first 4 months, have been mainly focused on the Commission's reports that directly stated about FEMA's delivery programs to get that.

I think our national long-term recovery strategy that the President has tasked us with and given Secretary Napolitano and the Secretary of HUD, the co-chairs of that, is really, I think, where we are going to start looking at some of these issues that go beyond the immediate response and get into recovery, and I would envision that to be the framework, that as we take the Commission's recommendations and we have been making sure that we have done outreach to the Commission and their constituencies when we have gone out and had these meetings to have them there, that those things that would be Stafford Act-driven, we are going to work on. But those things that require agencies to support that or that expertise resides in other agencies, we want to build that linkage.

But I think, ultimately, the National Response Framework will probably be the best vehicle to look at some of the more downrange issues, many of the issues you are pointing out here, schools and other things that are going to go beyond just Stafford Act, rebuilding the schools. We have got to make sure we have teachers. We have got to make sure we have all the support mechanisms. Those are the kinds of things that I think that long-term recovery framework is going to give us a better way to hook our agencies together.

Senator LANDRIEU. Well, you know I have shared this with you privately and publicly many times. I don't expect, as the Chairman of this Subcommittee, and I think no one in the Federal Government expects FEMA to do everything. We understand that you have statutory limits and budgetary limits. But what we are looking for FEMA to be is the expert on disaster, the coordinator, the nudger, the pusher, the prodder to other agencies to step up and do what they do so that we can have a successful response and not a patchwork response. We can have a successful recovery, not a patchwork recovery.

And really, as I continue to study and observe this, it is almost breathtaking in the gaps that still exist, even after Hurricanes Katrina and Rita, and even after the good work that you and particularly this Administration has done. We still don't seem to have a consensus almost 4½ years later how to finance day care centers, how to basically accommodate tens to, in the case of Louisiana, re-

member, we had 40,000-plus children displaced—not 400, not 4,000, not 14,000, 40,000—47,000 children looking for a place to go to school on that Monday morning. And we still haven't really resolved that issue at the Federal level as to whether they are going to go to a school that is public, private, Catholic, etc. I mean, this is 4½ years later.

I am looking at a report card from "Are States Prepared to Protect Children During Disasters," from Save the Children, and was actually quite aghast when I saw that over half of the States do not require plans for have evacuation, reunification, or special needs of children in care, including the State of Louisiana, and the States of Kansas and Missouri, which have had tornadoes, including Kentucky, Georgia, and Florida, which have been hit hard recently, that there is no law on the books in those States—even in my own State, which I am floored to learn. They don't have requirements for these evacuation and reunification plans.

Now, I don't know if this Subcommittee has the time to pass legislation requiring all these things. It would seem to me to be sort of a common sense administrative approach, either through holding back Federal funding or saying you can't get Federal funding unless you do these certain things, to require this. So again, I mean, that is part of what this hearing is about, is how much new law do we need and why is this not so obvious to people, particularly given the tragedies that have happened recently just from hurricanes, let alone some of the other disasters that we have experienced.

So if you all would just ponder that, I am going to recess for 10 minutes, go vote and to come back. We will reconvene with maybe a question to each of you all and then go right into the second panel. Thank you very much.

We stand in recess.

[Recess.]

Senator LANDRIEU. Thank you very much for your patience. The meeting will come back to order after our brief recess.

I am going to finish up with a question for each of our first panel and then go right into our second panel.

The Department of Education, as you know, under the really extraordinary leadership, as I vividly remember, of Senator Kennedy and Mike Enzi, Senator Enzi, Congress quickly established the Emergency Impact Aid Program in October 2005 to provide tuition reimbursement for K-through-12 students who were displaced. There were, as I said, over 300,000 students displaced. The Department of Education administered this program until it sunset at the end of the 2005–2006 school year. It served over 180,000 students in 49 States.

According to your review, Mr. Modzeleski, how did that program work? How did it function? What are your views? And should we put something permanent into the law so we could quickly access it again if we needed it?

Mr. MODZELESKI. Thank you, Senator. Please note that, in my written testimony, I provide a lengthy statement about that particular program, and one of the things that really worked very well with that program is the ability to move it out very quickly. Other aspects of that are being reviewed and we would be more than

happy to work with you to give you a complete review of how it worked.

If you would allow me, I would like to take one minute on the question that you had about the evacuation plans from schools because I think it is very important.

Senator LANDRIEU. Go ahead.

Mr. MODZELESKI. We have, as I said, provided funds for 717 school districts in the area of readiness emergency management for schools, trying to get schools prepared to deal with disasters. Our approach has been to provide them with a broad-based rubric to develop their crisis plans, make sure it is an all-hazards plan, make sure it deals with all four phases of crisis planning, and——

Senator LANDRIEU. And how many school districts did you say?

Mr. MODZELESKI. Seven-hundred-and-seventeen.

Senator LANDRIEU. Do you know how many there are in the country?

Mr. MODZELESKI. There are 15,000.

Senator LANDRIEU. OK.

Mr. MODZELESKI. The "however" is that 23 of the 25 largest school districts have received funding, so when we look at the large school districts—when we look at the number of kids who have received funds or have benefitted from funds from the Department of Education for emergency management, it is approximately half. So we have about 50 million kids in schools in this country. We realize that there are a lot of small school systems that haven't received those fundings, and we plan to continue to provide them with funds in FY2010, funds that you have been gracious enough to appropriate.

But on evacuation, the point is that for schools, we must look not only at the district level, but at the school level because every school is different.

We took a look at the Louisiana law, because when the GAO reported on emergency management planning for schools, they basically said that Louisiana did not have a requirement for developing emergency management plans. Well, they do, and their requirement for emergency management plans is similar to a lot of other States, and that is that it is a very broad-based plan. And the reason why many of these plans are broad-based at the State level is because there is a recognition that the districts within the State are very different.

So rather than articulate specifically what needs to be done—because if they did that, it may be ten or 12 pages long of just all the things that need to be done—most States have adopted a procedure for schools which says, broadly speaking, here is what really we want you to do, and based upon your resources, based upon your needs, based upon your expertise to develop plans around that. We have tried to supplement that, and part of my written testimony goes into a rather lengthy discussion about the training and technical assistance that the Department of Education has provided and continues to provide to help schools improve their crisis planning.

Senator LANDRIEU. OK. I would like to ask Administrator Fugate, is this at all either shocking or troubling to you, or do you think this is just the nature of the way this works. This is 4½

years after Hurricane Katrina, and yet more than half the States, even having witnessed what happened, don't seem to have any laws in place requiring just this basic planning requirement. If you could respond.

Mr. FUGATE. I think, in general, when you look at day care, whether States even license day care facilities and those types of activities they are involved in there, this has not been something that has been uniformly applied. As the report shows, some States have requirements for emergency plans and other States do not. Some States only require it around certain hazards, like nuclear power plants.

And again, on the Federal side, our general ability to direct this is looking at what funding is available for day care centers. So, again, it may not be in the Federal Emergency Management Agency, within HHS, the funding that they provide to provide affordable day care. But again, partnering and looking at how we can incentivize that and provide not only a requirement with the Federal dollars to do training, but then provide the materials appropriate.

Because again, as we know, many of these are not very large facilities with a lot of resources, and a lot of times they are, as you point out, very small operations. So we don't want to come in with planning requirements so egregious that we put people out of business. But really, how do we provide them the tools to protect their children while they are there——

Senator LANDRIEU. Well, and I am more concerned—I mean, I am concerned about protecting children in day care centers, but I am also very much focused on how to reestablish them after they are either destroyed or impacted, because I realize that some people may think this is a side item, but again, when you think about rebuilding a community after a disaster, most of the people that can do that are parents.

The electricians have to repair the lines. The contractors have to lay new pavement on the streets. The debris removal teams have to remove trees. Most of those people have children. They are not retirees. Their children are of school age, just by the nature of who is in the workforce.

So this issue of who is taking care of children while you are trying to recover is central to the successful recovery effort. There is just no way around it. And so the sooner that I can grasp that the Federal agencies understand that, the better off we will all be, because it is not just a separate program. It is the basic foundation of recovery.

What is it that we have to do to either provide funding, support, etc, so that the parents that we are depending on to lead the recovery can actually do so, because if we don't, they are going to be taking care of their children while the streets don't get paved, the electric lines don't get up, and hospital operating rooms don't get turned back on because there is no one to run them. I mean, this is a problem in normal, regular life and daily life in America, but it becomes so obvious after a disaster if you have lived through it like I have.

Let me just go on to one or two more questions. For planning requirements for the HHS grants, let me ask Health and Human

Services about something that has come to our attention. You realize that there are thousands and thousands of children in the custody of parents when disasters happen, and grandparents and guardians. But there are also thousands of children actually in the custody of the government. Those would be foster care children.

In Louisiana when Hurricane Katrina hit, we had 5,000 children in foster care. Mississippi had approximately 2,700. Texas had 31,000. Florida had 30,000. And Alabama had 6,000. So just the Gulf Coast, that is almost 75,000 children.

What is our plan for foster children, because some of them may be in group homes with ten or 15 other children. Some of them are in family-like settings. Do we have any special plans in place that if a major hurricane hits the Gulf Coast again, these 75,000 foster care kids who are displaced can do what, go where?

Admiral LURIE. Well, it is certainly fair to say that there was not a plan in place before Hurricanes Katrina and Rita and I think everybody has really recognized the needs and the special needs of these children. As things stand right now, ACF's Children's Bureau very actively works with children in the foster care system, and post-disaster, the SAMHSA crisis counseling people also very frequently encounter children in foster care and families with children in foster care and start to serve as one-stop, at least triage to help children and foster children access the appropriate services.

Similarly, in the middle of response, through our ESF–8 mechanisms, our operations center is able to get everybody across the whole spectrum that touches the health of children involved to try to coordinate acutely.

Going forward, this is clearly one of the things that has to be a piece of a coordinated approach to children and all of the kinds of special issues they have. Going forward, our new Policy Office will have a focus on children, and these are the kinds of issues that absolutely need to be taken up.

Senator LANDRIEU. OK. And again, I just really, really encourage you to really understand just the dynamics of what happens in a major catastrophe and the special needs of this particular population and the limitations of the foster parents who under even normal circumstances struggle, and then when they have lost their home and they have lost any transportation, it makes their ability to meet the contract of fostering extremely difficult.

And finally, let me ask Health and Human Services, a major issue that came up was the portability and reciprocity between States relative to SCHIP. So as children left Louisiana and went to Mississippi, we had difficulty getting not just their medical records, but care for them in the 6 months they were in Mississippi, or if they went to Arkansas or they went to Texas. Has that been addressed, and if so, to what degree and what more do we need to do?

Admiral LURIE. Well, that, too, is just a really important issue to take on. I think it is fair to say that the statutory and regulatory policies within State Medicaid programs have mechanisms in place to ensure the portability issues. That doesn't mean that the parents on the ground understand how to navigate the Medicaid program to do it or that the providers understand on the ground how to do that, and I think that is a place where the connect between the

sort of administrative and bureaucratic procedures and the real life procedures and policies really have fallen apart and not done very well.

As you know, the CHIPRA legislation really requires a very hard look at all of this going forward. CMS has been actively engaged and involved in that. I believe that in the next week or two, in fact, the sort of external stakeholder engagement process will begin. I know there are already a lot of ideas that people have generated internally about how to do this and we are looking forward to much more of this. This has just got to be nailed down.

Senator LANDRIEU. OK. Well, thank you all very much. I am sorry I am going to have to dismiss our first panel. I appreciate your testimony. The record will remain open if there is anything else you would like to submit. And let me thank you all.

To save time, I am going to go through the introductions as the next panel comes forward.

Our first witness will be Paul Pastorek, Superintendent of Education in the State of Louisiana. For the last 20 years, he has been a leader in education reform, not only in our State but throughout the Nation. He formed Next Horizons, a nonprofit organization that serves as a state-wide think tank to connect Louisiana's leadership, spanning education and government. And most importantly, or equally importantly, he served in our State's Elementary Board of Secondary Education on the ground, so he gives a perspective that is real and relevant to the discussion today.

Matt Salo is Legislative Director of Health and Human Services, National Governors Association (NGA). Prior to joining the NGA, he was a health policy analyst at the National Association of State Medicaid Directors. We are appreciative to have him today.

Dr. Melissa Reeves, our third witness, is a certified school psychologist with an extraordinary background in this area.

And finally, Douglas Walker is Clinical Director at Mercy Family Center and Project Fleur-de-lis in Louisiana. We are very proud of that project. In response to the devastation caused by Hurricane Katrina, he created this project as an intermediate and long-term school-based mental health service model. It now operates in over 64 New Orleans schools. We are really proud of the work that he has done and look forward to potentially suggesting this as a national model. We are very anxious to hear his testimony today.

But, Mr. Pastorek, why don't we get started with you, and thank you for taking time out of your busy schedule to be with us.

## TESTIMONY OF PAUL G. PASTOREK,[1] SUPERINTENDENT, LOUISIANA DEPARTMENT OF EDUCATION

Mr. PASTOREK. Thank you, Madam Chairman. I am very pleased to be here today, and I want to thank you, first of all, for your leadership, particularly for our State but also for our Nation. This is a particularly important hearing and we have had quite a few experiences in recent years and I appreciate you allowing me to share those experiences, not only for Hurricanes Katrina and Rita, but also for Hurricanes Gustav and Ike, which was a slight reliving of that, although not quite to scale.

[1] The prepared statement of Mr. Pastorek appears in the Appendix on page 79.

I also want to thank our citizens in this country, our Federal agencies, and our Congress for the help that we did get after Hurricane Katrina. It was as speedy as it could be, I suppose, and it was as important and as substantial as it could be under the circumstances. Notwithstanding that, though, many challenges were experienced and continue to be experienced in Louisiana, all along the Gulf Coast, from both Hurricanes Katrina and Rita.

At that time, we had about 370,000 students in two States, Louisiana and Mississippi, that were displaced immediately after August 29, 2005. My children were part of that displacement, being a resident of New Orleans. Today, we still have many thousands of children who have not returned. In New Orleans itself, we had a population of about 65,000 students. Today, we have a population of about 38,000 students. In Saint Bernard Parish, probably the hardest hit parish from Hurricane Katrina, about 10,000 pre-storm and about 5,200 today. So the ability to recover is a significant challenge when you are dealing with storms of this magnitude.

Now, I would like to submit my testimony, but I am going to just mention a couple of key points that I think are important to keep in mind.

Immediately after the—well, on the onset of the storm, on August 28, when hundreds of thousands of people evacuated—millions of people, really, evacuated from Southeast Louisiana and Southern Mississippi, children moved to other locations. Children moved to Houston, to Baton Rouge, to Shreveport, to Atlanta, and, indeed, to 50 States around the country.

School districts were immediately impacted. When thousands of kids showed up in Baton Rouge the following Monday and Tuesday and Wednesday as they trickled in, and they showed up in Houston, districts had to immediately place teachers in the classroom, immediately had to find textbooks, computers, space, and immediately had to find transportation. Those costs were immediately incurred.

Now, even with the quick action of Congress after this event, and with your leadership, that of former Senator Kennedy, and others, Impact Aid Grants which were provided by Congress did not finally show up until January 2006, which means that districts all over this country had to provide resources to students which they did not plan for and did not really, frankly, have the resources to do.

Now, much was done within the State to reallocate resources, but communities in our State have local taxes and they did not share the local taxes that were formerly received in Orleans Parish associated with children, or formerly received in Saint Charles Parish. So when kids went to Baton Rouge, Baton Rouge's local taxes had to carry that weight of those children, and the same is true for out of State. When kids went to Houston and to Atlanta, they were having to carry that weight, as well, and immediately having to do so. So districts had to dig down deep inside to cash flow the operations until such time as emergency funds were received.

So I want to urge this Subcommittee and I want to urge Congress to consider a permanent fund to be available for these kinds of displacements so that school districts, not only in Louisiana, but all over the country, wherever a disaster may occur, would be immediately available to districts so that we would not have to cash

flow this kind of emergency response on the backs of those receiving school districts.

And the second major point I would like to bring to your attention is the issue of records and recordkeeping for students. When they do move, there are great difficulties in being able to translate the records of these students. Some districts and States are more prepared than others, but having some uniformity in this process would be a great assist for the receiving districts.

Just one example. As we know, special education students have Individualized Education Plans. When they leave Saint Bernard Parish in a hurricane or some other affected area, whether it be in Louisiana or otherwise, they show up at a school in Houston, let us say, and they don't have their IEP. They don't have their record of what grade they are in. And some kids don't actually tell us exactly what their needs are. [Laughter.]

Senator LANDRIEU. No.

Mr. PASTOREK. Some of them want to be in a higher grade than they actually are. [Laughter.]

So it really is a bit of a confusion. So at the end of the day, I would urge you to consider that as you go forward, as well.

And I have other points that I have raised in my testimony and I will reserve those for later comment.

Senator LANDRIEU. I really appreciate that. Thank you so much. Mr. Salo.

**TESTIMONY OF MATT SALO,[1] LEGISLATIVE DIRECTOR FOR HEALTH AND HUMAN SERVICES, NATIONAL GOVERNORS ASSOCIATION**

Mr. SALO. OK. Thank you, Madam Chairman. On behalf of the Nation's Governors, I really appreciate the opportunity to come before you and talk about the State role in making sure that the health care needs of kids were met post-Hurricanes Katrina and Rita.

Clearly, there is nothing we can do to prevent major catastrophes, but as you know, one of the key functions of State and local governments is to prepare for, react appropriately to, and recover from these incidents.

Hurricanes Katrina and Rita, unfortunately, were a disaster of a scope that we couldn't really have prepared for. No one was really prepared for that, and the devastation that the hurricanes and the flooding left in their wake totally ruined the infrastructure of government. It ruined the infrastructure of the health and social services networks all along the Gulf Coast and it was quite the challenge, clearly.

I do think that there are positives to take out of this. I think that we have learned a lot from that experience in knowing where the holes are, where the flaws in our preparedness planning are, where we do need to find improvements in the safety net. And I do think that given all of the challenges, there was an enormous effort on behalf of State officials to try to do as best as they could in that situation.

[1] The prepared statement of Mr. Salo appears in the Appendix on page 82.

Within 24 hours of what was, in effect, the largest and fastest mass migration in this country's history, we had Governors and State Medicaid directors on the phone with each other, with HHS, working and talking constantly to try to figure out how to best track, take care of, and protect the kids and the families, the seniors and people with disabilities who were in nursing homes who were displaced or otherwise affected.

Clearly, we do think we need to do more. Clearly, I think we have learned a lot of lessons. I would say, clearly, we need to spend more time and more focus on thinking about the unique needs of children. I think the point is very well taken that they are not just little adults. But I think it is also important to note that children are, at the end of the day, members of a family unit and it is important to keep that in mind, as well, as we try to really take care of them as best we can.

So with respect to actual recommendations that we would make in terms of what lessons we have learned since the hurricanes, I think four basic thoughts, the first of which is we need to strengthen and build upon the current framework of disaster planning and response. The lessons that we have is that all disaster planning really is local, and truly all disasters are different. Hurricanes Katrina and Rita were very different than sort of the wildfires and the interstate floods you saw in Iowa, and all of those are different than the terrorist attacks of September 11, 2001.

The fact that all of these things are different and the fact that the immediate response is always local means that we need to build upon and strengthen sort of the State and local structure that is there, and I think there are a number of ways that the Federal Government can help us in doing that. I think, clearly, in our work with the Department of Homeland Security, with the sort of tabletop exercises over the past number of years that have operated regionally, trying to respond to various things like hurricanes or avian flu or other terrorist attacks, we have learned a lot. I think we can build those up, we can refocus those on the needs of children.

Specifically what we learned in Louisiana and Mississippi and some of the other States is it is hard to get the infrastructure of the Medicaid system up and running when the State Medicaid employees had to worry about their child care needs. So it is not just the child care needs of the nurses who are taking care of people, but of folks who are actually in the infrastructure itself.

A second piece is funding. I think the funding is critical. We worked very well with HHS on all sorts of different waivers and waiver templates to help kids as they move from Louisiana to Arkansas and in every other State. But at the end of the day, there wasn't anything that HHS could do about the fact that, at the end of the day, those waivers just said the host State had to bill all the services back to the home State, and clearly, Louisiana and Mississippi and the other impacted States could not afford to pay the bills in those times.

Congress did come along and provided 100 percent Medicaid funding, provided uncompensated care package. That was extraordinarily useful. I would argue that I think we need to replicate

that, make it permanent somehow so that enacting that doesn't take quite so long the next time we have a situation like this——

Senator LANDRIEU. You have 30 seconds.

Mr. SALO. And then I think the other—I guess the final piece that I would mention is around health information exchange. It doesn't matter how much money there was or how much planning there was if the only records of someone's medications or of their medical history, kind of like their school records, if they were submerged six feet under dirty water in a metal filing cabinet, they weren't going to help anybody. And I think we have gone a long way towards making sure this country is prepared for an interoperable health information exchange, but we are not there yet and I think we need to continue to move forward. A lot of that will prevent some of the problems that we saw in Hurricanes Katrina and Rita. So thank you.

Senator LANDRIEU. Thank you, Mr. Salo. Dr. Reeves.

**TESTIMONY OF MELISSA REEVES, PH.D.,[1] CHAIRPERSON, PREVENT, REAFFIRM, EVALUATE, PROVIDE AND RESPOND, EXAMINE (PREPaRE) COMMITTEE, NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS**

Ms. REEVES. Good afternoon and thank you, Madam Chairman. It is a privilege to be here today on behalf of the National Association of School Psychologists and to share my view on the critical roles that schools must play in crisis response and recovery. In addition to being a graduate educator at Winthrop University and also a school psychologist, I am also lead developer of the NASP PREPaRE School Crisis Prevention and Intervention Training Curriculum and have more than 15 years of direct experience in helping schools respond to crises.

My remarks today are going to focus on the significant role of schools in keeping our children safe and healthy in the event of a crisis. After both September 11, 2001 and the Gulf Coast hurricanes, we saw America's schools thrust into the center of the Nation's crisis response, and I think it is safe to say that this country would have been unable to meet the needs of children and youth, even to the extent that we have, without our schools. As you have heard today, this support is vital because trauma can have significant psychological consequences that can interfere with learning and development.

First and foremost, schools are where children reside for a significant amount of time each day. The learning environment provides structure, support, and opportunities to build coping skills.

Second, school personnel know the students. They can monitor the residual and emerging effects of the crisis and provide continuity of support over time.

And third, schools are familiar and accessible to families. This increases the likelihood that they will seek and accept support for their children and be more engaged in their children's learning and recovery.

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[1] The prepared statement of Ms. Reeves with an attachment appears in the Appendix on page 88.

Community-based services are also critical to meeting the full continuum of children's needs. However, in schools, community services need to be closely coordinated with those provided by school-employed mental health professionals, such as school psychologists, counselors, social workers, and nurses. Ensuring the ongoing presence of school-employed mental health professionals is important because of our specialized training with children, knowledge of schools, and our familiarity with students.

I saw firsthand as a crisis responder following the Columbine High School shooting, there were many mental health professionals offering assistance, but some lacked the special knowledge and training needed to work in schools with traumatized youth. Those lacking this knowledge were not particularly helpful, and in some cases, they actually did more harm than good.

This brings me to a key point. School crisis response is not a matter of choice for schools. When a crisis occurs, the school can be immediately transformed from an environment focused on learning to a triage center, emergency shelter, evacuation site, counseling center, communication depot, and/or a liaison between families and community services. I can tell you that the entire school staff, including the front office staff, become crisis caregivers who provide a critical sense of normalcy for children.

The problem is that very few schools today are adequately prepared to perform this role. We need legislation that links schools into policies and funding to ensure that all phases of emergency response are efficient and effective.

So what does this look like? Effective school crisis response requires planning and strategies appropriate to the learning environment. These encompass physical and psychological safety, school community collaboration, a designated school crisis response team, and staff training. In training professionals across the country, I have often seen some of these components addressed, but rarely all.

For example, a crisis plan may address physical safety with minimal focus on psychological safety, or staff training may focus on plan development, but not on plan execution.

As a leader with NASP, I have had the privilege to help develop the PREPaRE School Crisis Curriculum designed to help schools build this capacity at the local level. NASP has long been a leader in school crisis response, providing direct support in schools, training, research, and free public resources. The PREPaRE Curriculum was developed by school-based professionals and integrates the U.S. Department of Education's Readiness and Emergency Management Guidelines and the National Incident Management System. PREPaRE combines the important aspects of crisis team and crisis plan development with extensive training on how to minimize children's traumatic impact within the school setting.

To date, PREPaRE has trained close to 5,000 school and community professionals from more than 38 States, we offered it in New Orleans after the hurricane, also in several foreign countries, and in addition, we have trained over 200 local trainers. As one administrator put it. PREPaRE has provided the continuity amongst providers that we have striven to reach for years.

How can Congress help schools build this capacity? We need clear policies that recognize the importance of schools in disaster

and crisis response. These policies must give schools the mandate and funding to develop crisis plans and teams, train school staff, strengthen the schools' capacity to deliver short- and long-term mental health services, and sustain these supports over time.

We need national school crisis response standards and a national repository for best practice resources and technical assistance. We also need research to evaluate the efficacy of school crisis training and strategies. Streamlined access to emergency funds in the event of a crisis with the goal of restoring learning environments as quickly as possible is critical. And we need a clearly-defined mechanism for school-community collaboration that lays out roles, responsibilities, and the use of resources.

Last, schools need an adequate number of school-employed mental health professionals such as school psychologists who can provide the ongoing expertise and support before, during, and following a crisis. These are the professionals trained to link services and interventions to learning, not just in the event of a major disaster, but through daily challenges that affect children's academic achievement and well-being.

Again, I would like to thank you for your leadership on these issues and the opportunity to be here today.

Senator LANDRIEU. Thank you very much for that excellent testimony. Mr. Walker.

**TESTIMONY OF DOUGLAS W. WALKER, PH.D.,[1] PROJECT DIRECTOR, FLEUR-DE-LIS PROJECT**

Mr. WALKER. Thank you, Madam Chairman, for allowing me to represent our State of Louisiana as a child psychologist and a father of two young children.

Friday after the storm, we found ourselves evacuated to East Baton Rouge Parish, and I was lucky enough to be at the right place at the right time to be invited to the Louisiana Department of Education Office of Community Services. When I arrived there to discuss a possible plan, I was shocked to find out, as I was handed the evacuation sheet, that there was no plan. And at the end of that day, they sent me out that weekend to develop a plan for the State.

As politics would have it and the Stafford Act, the calls stopped coming for meetings at the Department of Education, so I turned to the schools that were opening in our area. Along with Father William Maestri, the Catholic Schools, was linked with Catholic Charities and found funding to start what is now called Project Fleur-de-lis. Project Fleur-de-lis is now the largest school-based mental health response to Hurricane Katrina. We currently have 64 schools in our program.

We started in that fall, and gathering a consensus of what the area schools needed. We gathered along the way evidence-based practice and we layered it in such a way that made sense to the needs of our schools.

The first school we entered was Cathedral School in the French Quarter. We chose that school because the first responders children

[1] The prepared statement of Mr. Walker with attachments appears in the Appendix on page 94.

were going there. We were fully operational in our three-tiered model of care in the fall of 2006. One side of the care involves triaging. Every single week for nearly the past 4 years, counselors come to Mercy Family Center and triage kids who are in need of care. Now, early on, they asked me, Dr. Walker, so you are just going to serve the kids who are traumatized, correct? I said, well, tell me who those are going to be. Tell me who. It is everybody. It is my kids. It is your kids, its everyone.

So through funding by Catholic Charities, American Red Cross, Booth-Bricker, Freeport-McMoran, we entered out of the Catholic schools (we still have about 32 Catholic schools) and entered into the charter schools, the public schools, and we also have a couple of private schools. So we have helped as many as 1,000 students with free care, kids every single week provided free care.

Our triage model of care, as far as school-based interventions, involve now psychological first aid. We use PREPaRE, actually, for untimely deaths and CBITS, Cognitive Behavioral Intervention for Trauma in Schools. And at the top of the triangle is Trauma-Focused Cognitive Behavioral Therapy. I am now a certified trainer in CBITS. I have trained over 200 counselors in Southeast Louisiana. Over the past 4 years of service, we have provided services for as many as 200 kids in CBITS, over 100 kids for Trauma-Focused Cognitive Behavioral Therapy, and, of course, are available to provide psychological first aid if, God forbid, we have to roll out that first level of care.

I am proud to say that it is a grassroots organization. Project Fleur-de-lis is part of the Sisters of Mercy Health Care System, and I am a father of two young boys, and I can say that every single night that Project Fleur-de-lis keeps me up at night, but it is why I get up in the morning.

Recommendations—I think that we need to fund intermediate and long-term care, and with particular focus on the schools and providing care in the schools. The Success of Project Fleur-de-lis comes about by two areas of expertise. First and the foremost is the expertise that lies in the school counselors in the schools. They know their community best, and that is why Project Fleur-de-lis has been successful, combining that expertise with evidence-based practice available through the National Child Traumatic Stress Network and other fine organizations such as NASP.

Second recommendation, that we look at a coordinated effort in training school psychologists, mental health professionals, counselors in the community and school-based throughout the United States so when something like this again happens, we have a standard registry to pull from for expertise to help.

Finally, I would like Fleur-de-lis to be considered as best practice, a tiered model of care, finding kids where they live in schools and providing the services they need post-disaster.

Again, Madam Chairman, thank you for your invite today and I look forward to working with you all in the future.

Senator LANDRIEU. Thank you very much, and thank you for creating this new model, and also your passion.

Let me ask you, as a professional, the work that you were doing before Hurricane Katrina and then the work that you started to do after Hurricanes Katrina and Rita with the Fleur-de-lis Project,

what training did you lack that you just had to learn as you went that maybe we should be aware of in just the basic training for your profession? Could you try to describe——

Mr. WALKER. Yes.

Senator LANDRIEU [continuing]. A little bit of your learning curve——

Mr. WALKER. I was minding my own business before the storm. [Laughter.]

I had a fellowship in pediatric psychology and infant mental health, so I knew trauma pretty well by way of hospitals and certainly abuse and neglect of young children by way of those fellowships. What I lacked was evidence-based treatment, treatment that provided not only the best research, but also combined the value and cultures of the community and the expertise of the clinicians themselves.

We were trained first with CBI which was sponsored by Save the Children at the time. That was our large group intervention. Next came that summer was Cognitive Behavioral Intervention for Trauma in Schools. And finally, Trauma-Focused Trauma Behavioral Therapy. And it is a tiered level of care where the large CBI and now psychological first aid blankets an entire school, and that is where you start. That is where you begin. And those kids are then in turn triaged up to CBITS, to small group intervention, usually about ten kids, primarily ages four to nine. And then if those kids, in turn, need additional therapy, then we do more intense work, one-on-one work through Trauma-Focused Cognitive Behavioral Therapy. So those are the things—that have been really our keystones or our building blocks for the past 4 years.

Senator LANDRIEU. Were you limited in any way either by your own vision of the program or the funding you received for actually treating the child in the context of their family? For instance, if brothers and sisters were going to other schools or cousins were in the same school, or a single mom, is the work that would be done at the school level only for the children, or were there times when family members came in, as well?

Mr. WALKER. Well, I would say the time after Hurricane Katrina for all of us was frenetic, and we have a lot of evidence to suggest that traditional mental health therapy in clinics like my own (I still do patient care 2 days a week) is difficult to achieve. We can't expect parents to go to a clinic, like you said before, Madam Chairman, that doesn't exist anymore. It is the schools and it is the kind of a center where we meet up with parents for school meetings, as well.

When children are spread out and treated as a family, that is more of a challenge, when you have a teenager, you have a fourth grader. But we do the best we can and the school environment really needs to be opened up to provide this type of treatment post-Katrina—I mean, after storms, especially when we consider that is where we live and we know the impact of trauma on learning. So it is a slam dunk and a win-win, in my opinion.

Senator LANDRIEU. Mr. Pastorek, two questions. You weren't the Superintendent when Hurricanes Katrina and Rita hit, but you have been for the past few years. Is this issue coming up to you still from your principals and your teachers at schools that are in

the disaster-affected area, how has it come up, and what are you doing about it, or what are some of the things that they share with you about their ongoing needs in this area?

Mr. PASTOREK. Well, I was just in New Orleans a few weeks ago visiting four schools. The challenges are still quite significant. I think the emergency response most readily gravitates to buildings and infrastructure and least easily gravitates to the soft side of supporting kids in this situation.

So you can see relatively quick response on the facility side, even though that was a long response, but relatively quick. But on the psychology, psychological services, the other kinds of services, it has been very difficult, very slow, and very inadequate.

So what I hear from principals is that the numbers of kids who are homeless in New Orleans are much larger than they have ever been before the storm. These are functionally homeless and real homeless, kids who literally are living in other people's homes, kids who are living with non-relatives. And I was at a high school in New Orleans, and you know Ms. Laurie at O. Perry Walker High School. She was telling me that she estimates the numbers of homeless now in her high school at about 20 percent, which is a pretty phenomenal number.

The impact is significant, and when you consider the psychological and psychosocial impact of these kinds of kids who are still suffering from the storm nearly 5 years later, it is significant. And it isn't because people aren't trying, and it isn't because we don't want that to happen. But the infrastructural support and the focus of emergency response and recovery is not really as heavy on that as it could be. So that is part of it.

And then I think the other part of it is that kids who are coming back are coming back today—literally since the start of school in September, we have had 1,700 new students come into the City of New Orleans to return to school, and they come back without really having been in school in a number of cases, living in a homeless-type or functional homeless-type situation. So these kids are coming back with tremendous needs even now, almost 5 years later.

So the challenges are great. The challenges are significant. I think, I don't think people still understand the magnitude of what has happened and how much and how difficult it is.

And then I will add one other piece in here. The impact on the adults who are trying to educate the kids and trying to provide other services to kids are also still being felt. Those people are still trying to recover homes, even today, and trying to rebuild homes. So they are trying to do two things at one time, do their work and rebuild their homes and also manage and take care of their kids. So while there are certainly parts of the city and parts of the school system that have recovered, it continues to be a long slog.

I will give you one final point. We had our first new school that was built from the ground up post-Katrina and it was opened only 3 months ago. We have many schools slated for reopening and we have many facilities slated for reopening. And we have probably moved at lightning speed, frankly, in the education arena at rebuilding schools. But it is still a long haul to go.

Senator LANDRIEU. Ms. Reeves, did you want to add anything to that? I see your head nodding as he is speaking.

Ms. REEVES. Yes. All of their points are really valid and we tend to focus more on what we refer to as physical safety. The psychological safety piece is either completely overlooked or it is really minimized. I know from the schools' perspective, there are a lot of different contributing factors, but one of the biggest pieces is there is a shortage of school-employed mental health professionals. Those that are there are just spread so thin. There are huge ratios of the school-employed mental health professionals to students and they just can't meet all of the needs.

In addition to that, we also have key decision makers within the educational system that draw these arbitrary boundaries between academic achievement and mental health. I even had one decision-maker in a larger school district say to me, "well, mental health is not the responsibility of schools." And I think that person meant that from the aspect of we have so many other priorities coming at us as educational administrators that somewhere we have to say, here is the line. But you can't arbitrarily separate those. They do go hand in hand, and I think all of us today have spoken to the importance of that.

In addition, school-employed mental health professionals, and I will speak from the angle of a school psychologist, still have many ikey decisionmakers and administrators that see us in the role that we were in 20 years ago; which is assessing students for special education qualification. Our roles have expanded tremendously to include direct mental health services. But again, those key decision makers that determine how many school psychologists are going to be employed and determine what our job roles look like, they keep wanting to put us back in that old testing role. And a lot of times, we have barriers put up that don't allow us to utilize our training in providing direct services to children.

The Project Fleur-de-lis is a great example of school-community collaboration and the importance of providing those direct mental health services to kids, and school-employed mental health professionals can help with that if we are allowed to and if we have the resources to be able to do so.

Senator LANDRIEU. Our time is coming to an end, but Mr. Walker, just again for the record, your organization, Fleur-de-lis, received how much money from government sources and how much from charitable contributions?

Mr. WALKER. Yes. We are a proud member now of the National Child Traumatic Stress Network and we are funded for $1.4 million until 2012. We are also currently funded by a——

Senator LANDRIEU. Through a Federal grant?

Mr. WALKER. Federal grant, through SAMHSA, yes, the NCTSI grant. We also currently are funded from Baptist Community Ministries locally. And prior to that, throughout the years, our other major contributors included American Red Cross, Booth-Bricker, Freeport-McMoran local——

Senator LANDRIEU. So it was truly a private——

Mr. WALKER. Yes.

Senator LANDRIEU [continuing]. Not-for-profit——

Mr. WALKER. Correct. Yes.

Senator LANDRIEU [continuing]. And now a government-supported collaboration.

Mr. WALKER. Exactly. We entered the NCTSN last fall, but until 2007, it was a private enterprise.

Senator LANDRIEU. OK. Mr. Salo, do you have anything to add, because I have got one more question for Mr. Pastorek and I didn't want to pass you up. Anything that is on your mind that you want to add or answer?

Mr. SALO. Yes. No. I just think that all of my fellow panelists have raised really legitimate issues. One of the things that I worry about moving forward with is how do we build the capacity to do all these things given the current economy and the state of the State budgets.

Senator LANDRIEU. Well, let me ask you this. Has the National Governors Association either post-Hurricanes Katrina, Rita, Gustav, or Ike, or post any major disaster established a permanent subcommittee among the National Governors to work on these issues. Coordinated evacuation plans? Reciprocity? Have you ever established that through National Governors——

Mr. SALO. Yes.

Senator LANDRIEU [continuing]. And if so, is there one that exists today, such a committee?

Mr. SALO. Yes. We do have our State-Federal affairs side of our organization, sort of a homeland security committee, broadly written, whose function is a lot of these issues. We also have our Center for Best Practices, where we have a number of staff who are devoted precisely to preparedness planning, public health, and a number of the issues that go hand-in-hand with a lot of the Memorandums of Understanding that go on between the States. So we do have that in place. We are there to work with States. I know also the State Medicaid Directors Association was working very well with the States in terms of the Medicaid and sees the SCHIP Directors post-Katrina——

Senator LANDRIEU. Well, I raise that because as this Subcommittee continues this work—this is a special focus, it is not our only focus, but a special focus on pushing through a major piece of legislation relative to reforms regarding how governments and our partners respond and treat and help children recover in the context of children as members of the family. I would really appreciate input from the National Governors Association and potentially maybe establishing some sort of committee for the next 6 months to work with us would be welcomed on our part.

Final question to you, Mr. Pastorek. We are debating right now, how do we establish this reimbursement for students moving from one school to another school and whether that reimbursement should follow the student, whether there should be any restrictions or guidance relative to students going from public school to private school or parochial school to public or public to parochial. Do you have any views on that? Is it wise for us to consider some of those restrictions, or is it better just to let parents get their kids in whatever school they can and figure out the details later?

Mr. PASTOREK. I have given actually great thought to that issue, and frankly, I think you need to have the money following the child, regardless of the sources of either public-private on the starting end or on the receiving end. I think it is extremely important to understand that in this emergency circumstance, people are

struggling to figure out what to do, where to go, and sometimes their choices are quite limited. Sometimes their choices are quite problematic.

So I do think it is important to recognize that everyone is entitled to an education and everyone is entitled to get a quick recovery for themselves to get back in the cycle. And it is important for the children especially not to get into the haggling over where do you come from and where are you going to, but what is the community's obligation to get children back online as promptly as possible.

It is not only from an academic education perspective, but I would argue it is from a psycho-social perspective, as well. Children need to be back in the classroom. That actually was a quite calming influence for children who had to be uprooted and moved from one location—from their home, from their community, from their school—and placed elsewhere. To come back to a school setting is extremely important.

So I think it is very important to be focused on the child and not only the restrictions and so on and so forth, because even applying those restrictions are going to give rise to all kinds of uncertainty on the part of the parent as to what to do, what they can do, what they can't do, and then it causes restraint on them to be able to make decisions that are in the best interest of their children.

Senator LANDRIEU. Thank you very much.

This tuition reimbursement provision will be in the children's bill, which is what we are putting together now. So that is a major portion of this bill.

But I thank you all. Unfortunately, our time to close the hearing has arrived. We have received tremendous testimony. A variety of different issues have come forward, and I thank you all for participating.

Again, the record will stay open for 15 days. Please feel free to add any supplemental material or additional comments from colleagues or others that you would like to submit to the record. We will be using this record to build the provisions of this part of the bill.

So I thank you all very much, and the hearing is adjourned.

[Whereupon, at 4:30 p.m., the Subcommittee was adjourned.]

# APPENDIX

**Opening Statement of Chairman Landrieu**
Subcommittee on Disaster Recovery
*Children and Disasters: A Progress Report on Addressing Needs*
December 10, 2009

**Introduction**

Good afternoon, and thank you all for being here today for this hearing of the Subcommittee on Disaster Recovery. Today's hearing is entitled "Children and Disasters: A Progress Report on Addressing Needs." The committee's overall objective today is to evaluate the special needs of children during the preparedness, response, and recovery phases of disasters and the extent to which current planning and programs address those needs. This committee held a previous hearing on children and disasters on August 4th, and we have convened once again to evaluate the progress that has occurred in the four months since.

**Legislative History of the Children's Commission**

The National Commission on Children and Disasters was created as a result of the "Kids in Disasters Well-Being, Safety, and Health Act," which was introduced in 2007 by Congresswoman Corrine Brown from Florida and Senator Chris Dodd from Connecticut, and enacted as part of the Omnibus Appropriations Act of 2008. I was proud to cosponsor that measure along with Senator Kennedy and 31 other Members of Congress, and very glad that its creation led to this excellent report and our discussion here today.

**Hearing Overview**

We will begin today by reviewing the recommendations of the Commission, which issued its Interim Report on October 14th. Next we will hear from our federal partners to learn what they have done since that time to address recommendations in the report. Lastly, we will discuss the challenges that displaced families and host communities encountered following the Gulf Coast hurricanes in 2005, as they sought to secure health care for children and enroll them in schools and child care.

**Restoring Schools & Child Care Centers**

We are focused in particular on the needs of children, because children are the focal point of the family, and parents who cannot find an open school or day care center may be forced to relocate or stay home instead of showing up to work. There are 32.5 million families with children in the United States. 90% of them include a parent who works. In 62% of the households that contain married couples and children, *both* parents are members of the workforce. If parents can't work, the community will have no workers – no nurses, teachers, first responders, grocery store owners, gas station operators, carpenters, or bus drivers - and without those things, the community cannot function under any circumstances, let alone in the aftermath of a disaster. Provision of child care and reopening of schools are essential elements of recovery that must be top priorities after a disaster, so parents can get back to work and start rebuilding.

Funding is generally available to repair public and nonprofit schools after a disaster, but child care facilities are a different story. Some of them are nonprofits and therefore eligible for FEMA Public Assistance, but the vast majority are privately owned and operated, with very slim profit margins and sometimes run out of people's homes. Slim profit margins make them financially risky, and once flood waters have destroyed the value of the real estate, there is little if any collateral available to secure disaster loans from the Small Business Administration.

(Chart #1) This chart indicates the number of child care facilities that applied for SBA loans in the wake of several recent hurricanes. Fewer than half of the child care operators that applied for SBA loans and completed the review process were approved (169 out of 367=46%). We can probably assume that the majority of people who withdrew their applications along the way did so because they realized they wouldn't qualify, in which case the effective approval rate was for these loans was only 37% (169 out of 462). The Stafford Act prohibits assistance to restore private facilities, and the SBA is only authorized to provide loans, not grants, so it has to look after the fiscal solvency of its program. But if our goal is to help families recover, we have to do better. Not a single one of the child care centers in St. Bernard Parish was rebuilt for two years after Katrina. We can't continue to neglect these facilities and the families who rely upon them, nor can we underestimate their importance to a full and robust recovery.

(Chart #2 and #3) These other two charts indicate the number of K-12 schools and child care centers that have reopened in the Greater New Orleans area since the 2005 hurricanes. As you can see, only 65% of the area's child care centers are back (326 out of 498), whereas 84% (394 out of 469) of the area's public and private K-12 schools have reopened.

**Helping Displaced Families & Host Communities**

Reopening schools and day care centers inside the disaster area is critical, but we must also look *outside* the disaster area, and address the needs of displaced families and host communities. Hurricanes Katrina and Rita displaced over 370,000 children along the Gulf Coast, many of whom lost their homes and were unable to return for months. Families had to enroll their children in new schools, new child care centers, and new state-run health care programs, and in many instances, that was extremely challenging. The federal government and several states established ad hoc programs to assist displaced children. We will spend some time today examining those programs, and we will also consider whether we should establish new mechanisms to deal with these problems in advance of the next catastrophe, since many have expired.

**Emergency Planning**

Children have unique needs that require specialized planning. As the FEMA Administrator Fugate stated during our last hearing, "children are not small adults." We must ensure that emergency planning at every level accounts for all the citizens in a community, not just the able-bodied adults with ample resources and access to transportation. Local response plans must provide for the evacuation, sheltering, and continued care of children from the facilities where they are likely to be clustered – including day care centers, schools, and hospitals.

(Chart #4) Save the Children issued a report in July called "The Disaster Decade" indicating that only 7 states require schools and day care centers to develop comprehensive evacuation and reunification plans. Those states are Alabama, Arkansas, Hawaii, New Hampshire, Maryland, Massachusetts, and Vermont. No states have enacted new legislation since that report was released, and I would like to find out why.

**Mental Health**

Children are also disproportionately affected by disasters in comparison to adults when it comes to mental health. Children suffer higher rates of depression, post-traumatic stress disorder, and behavioral problems following a disaster. LSU's Department of Psychiatry screened 12,000 children in schools during the 2005-06 school year. 18% of them had a family member who was killed in the hurricane. 49% of them met the

threshold for a mental health referral. One year later, the referral rate was lower, but it was still 30%. According to research conducted by Dr. Irwin Redlener, Director of the Children's Health Fund and a member of the Commission, 28% of displaced children in Louisiana are still suffering from depression or anxiety and 33% still exhibit behavioral problems.

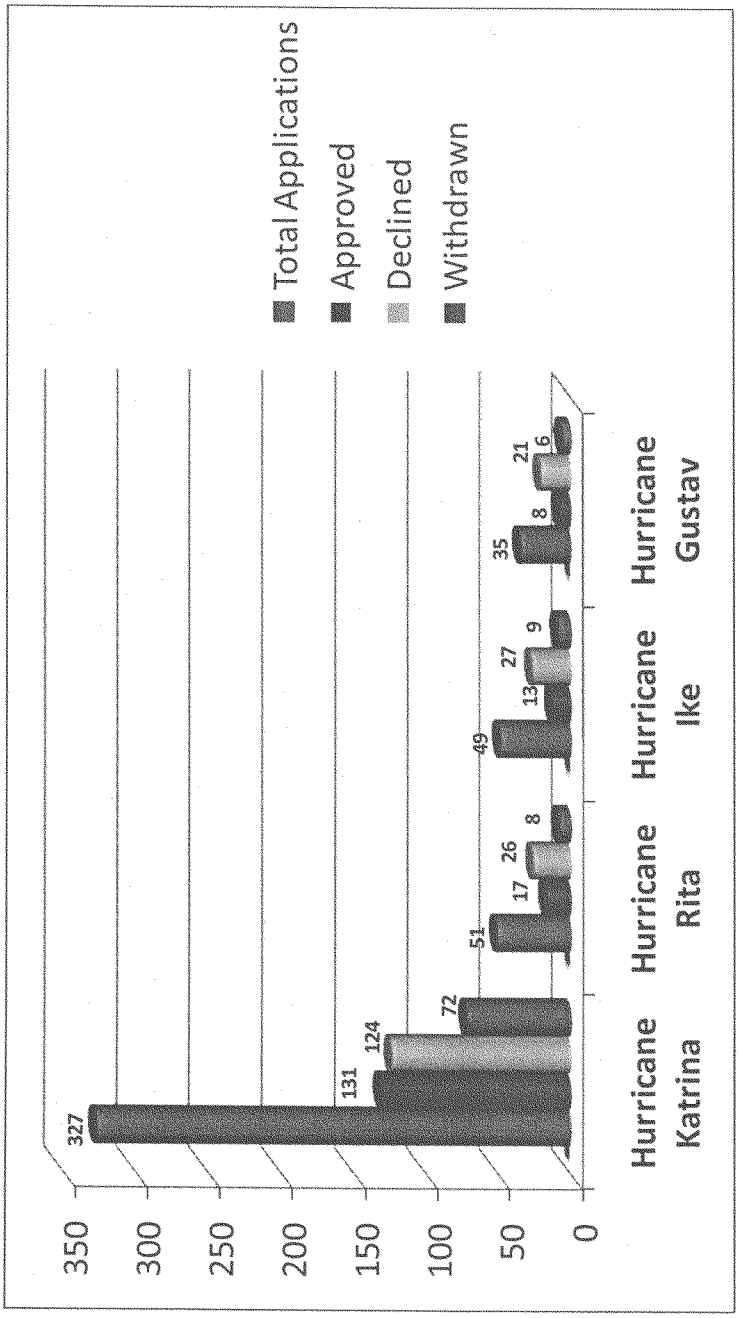
The Government Accountability Office has conducted research indicating that many of the children affected by the World Trade Center attacks in 2001 didn't come forward for treatment until more than a year after the event. These figures are important, because they not only indicate the wide-scale prevalence of mental health problems among children after disasters, but the fact that problems can persist for years and may not manifest themselves right away. Lack of mental health providers was cited by the majority of GAO's survey respondents for this second report as the greatest barrier to providing mental health services for children, whereas transportation, stigmatization, and financial problems were among the barriers to accessing these services.

**School-Based Counseling**

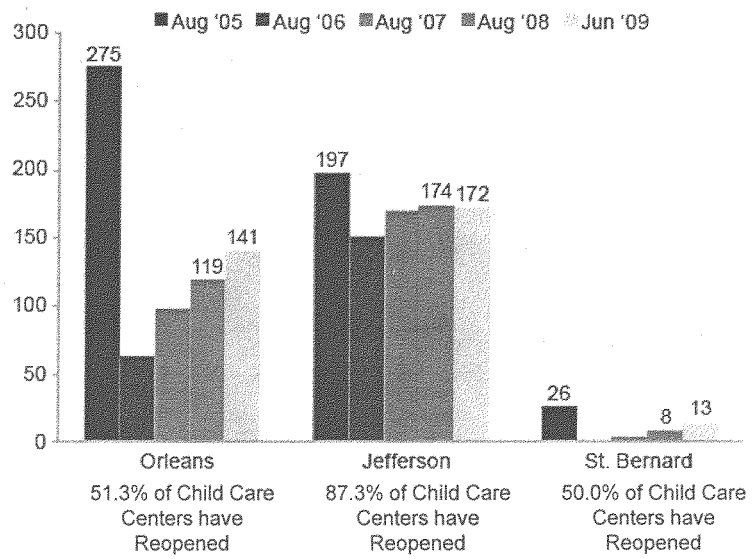
A GAO report on children's mental health needs in Greater New Orleans emphasized an approach to service delivery that I would like to focus on today, which is the model of school-based counseling. Save the Children and RAND have also commended this approach. Schools that *require* psychological assessments after a disaster can help to remove the stigma attached to mental health treatment and create an environment where students perceive counseling as common, healthy, and normal. Placing providers in schools helps parents save money on treatment costs and avoid having to leave work to drive their children to the point of service, particularly when hospitals have been closed and doctors' offices destroyed. School counselors also represent an existing workforce that can be trained in advance of disasters to treat their effects and remain after surge response programs are closed out for children who may not experience problems until a year or two after the event. We need to learn how to better utilize our school-based counselors, psychologists, and the 11,000 medical personnel who operate under the Commissioned Service Corps and National Disaster Medical System, to aggressively and unapologetically tackle the overwhelming mental health needs that accompany disasters.

**Conclusion**

Millions of parents, educators, counselors, social workers, nonprofit innovators, and community leaders work hard everyday to improve the lives of children in this nation. Through the continued efforts of the Commission and the state and federal partners who are here today, we must provide strategic leadership and resources to move our children out of harm's way before disaster strikes, get them quickly back into school and day care after a disaster has passed, and invest in community-based support networks to promote their long-term mental health. These are just a few of the issues I hope we will cover today as we continue, through administrative and legislative actions, to build a better national framework for disaster response and recovery.

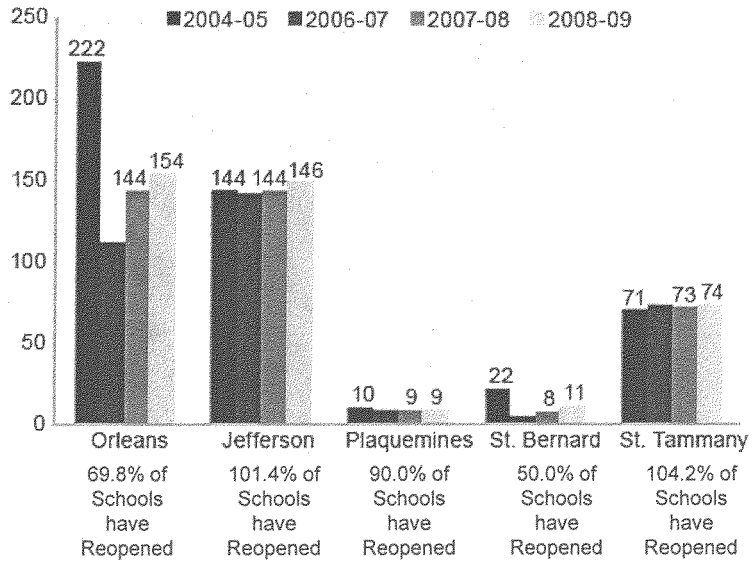

SBA Disaster Loans for Child Care Centers
350
300
250
200
150
100
50
0
Total Applications
Approved
Declined
Withdrawn
327
131
124
72
51
17
26
8
49
13
27
9
35
8
21
6
Hurricane Katrina
Hurricane Rita
Hurricane Ike
Hurricane Gustav

# NUMBER OF OPEN CHILD CARE CENTERS IN THE GREATER NEW ORLEANS AREA




Source: Agenda for Children and Louisiana Department of Social Services Bureau of Licensing

# NUMBER OF OPEN PUBLIC AND PRIVATE SCHOOLS IN THE GREATER NEW ORLEANS AREA




Source: Louisiana Department of Education

# Testimony of

## Mark K. Shriver
## Chairperson, National Commission on Children and Disasters

Chairman Landrieu, Ranking Member Graham and members of the Senate Ad-Hoc Subcommittee on Disaster Recovery. I am Mark Shriver, Chairperson of the National Commission on Children and Disasters. Thank you for the opportunity to testify today.

The Commission is especially grateful for the Subcommittee's continued focus on the recovery needs of children affected by disasters. The Commission's Interim Report contains 21 primary recommendations and 25 supporting statements to help guide implementation. For the purpose of today's hearing, I will focus my testimony on a few key areas.

**Long-Term Recovery**

The Commission strongly urged FEMA and the Obama Administration to aggressively intensify efforts to develop a National Disaster Recovery Framework. We are pleased that the President established a Long-Term Disaster Recovery Working Group and the Commission intends to make meaningful contributions to the report due to the President in April 2010 and the design of the framework, due in June 2010.

As noted in our Interim Report, 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 National Disaster Recovery Framework currently in development should specify services that must be provided to children affected by disasters, such as: safe, stable housing; access to physical, mental health and oral health services; academic continuity and supervised after-school activities; child care; adequate nutrition; and disaster case management. A specific federal entity should be designated with oversight, coordination

and guidance responsibilities, to create awareness of all forms of federal assistance to states and localities that address the needs of children and families affected by disasters.

**Disaster Case Management Services**

The Commission is pleased that FEMA and the Administration for Children and Families (ACF) have recently come to terms on an Inter-Agency Agreement. In many respects, ACF's disaster case management implementation plan corresponds with the recommendations in the Interim Report. The ACF model is comprehensive in scope and focused on achieving measurable positive outcomes for children and families. Importantly, ACF's program was originally intended to transfer responsibilities to local agencies as quickly as possible. However, FEMA prefers that disaster case management responsibilities transfer to the affected state. Recognizing the difficulties encountered in the state-led programs envisioned for Texas and Louisiana following Hurricanes Gustav and Ike, which resulted in extensive delays in the delivery of services, the Commission has posed the following questions to FEMA:

- How will FEMA assess a state's capability to continue case management services, once the ACF mission is concluded? What case management model will be implemented by the state?
- What will happen if FEMA determines that a state lacks capacity to assume management of the case management program at the expiration of the ACF mission?
- How will FEMA support ACF and states with pre-event guidance and funding to develop the capacity to perform case management services?

**Child Care**

There are nearly 12 million children under the age of five in child care each week. 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 for parents, guardians, employees and employers in the aftermath of a disaster.

The Commission sees the reauthorization of the Child Care Development Block Grant (CCDBG) program as a prime opportunity to address the lack of basic disaster preparedness among child care providers across the nation. States and child care providers should be required to have minimum disaster preparedness standards in place to receive CCDBG funding. The Commission recommends requiring licensing and regulatory standards that include comprehensive all-hazards planning and staff training, which in turn must be coordinated with local and state disaster plans.

In addition, the Commission has been collaborating with FEMA to identify areas of potential disaster assistance for child care services. We are pleased that FEMA has committed to provide temporary facilities for child care providers that sustain damage beyond repair and to support states' efforts to stand up emergency child care facilities and provide emergency child care services for a very brief term in the immediate aftermath of a disaster. However, the Commission recommends a change in the Stafford Act that would allow FEMA to continue supporting the provision of child care services for a longer duration in the recovery phase and to provide assistance to affected families for placement of children in child care.

A major shortcoming of the Stafford Act is the inability to support the repair, restoration or rebuilding of private for-profit entities, such as child care facilities, that provide essential community services. Absent this, the Commission recommended an alternative measure, the authorization of an emergency child care contingency fund to not only help rebuild child care facilities but also assist state and local governments in meeting additional child care needs resulting from an influx of displaced families from other localities.

**Sheltering and Housing**

With assistance from FEMA, the American Red Cross, the American Academy of Pediatrics and several disaster partners, the Commission developed shelter standards and indicators responsive to the needs of children and a shelter supply list for infants and toddlers, which are included in the Interim Report.

We are now focused on establishing age ranges of children, from birth to 18, in order to facilitate consistent and comprehensive data collection by emergency shelters and other multi-agency mass care projects. More specific data on numbers of affected infants, toddlers, adolescents and teens will foster a more effective disaster response. For example, data collection on the ages of children may be used for the purposes of evacuee tracking and shelter intake to better anticipate children's needs, including age-appropriate equipment and supplies such as formula, diapers and medicines.

As noted in the Interim Report, children displaced following Hurricane Katrina experienced an average of three moves per child, which was highly disruptive to their education, as well as their psychological and social wellbeing. Therefore, immediate access to stable, 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 connecting children to health and mental health care providers. The Commission is collaborating with the National Disaster Housing Task Force to make families with children a priority for disaster housing assistance and to incorporate the unique considerations of families with children, such as proximity to schools and child care, into federal and state disaster housing guidance documents.

In conclusion, I wish to thank the subcommittee for today's hearing and for holding each of us accountable on our promises to make children a greater priority in disasters, especially as they struggle to recover from these traumatic and unsettling events.

The Commission delivered its Interim Report to President Obama and every member of Congress on October 14, 2009.

I believe the Interim Report has led to calls for change, but it must inspire action. While there are signs of progress, action has not come soon enough, and children continue to suffer from benign neglect.

Lessons learned and best practices are inadequate if not supported by changes in law and policy that remove barriers and instill confidence that children have become a priority in the way our nation prepares for, responds to, and recovers from disasters. All Americans, especially children, expect and deserve no less from us.

Again, I greatly appreciate the opportunity to testify today on behalf of the National Commission on Children and Disasters. We look forward to providing updates on the important work of the Commission to you in the future. I would be pleased to answer your questions.

## National Commission on Children and Disasters - Interim Report Recommendations

1. **DISASTER MANAGEMENT AND RECOVERY**

**FEMA and Non-Profits**

- Integrate the needs of children into all disaster planning activities and operations.

**The Administration**

- Accelerate development of a National Recovery Strategy with an emphasis on addressing immediate and long-term physical and mental health, educational, housing, and human service needs of children.

2. **MENTAL HEALTH**

**HHS, State and Local governments**

- Integrate mental health practices for children into all public health, medical preparedness, and response activities.

**HHS Department of Education, State and Local governments**

- Enhance pediatric mental health training for medical professional and school employees.

3. **CHILD PHYSICAL HEALTH AND TRAUMA**

**Congress, HHS and DHS**

- Fund development, acquisition, and stockpile pediatric counter measures for inclusion in the Strategic National Stockpile.

**HHS and DHS**

- Form a standing body of federal partners and external experts to advise on pediatric counter measures relating to updates and advances in treatment and medication.

**HHS**

- Expand the medical capabilities of all federally funded response teams and integrate pediatric specific training, guidance, exercises, supplies and personnel.
- Ensure adequate pediatric clinical training for all health care professionals who may treat children during an emergency.
- Provide funding to enhance regional pediatric systems of care.

## National Commission on Children and Disasters - Interim Report Recommendations

### 4. EMERGENCY MEDICAL SERVICES AND PEDIATRIC TRANSPORT

**Congress and DHS**

- Establish a dedicated federal grant program for pre-hospital Emergency Medical Services.
- Provide additional funding to Emergency Medical Services for Children program.

**Centers for Medicare and Medicaid Services (CMS)**

- Require first response and emergency medical response vehicles to acquire and maintain pediatric equipment and supplies as an eligibility guideline for CMS reimbursement.

### 5. DISASTER CASE MANAGEMENT

**FEMA and ACF**

- Establish a holistic federal disaster case management program.

### 6. CHILD CARE

**State and Local Governments**

- Require state child care regulatory agencies to include disaster planning, training, and exercise requirements as a standard for child care licensing.
- Require state child care administrators to develop statewide child care plans in coordination with state and local emergency managers.

**Congress and DHS**

- Include the provision of child care as a human service within the National Response Framework, and provide reimbursement under the Stafford Act to establish temporary disaster child care and repair and reconstruct child care facilities.

## National Commission on Children and Disasters - Interim Report Recommendations

### 7. ELEMENTARY AND SECONDARY EDUCATION

**Congress**

- Establish a school disaster preparedness program, and appropriate funds to the Department of Education for a state- and district-level disaster response planning and, training.

**Department of Education and State and Local School Districts**

- Develop training programs for teachers and school staff to assist them in identifying students in crisis.



### 8. CHILD WELFARE AND JUVENILE JUSTICE

**Administration on Children and Families**

- Provide guidance, technical assistance and model plans to assist state and local child welfare agencies in meeting applicable disaster planning requirements, and require collaborations with state and local emergency management, courts and other key stakeholders in the development of these plans.

**Department of Justice**

- Conduct a national assessment of disaster planning and preparedness among state and local juvenile justice systems.

## National Commission on Children and Disasters - Interim Report Recommendations

### 9. SHELTERING STANDARDS, SERVICES AND SUPPLIES

**FEMA**

- Provide safe and secure mass care shelters for children, including access to essential services and age-appropriate supplies.

**FEMA and DOJ**

- Create a database to identify sexual predators as they enter a shelter.



### 10. HOUSING

**FEMA and HUD**

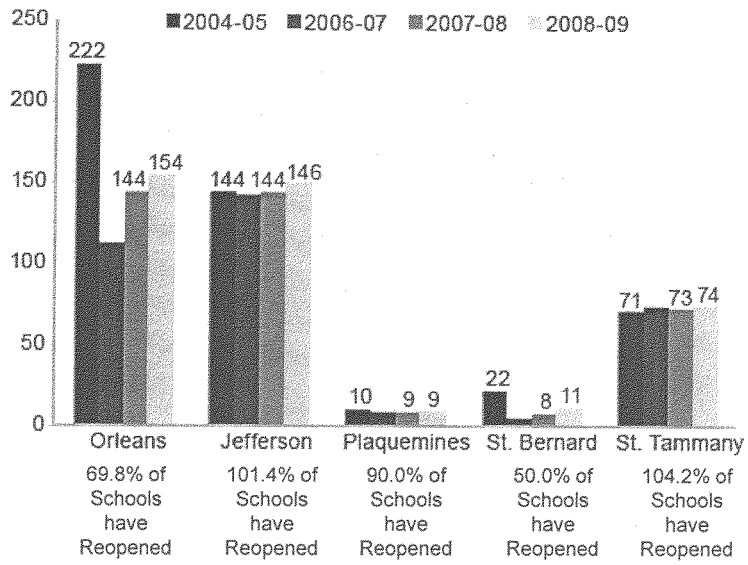
- Prioritize families with children for disaster housing assistance, expedite transition into permanent housing.

### 11. EVACUATION

**FEMA**

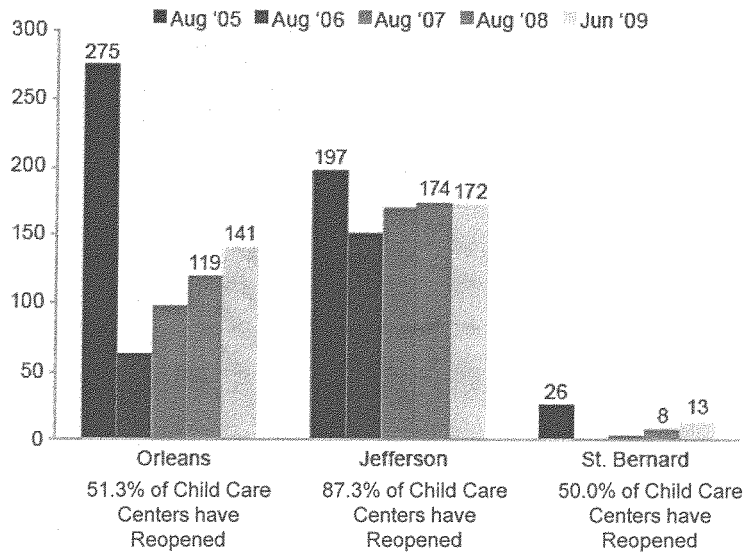
- Establish a nationwide interoperable database to assist in family reunification.

# NUMBER OF OPEN PUBLIC AND PRIVATE SCHOOLS IN THE GREATER NEW ORLEANS AREA

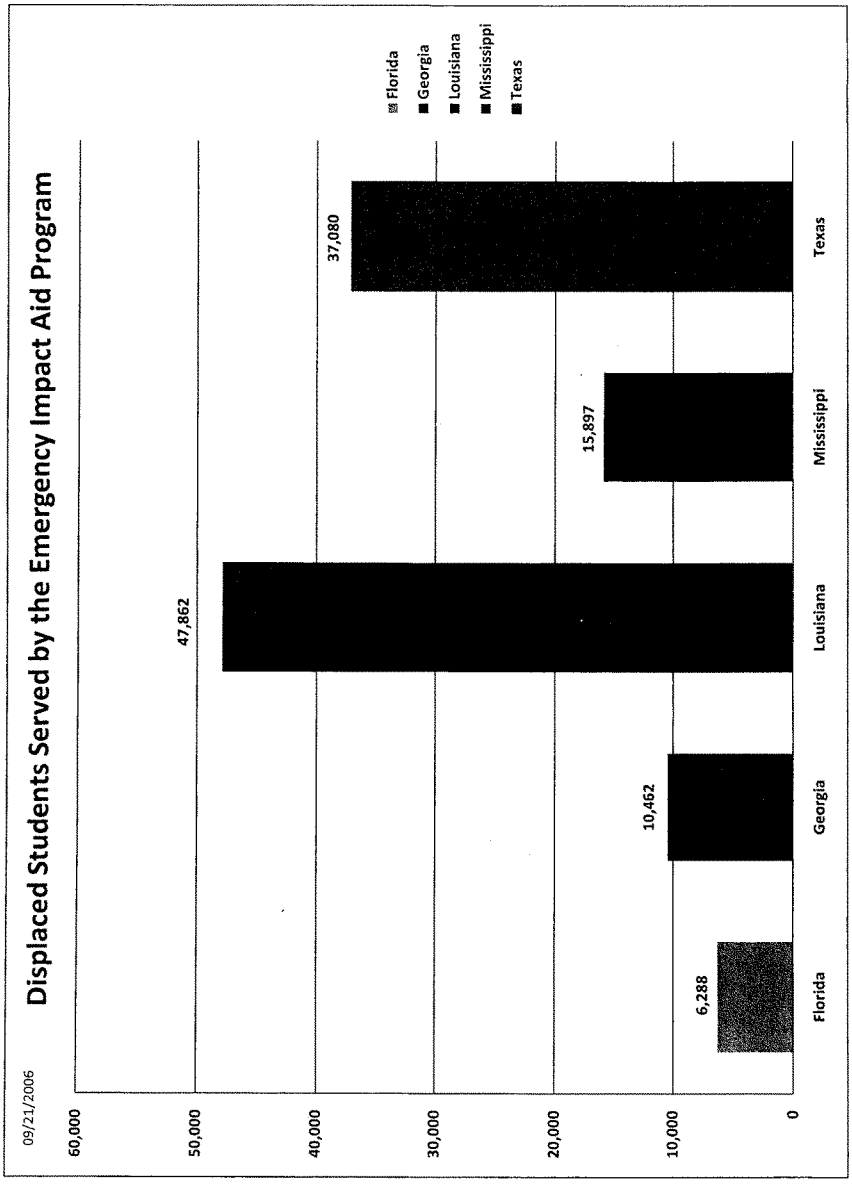


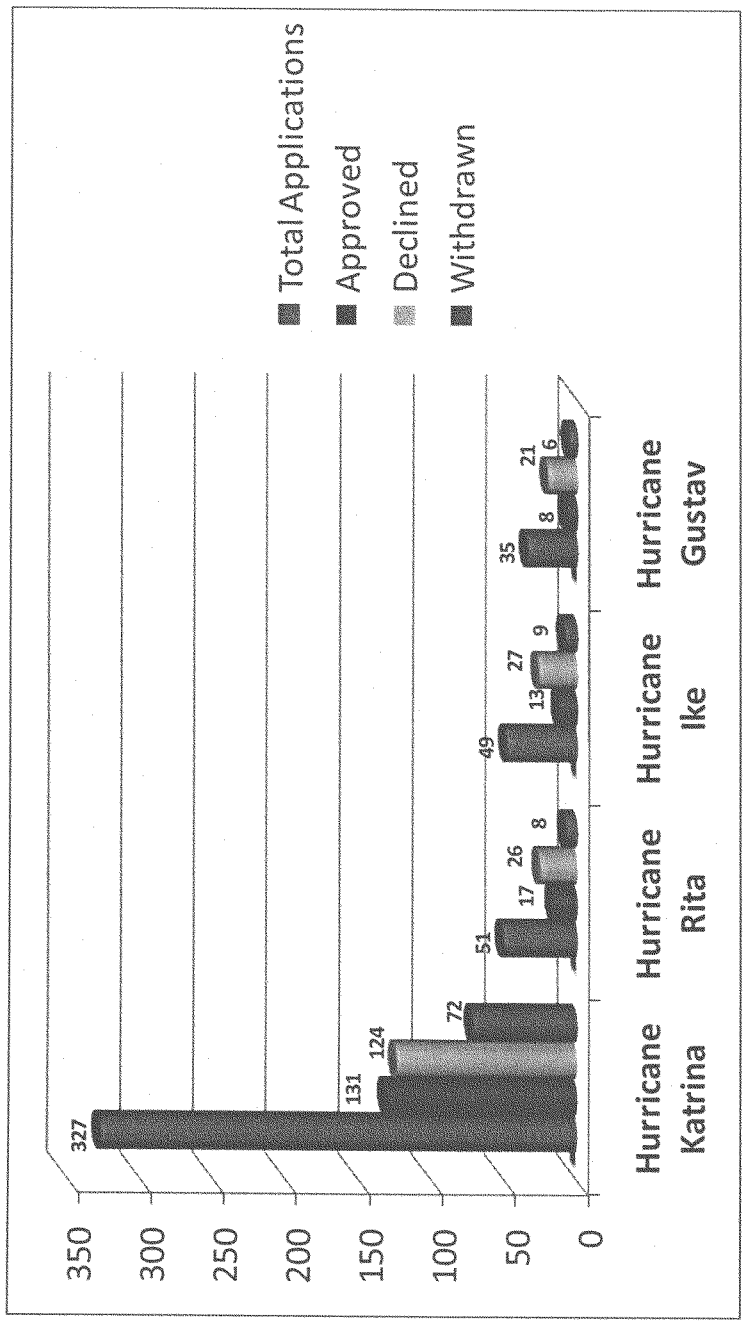

Source: Louisiana Department of Education

# NUMBER OF OPEN CHILD CARE CENTERS IN THE GREATER NEW ORLEANS AREA




Source: Agenda for Children and Louisiana Department of Social Services Bureau of Licensing


09/21/2006
Displaced Students Served by the Emergency Impact Aid Program
60,000
50,000
40,000
30,000
20,000
10,000
0
Florida
Georgia
Louisiana
Mississippi
Texas
6,288
10,462
47,862
15,897
37,080
Florida
Georgia
Louisiana
Mississippi
Texas


SBA Disaster Loans for Child Care Centers
350
300
250
200
150
100
50
0
Total Applications
Approved
Declined
Withdrawn
327
131
124
72
51
17
26
8
49
13
27
9
35
8
21
6
Hurricane Katrina
Hurricane Rita
Hurricane Ike
Hurricane Gustav

STATEMENT OF

HONORABLE CRAIG FUGATE
FEDERAL EMERGENCY MANAGEMENT AGENCY
U. S. DEPARTMENT OF HOMELAND SECURITY

**Introduction**

Good morning Chairwoman Landrieu, Ranking Member Graham and other distinguished members of the Subcommittee. It is a privilege to appear before you today on behalf of FEMA and the Department of Homeland Security. I appreciate the opportunity to testify at this hearing, as I firmly believe that we, as a nation, must do more to effectively meet the critical needs of children who are affected by disasters.

Historically, the United States has approached disaster planning by focusing heavily on the needs of what many refer to as the general adult population, and has not devoted sufficient advance attention to those who may have unique needs and thus require specific and immediate attention in a crisis- such as children, the disabled and the elderly. As a result, our nation's ability to respond effectively in support of children's needs following a disaster has been hampered. With the continued support of this Committee and the Congress, we will work to change this approach and ensure that all members of our communities, particularly children, are adequately and appropriately provided for in all planning, response and recovery efforts.

In December 2007, Congress created the National Commission on Children and Disasters to assess how the needs of children impact disaster preparedness, response, and recovery. The Commission has evaluated existing laws, regulations, policies, and programs that affect children in disaster situations, and has been charged with submitting a report to the President and Congress on its specific findings, conclusions and recommendations. An Interim Report was completed earlier this fall and will be followed by a Final Report in 2010.

When I last appeared before this Committee to discuss children's issues, I announced my intention to create a Children's Working Group at FEMA. The Working Group was established in August of this year and serves as FEMA's internal working team responsible for ensuring that the unique needs of children are addressed and integrated into all disaster planning and operational efforts initiated at the federal level. The team is comprised of a Chairperson, a Lead Coordinator, and representatives from virtually all sectors of FEMA. Tracy Wareing, Counselor to Secretary Janet Napolitano, chairs the Working Group. It is the goal of the Children's Working Group to help create a lasting positive change, at every level of government, when it comes to planning for and successfully addressing children's needs in times of disaster.

The Working Group is designed to provide a centralized forum that facilitates improved coordination across FEMA in addressing the needs of children following a disaster. This group is also working collaboratively with other federal agencies and non-governmental stakeholders, including the National Commission on Children and Disasters, with which it has a close partnership.

The Commission's Interim Report, issued in mid October, makes eleven overall recommendations for improving the nation's ability to support the needs of children in a disaster. Working with the Commission, we are already addressing and implementing

many of those recommendations.

**Disaster Case Management**

The Commission recommended the establishment of a holistic federal disaster case management program with an emphasis on achieving tangible positive outcomes for all children and families within a presidentially-declared disaster area. Toward this end, we have worked closely with the Department of Health and Human Services and its Administration for Children and Families (ACF) to develop an Interagency Agreement that will provide for the immediate deployment of the ACF holistic disaster case management model when requested by a state following a disaster declaration. The ACF model involves deployment of the ACF National Team to initiate Disaster Case Management services to clients in the impacted area within 72 hours of notification by FEMA and will provide disaster case management services to individuals and households to assess unmet disaster-related needs including healthcare, mental health and human services needs that may adversely impact an individual's recovery if not addressed. The ACF model ensures that case managers facilitate the delivery of appropriate resources and services, work with the client to implement a recovery plan and advocate for the client's needs to assist him or her in returning to their pre-disaster status while respecting human dignity. The agreement also identifies and provides for a transition to a State-administered program to address longer term needs.

The agreement will allow FEMA to provide funding for ACF to initiate the rapid deployment of disaster case management assistance to individuals and families impacted by a presidentially declared disaster for Individual Assistance. FEMA and ACF worked together to ensure that the agreement incorporates lessons learned and best practices from previous disaster case management delivery models and will offer comprehensive services for disaster survivors, and a flexible model that can easily be adapted by state, local, non-governmental and volunteer organization service providers.

This is an important milestone in addressing the needs of children in disasters and we are grateful to the Commission for its work in assisting FEMA and the Department of Health and Human Services.

**Disaster Management and Recovery**

The Commission made the following recommendations regarding disaster management and recovery issues: (1) distinguish and comprehensively integrate the needs of children across all inter- and intra-governmental disaster planning activities and operations and (2) accelerate the development of a National Disaster Recovery Strategy with an explicit emphasis on addressing the immediate and long-term physical and mental health, educational, housing and human services recovery needs of children. We have already taken several steps towards addressing these issues.

At FEMA, we have begun a review of our base planning guidance, and in consultation with the Commission, we will work to ensure that the needs of children are addressed universally as a basic planning consideration. FEMA is committed to fully integrating

the needs of all children, including children with disabilities, in all aspects of emergency planning and disaster response and recovery, rather than as a secondary, supplemental or special effort. In FY10 guidance for HSGP, FEMA emphasized the importance of incorporating children's needs in preparedness and planning activities. Among other things, the HSGP guidance encourages funds to be used for planning activities associated with the health, safety, education, and care of infants and children, and invites grantees to integrate the needs of infants and children into their base plans rather than independently within the special needs framework. The HSGP guidance also supports training for volunteers, infants, and children in disasters, provides for pediatric care, and addresses evacuation and sheltering requirements with a particular emphasis on children.

In September, President Obama asked Secretary Napolitano and Department of Housing and Urban Development Secretary Shaun Donovan to co-chair a Long Term Disaster Recovery (LTDR) Working Group. This Working Group includes representatives from more than 20 federal departments, agencies and offices, and its charge, in partnership with stakeholders at all levels, is to provide the President with recommendations on how to improve long term disaster recovery for communities and individuals.

The LTDR Working Group has already held more than10 joint, DHS-FEMA /HUD video teleconferences in each of the FEMA/HUD regions as well as 5 regional stakeholder forums around the country. We have sought broad participation, from children's advocacy groups, non-profit organizations and disaster survivors. The Working Group is working directly with the Commission to ensure their input is also heard.

Based upon these forums, and solicitation of input through the web site, the Long Term Disaster Recovery Working Group will provide the President with recommendations to improve long-term disaster recovery, particularly in the wake of catastrophic events. In addition, by June 1, 2010 a National Disaster Recovery Framework will be published that will provide detailed operational guidance to recovery organizations under existing authorities.

**Child Care and Sheltering**

The Commission made several recommendations with respect to reimbursement of costs related to child care facilities and services. In response to those recommendations, FEMA has clarified its reimbursement rules in a presidentially-declared disaster as outlined below:

> **Emergency Sheltering.** The Stafford Act authorizes funding for emergency sheltering following a declared disaster. If a state or local government provides child care services to families that are in shelters, the cost to provide the child care services are considered a part of the sheltering operations and are eligible for Stafford Act funding. In addition, FEMA may reimburse a state and local government for the cost to establish and operate stand-alone day care centers as emergency shelter for a limited time immediately after a disaster.
>
> **Temporary Facilities**. The Stafford Act authorizes the provision of temporary

facilities for schools and other essential community services. FEMA has determined that the provision of day care services is an essential community service. As such, if an eligible applicant (public or private non profit facility) operated a child care facility prior to the disaster and the facility was damaged, the cost of obtaining temporary facilities until the damaged facility is repaired is a reimbursable cost.

**Repair, Restoration or Replacement of Public and Private Non Profit Facilities.** The Stafford Act allows for funding the repair, restoration or replacement of damaged public and private nonprofit facilities that provide essential services of a governmental nature. FEMA has interpreted this category of services to include child care centers and will revise its Public Assistance regulations to specifically include child care centers for children as an *essential service of a governmental nature.*

The Stafford Act does require that private, non profit day care centers apply for Small Business Administration loans before applying to FEMA for assistance to repair facilities. If SBA does not approve the private nonprofit operator's loan or approves a loan for less than the amount required for repair, the operator may apply to FEMA for assistance with the difference.

Our Children's Working Group also collaborated with the Commission, the American Red Cross and other pediatric experts to develop a Shelter Supply List identifying the basic items necessary to sustain infants and children in a mass care shelter and emergency congregate care environment. Some items that appear on the Shelter Supply List have been incorporated as allowable expenses into the FY2010 Homeland Security Grant Program guidance mentioned above. Their inclusion depicts the results of a unified collaboration between the Federal government and external stakeholders. Further, I have directed FEMA's Logistics Management Directorate to develop a plan to address critical needs, according to the Shelter Supply List, by identifying suppliers, pricing supplies and developing plans to procure and deliver necessary items to communities in need following a request associated with a disaster declaration.

**Conclusion**

In times of crisis, government plays a critical role in coordinating response and recovery efforts, especially in protecting and providing for the most vulnerable members of our population. The needs of children and other members of our communities with special access and functional needs cannot simply fall to secondary planning considerations, but must be one of the central focuses of our planning, response and recovery.

While we have made recent strides to improve our ability to address children's needs in disasters, we believe that even greater progress is within reach, thanks to our new Children's Working Group, its partnership with the Commission, and the continued support of this Committee and the Congress.

Above all, our efforts must begin with personal preparedness – basic steps that each of us, and our families, must take to help prevent and prepare for the next disaster.

Thank you, Madam Chairwoman and members of the Committee, for allowing me to testify today. I am happy to answer any questions you may have.

**Testimony**
**Committee on Homeland Security and Governmental Affairs**
**Ad Hoc Subcommittee on Disaster Recovery**
**United States Senate**

# "Children and Disasters: A Progress Report on Addressing Needs"

*Statement of*


## Nicole Lurie, M.D., M.S.P.H.

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***RADM, U.S. Public Health Service***
***U.S. Department of Health and Human Services***


**For Release on Delivery**
**Expected at 2:30 pm**
**Thursday December 10, 2009**

Good afternoon Madam Chairwoman Landrieu, Ranking Member Graham, and other distinguished Members of the Ad Hoc Subcommittee on Disaster Recovery. I am pleased to be here today on behalf of the U.S Department of Health and Human Services (HHS) to provide you with an update on our disaster preparedness, response, and recovery activities related to children and families. Today I will talk to you about some of my Department's recent efforts, particularly those that relate to the recommendations of the interim report of the National Commission on Children and Disasters (NCCD, or "the Commission") in the areas of health, mental health, and overall coordination.

I want to begin by commending this Subcommittee for its attention to the needs of children. As Assistant Secretary for Preparedness and Response, I am mandated to address the needs of children. As a mother and a community physician, I know firsthand how critical that mandate is and I firmly support efforts to address the needs of children.

The Commission report makes several recommendations that focus on child physical health and trauma. Let me begin by talking about a few relevant activities aimed at enhancing the provision of healthcare services to children during a public health emergency or mass casualty event.

ASPR is undertaking several efforts to better assess healthcare system needs. Through our HavBed system, we have a tool to identify healthcare system stress and demand in the event of a public health emergency or mass casualty event. Currently we collect data

weekly in response to the H1N1 flu outbreak. Data elements specific to pediatrics include:

- Available Pediatric Med/Surge beds and Pediatric ICU beds.
- Total number of full feature ventilators available to the facility that can support both adult and pediatric patients.
- Number of patients who are currently being managed on rescue therapies including the number of children birth to 12 years of age.

In addition to HavBed, ASPR has a web-based capability called MedMap that incorporates information from various sources into a single environment for enhanced awareness. MedMap can provide information about the locations of public schools, daycare facilities, pediatric intensive care units, and hospitals that provide pediatric services.

Another assessment effort currently underway is examining ventilators for pediatric patients, an issue of extreme importance during the H1N1 epidemic. ASPR recently initiated an inventory of mechanical ventilators owned by US acute care hospitals. Respondents represented 85 percent of US pediatric and neonatal ICU beds. The inventory identified thousands of full-feature ventilators, mechanical ventilators designed for select pediatric and neonatal populations, and more than 16,000 transport ventilators at US responding hospitals. While the number of ventilators was about 36 per 100,000 children under 18, staff expertise for ventilating pediatric patients may be limited. Therefore, ASPR has contracted with the Society of Critical Care Medicine (SCCM) to

develop a critical care cross-training course. This web-based course will include pediatric modules and be available at no cost to US healthcare workers.

Beyond these activities, HHS utilizes epidemiological data and other data on system capacity to inform our work and anticipate future needs. This information feeds back to our Hospital Preparedness Program (HPP) grants and all our other activities. The HPP has already awarded grants focusing on pediatric issues and has elaborated on the need to integrate all "at-risk" groups into grant activities.

To enhance the National Disaster Medical System (NDMS) focus on pediatric issues, we recently hired a pediatrician as a Deputy Chief Medical Officer. This physician will be leading several initiatives aimed at improving our NDMS response capabilities with respect to our pediatric population and engaging in ongoing liaison with the American Academy of Pediatrics and pediatric hospital partners. He will also be assisting us with analyzing the findings of our recent workshop "Pediatric Preparedness and Response in Public Health Emergencies and Disasters." This workshop covered topics related to medical response and medical countermeasures for the pediatric population. Approximately 69 percent of NDMS clinicians have training in pediatric care, including nine percent who are pediatricians or pediatric specialists. The NDMS is currently evaluating its equipment caches to determine how they can be modified to meet the needs of children during responses.

ASPR is also working closely with the American Academy of Pediatrics and its Disaster Preparedness Committee. ASPR representatives attend the AAP Committee's quarterly meetings and AAP representatives have participated in ASPR pediatric conferences.

The Commission report also addresses the critical area of medical countermeasures. Our BioMedical Advanced Research and Development Authority (BARDA) actively considers the needs of the pediatric and other special populations in the community in the Chemical, Biological, Radiological, and Nuclear (CBRN) and Influenza Programs. The work of our Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Integrated Program Teams and other interagency and internal program task forces and teams review and set requirements in contract solicitations that include the special considerations and instructions within the scope of work addressing children and other special populations such as immunocompromised persons. Contract awards for countermeasure product development, acquisition, and clinical studies provide special instructions for pediatric and other special populations.

While we move forward in planning for the needs of children, we cannot forget the critical lessons learned during past events. In the aftermath of Hurricanes Katrina and Rita, HHS' Centers for Medicare & Medicaid Services (CMS) worked to ensure the portability of Medicaid and the Children's Health Insurance Program (CHIP) benefits for children and adults displaced by the disasters. Both Medicaid statute[1] and regulation[2] require State Medicaid agencies to have in place a mechanism for ensuring that Medicaid

[1] 1902(a)(16) of the Social Security Act.
[2] 42 CFR 431.52.

beneficiaries have access to care when they are out-of-state. Such State coordination typically happens in one of two ways:

1) A provider who furnishes services to a resident of another State temporarily enrolls in the Medicaid program of the individual's home State in order to receive reimbursement directly from the individual's home State, or
2) The host State provider can (pursuant to an interstate agreement) bill the host State as they would for any other Medicaid beneficiary, and then payments are later reconciled between the home State and the host State Medicaid programs.

Despite existing statutory and regulatory policies that accommodate the needs of Medicaid beneficiaries when away from home, the magnitude of devastation of Hurricanes Katrina and Rita posed unique problems for beneficiaries receiving out-of-state care. The Secretary signed a waiver, effective the day before Hurricane Katrina made landfall along the Gulf Coast that gave CMS the authority to waive normal rules and regulations to accommodate these special circumstances. CMS responded after Hurricane Katrina through a section 1115 demonstration project to ensure that displaced evacuees could receive services under Medicaid and CHIP in whatever State they were currently located.[3] Through this process, evacuees enrolled for up to five months in host-State Medicaid or CHIP programs and allowed the host-State to bill CMS directly for the cost of services provided to evacuees. CMS provided templates for the States to use in requesting a section 1115 demonstration project, and it deemed such demonstrations to be budget-neutral, to streamline approval. CMS also assigned designated casework staff to

[3] CMS State Medicaid and CHIP Directors Letter, September 16, 2005, SHO # 05-001, http://www.cms.hhs.gov/smdl/downloads/SHO091605.pdf.

work with all States hosting evacuees to ensure speedy access to Medicaid and CHIP benefits by those in need.

The work of CMS and of other HHS components on these portability concerns continues. In the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), Congress required the Secretary, through CMS, to develop a model process for the coordination of the enrollment, retention, and coverage under Medicaid and CHIP of children who frequently change their State of residency or otherwise are temporarily outside of their State of residency due to family migration, emergency evacuations, natural or other disasters, public health emergencies, or educational needs.[4] CMS is currently consulting with State Medicaid and CHIP directors and other stakeholders to fulfill this requirement and will produce a Report to Congress describing additional steps or authority that may be needed to make further improvements to coordinate the enrollment, retention, and coverage under Medicaid and CHIP. We anticipate these consultation efforts will enhance CMS's knowledge about ways to help improve the coordination of care for displaced children.

In the area of mental health, HHS has some significant initiatives that benefit children in the response and recovery phases of disasters. Effective disaster preparedness and response are an essential part of HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) public health responsibility.

[4] Children's Health Insurance Program Reauthorization Act of 2009, Section 213.

As you are aware SAMHSA has an interagency agreement with the Federal Emergency Management Administration (FEMA). Under the agreement, FEMA provides funds for Crisis Counseling Training and Assistance Program (CCP) and SAMHSA manages those funds and monitors their use. For over thirty years, the CCP has supported short-term, solutions-focused interventions with individuals and groups experiencing psychological and behavioral problems associated with large scale disasters. These interventions help disaster survivors understand their situation and reactions, mitigate against additional stress, help survivors review their options, promote mental health using specific evidence-based coping strategies, provide emotional support, and encourage links with other individuals and agencies able to help survivors recover to their pre-disaster level of functioning. As with many of SAMHSA's disaster related programs, these funds are geared to help States address the immediate needs of the affected communities until the State is capable of addressing the needs of its citizens.

In addition to the CCP, with which you are familiar, there are several other programs which help address ongoing mental health needs in local communities.

The *Children's Mental Health Initiative* provides funding to local communities to establish systems of care for children with serious emotional distress. The *Children and Violence Initiative*, carried out in conjunction with the Department of Education, provides funding to local education agencies to promote mental health and reduce violence in schools. The *Garrett Lee Smith State and Tribal Grants* provide funding to States to prevent youth suicides. The accompanying *Garrett Lee Smith Campus Grants* are

available to colleges and universities to address suicide. For several years we have funded efforts across the United States, including Louisiana, to address the effects of trauma on children through the *National Children's Trauma Service Initiative*. *LAUNCH* is a new program that promotes mental health among children under 8 years old. SAMHSA also funds *Homeless Programs* that support mental health services for adults and children who are or expect to be homeless, including supportive housing. Such grants are available from both the Center for Mental Health Services and the Center for Substance Abuse Treatment. The *Community Mental Health Service Block Grant* provides financial support to States to address the needs of adults for a serious mental illness and children with a serious emotional disturbance. And finally, the *Projects of Assistance in Transitioning from Homelessness* funds are available to States to provide mental health services to homeless individuals. More information on SAMHSA programs relative to disasters is included as an appendix to this testimony.

In a final note on mental health, my staff recently met with the staff of the NCCD to plan a coordinated response to the Commission's Interim Recommendations and the Disaster Mental Health Recommendations of the National Biodefense Science Board (NBSB). There is a great deal of synergy between the recommendations of the Commission and those of the NBSB on mental health issues. Close collaboration will be extremely beneficial to the implementation of strategies that better address the needs of children throughout each phase of disaster.

None of these efforts will have any impact without coordination between various involved agencies. ASPR has continued its commitment to take into account the needs of children in its plans for preparedness, response, and recovery through a number of coordination meetings and listening sessions with various federal and non-federal partners, including the American Academy of Pediatrics.

HHS' Administration for Children and Families (ACF) is fully committed to making children a priority at the highest level of response before, during, and after catastrophic disasters and emergency events. The agency is focused on promoting the recovery of children and their families affected by disasters and emergency events. As a whole, HHS disaster response and recovery efforts emphasize meeting the needs of children, one of our most vulnerable populations in times of crisis and emergency.

During disasters, ACF gathers information about the Head Start and child care programs, which serve children across the age range. ACF maintains contact with State human services and emergency management agencies to determine if there are any other issues that affect children. ACF has conducted shelter assessments revealing unmet human services needs for children, particularly a lack of and/or inappropriate child care in some shelters. ACF also has developed a disaster case management model with FEMA. Finally, ACF provides operational support to the NCCD and has initiated programs and policies on a number of issues to ensure that children are given the attention they deserve before, during and after a disaster.

Throughout its Interim Report, the NCCD states that children are given less attention than necessary when disaster plans are written and exercised and that children must be considered and planned for as children. HHS recognizes that the needs of children are different when planning for disasters, and that they require different resources to assist them in recovering from disasters because they are far more than just "small adults." As part of HHS' commitment to the Commission's Interim recommendations, the agency has taken steps to help ensure that child care is addressed in both emergency preparedness planning, as well as disaster recovery and response efforts. However, much more needs to be done.

HHS supports the Commission's recommendations to require disaster planning capabilities for child care providers, and improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster. Child care provides critical support in helping families in the event of a disaster. For children, early childhood programs support healthy growth and development, which is especially important in an emergency. Parents need to know that their children are safe and supervised as they take steps to rebuild their lives.

For the Subcommittee's information, my statement today is appended with additional material specific to the Commission's recommendations that relate to ACF programs.

In closing, I would like to thank you again for providing the opportunity for me to talk with you today about the Department's many efforts to address the needs of children

affected by disasters and public health emergencies. We have made significant strides and we anticipate continuing this momentum in the future.

The Commission's report brings attention to the importance of children and offers many laudable recommendations. We recognize the continual need to improve our efforts and we look forward to working with the Subcommittee, the Commission, and other partners to do so. I would be happy to answer any questions.

**Appendix 1**

**Substance Abuse and Mental Health Services Administration**
**Disaster Related Programs**

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Effective disaster preparedness and response are an essential part of SAMHSA's public health responsibility. SAMHSA was on the ground in Louisiana and elsewhere in the Gulf region within days of Hurricane Katrina. SAMHSA's practice and expectation is that it will be first to respond to a natural disaster with all available assistance it can provide. SAMHSA is concerned about adults and children who, at the time of a disaster, has a pre-existing mental health problem with no access to care or medications; those who may have developed a serious mental health problem as a result of the disaster; and those dealing with the depression of having lost family, friends, neighbors, neighborhoods, work and other familiarities of everyday life.

SAMHSA's disaster related programs are geared to help States address the immediate needs of the affected communities until the State is capable of addressing the needs of its citizens. Three programs specifically available to help individuals affected by natural disasters are described below.

- ***Crisis Counseling Training and Assistance Program (CCP):*** When it comes to disaster mental health services, SAMHSA's support comes primarily through an Interagency Agreement with Federal Emergency Management Agency (FEMA) which funds the SAMHSA-implemented and monitored Crisis Counseling Training and Assistance Program (CCP), a program authorized under Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974.

  For over thirty years, the CCP has supported *short-term*, solutions-focused interventions with individuals and groups experiencing psychological and behavioral problems associated with large scale disasters. These interventions help disaster survivors understand their situation and reactions, mitigate against additional stress, help survivors review their options, promote mental health using specific evidence-based coping strategies, provide emotional support, and encourage links with other individuals and agencies able to help survivors recover to their pre-disaster level of functioning. The Crisis Counseling Program uses an outreach model that includes, individual crisis counseling, group crisis counseling, public education, community networking and assessment and referral to reach those affected in a federally declared disaster area. The program includes both short-term (60 day) and long-term (9 month) grant funding. At the end of that period, the State becomes responsible for ongoing services. In some major cases that period is extended, but it is still the expectation that the State will right itself and serve those who are in need.

- ***SAMHSA Emergency Response Center (SERC):*** The SAMHSA Emergency Response Center, or SERC, was established to coordinate the overall Federal response for mental health and substance abuse issues around Katrina. In the days, weeks, and months immediately following Katrina, the SERC operated 12 hours a day, seven days a week at the height of the disaster.

- ***National Suicide Prevention Lifeline:*** When faced with the effects of a natural disaster, many become depressed and unfortunately too often think about or even try to commit suicide to avoid the pain. SAMHSA runs a Suicide Prevention national hotline that is connected to over 140 crisis centers to address the needs of individuals and to connect them with services.

**Appendix 2**

**National Commission on Children and Disasters Recommendations Relative to the HHS Administration for Children and Families.**

The Commission's recommendations specifically relate to the following ACF program areas:

1) Child Care;
2) Disaster Case Management; and
3) Child Welfare.

Child Care

The Commission's interim recommendations related to child care require States to develop comprehensive disaster plans for child care to ensure coordination with key stakeholders, including public health and child care resource and referral agencies. The ACF Child Care Bureau (CCB) has already taken some initial steps by providing technical assistance on emergency planning and asking States to report on disaster preparedness efforts in their State Plans for the Child Care and Development Fund (CCDF) program. In addition, ACF supports the Commission's recommendations to require disaster planning capabilities for child care providers, and improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster. The CCB also developed the Child Care Resources for Disasters and Emergencies Web site. The site is available at http://nccic.acf.hhs.gov/emergency. The site includes a wide range of information and resources about emergency preparedness, disaster and emergency response efforts, recovery resources, and lessons learned.

Disaster Case Management

ACF's approach to disaster case management seeks to assist States in rapidly connecting children, families, the elderly, and persons with disabilities with critical services that can restore them to a pre-disaster level of self-sufficiency that maintains clients' human dignity. The ACF model is based on five principles: self-determination, self-sufficiency, Federalism, flexibility and speed, and support to the States. The Commission recommended establishment of a holistic federal disaster case management program with an emphasis on achieving tangible positive outcomes for all children and families within a Presidentially-declared disaster area. ACF agrees, and on December 1, 2009 ACF and FEMA signed an Interagency Agreement to allow for implementation of the ACF Disaster Case Management Program after a future major disaster has been declared by the President. We believe this program is fully consistent with the Commission's recommendation.

Child Welfare

Although State welfare agencies are required to have disaster plans, the Commission recommends that guidance, technical assistance, and model plans be provided to assist State and local child welfare agencies in meeting currently applicable disaster planning requirements and further require collaboration with State and local emergency management, courts and other key stakeholders.

Toward the goals of this recommendation, ACF's Children's Bureau (CB) Training and Technical Assistance Network proactively addresses disaster preparedness, response and recovery by providing onsite technical assistance and by developing a variety of materials, disseminated through the National Resource Centers' newsletters, websites, web casts, list serves and technical assistance. A link to the Children's Bureau Training and Technical Assistance Network can be found at
http://www.acf.hhs.gov/programs/cb/tta/index.htm.

The client population served by the CB programs includes children who are particularly vulnerable and at risk due to abuse and neglect. Many of these children are already separated from birth parents or family members and may be in the custody of the State child welfare agency and placed in temporary foster homes. The Children's Bureau has worked with ACF Regional Offices and the State child welfare agencies and courts to build disaster preparedness, response and recovery plans. After the 2005 hurricanes, the CB National Resource Centers received additional funding to help States address their training and technical assistance needs and to promote disaster preparedness by State child welfare agencies.

Other initiatives and activities developed and implemented by ACF related to children and disasters include:

Office of Head Start

The Office of Head Start (OHS) has printed and will disseminate the Head Start Emergency Preparedness Manual this month. The manual will also be available for download on the Early Childhood Learning and Knowledge Center website. The manual focuses on planning for emergencies and offers grantees a wide variety of tools for assessing risks, identifying resources, and developing action plans. The manual was reviewed by the ACF Office of Emergency Preparedness.

On December 3, 2009, OHS conducted a webcast on Emergency Preparedness. The webcast featured information about the phases of emergency preparedness, including: 1) Impact: How Head Start and Early Head Start programs across the country cope with disaster while it is occurring; 2) Relief and Recovery: How Head Start and Early Head Start programs resume services and help children and families get back on their feet; and 3) Planning and Practice: How you can plan and practice your strategy to respond to a variety of potential crises that may impact Head Start programs. The website was viewed by approximately 1,400 sites across the country.

Family and Youth Services Bureau

The Family and Youth Services Bureau (FYSB) developed a disaster planning guidance document for the Runaway and Homeless Youth program. FYSB has taken the "P's and R's" approach to planning (Prevention and Preparedness, Response and Recovery). The document is called *Ready for Anything: A Disaster Planning Manual for Runaway and Homeless Youth Programs*

**STATEMENT OF**
**WILLIAM MODZELESKI**
**ASSOCIATE ASSISTANT DEPUTY SECRETARY**
**OFFICE OF SAFE AND DRUG-FREE SCHOOLS**
**US DEPARTMENT OF EDUCATION**

**BEFORE THE**
**SUBCOMMITTEE ON DISASTER RECOVERY**
**COMMITTEE ON HOMELAND SECURITY AND GOVERMENTAL AFFAIRS**
**UNITED STATES SENATE**

**DECEMBER 10, 2009**

Thank you Chairman Landrieu, Ranking Member Graham, and Members of the Subcommittee. I appreciate the opportunity to be here today to discuss how the Department of Education (ED) has responded to the needs of children affected by disasters, including the role we played in the aftermath of Hurricanes Katrina and Rita. I am also pleased to provide information about the steps we are taking to address recommendations related to elementary and secondary education made by the National Commission on Children and Disasters in their October 2009 Interim Report.

I want to begin by providing a brief overview of the status of emergency management planning in elementary and secondary schools. I am pleased to report that almost every school in the country has developed an emergency management plan, as required for school districts receiving funds under Title IV of the Elementary and Secondary Education Act of 1965 (ESEA), as amended . While most schools have these plans, we know from our grant monitoring activities, from trainings we have provided to school districts, and from our review of applications for funding under our emergency management grant programs that a number of the plans have weaknesses.

For example, some schools' emergency management plans fail to take a comprehensive "all hazards" approach, and instead focus heavily on relatively rare incidents with significant consequences, such as school shootings. Others do not address the needs of all of the populations present in schools, such as students, staff or faculty with disabilities. Sometimes the content of the plans is not thoroughly communicated to staff, students, and their families, or plans are not practiced and revised based on the results of drills and simulations. Still other plans fail to use the "four phase" approach to emergency management developed by the Federal Emergency Management Agency (FEMA), which include prevention-mitigation, preparedness, response, and recovery. In our experience, schools are most likely to struggle with plans for the recovery phase. Not every school emergency management plan faces all of these challenges, but many do have one or more of these shortcomings.

To help schools address these challenges and help ensure that they have the necessary resources to plan for, respond to, and recover from emergencies, ED is implementing a variety of activities. These activities include:

**Project School Emergency Response to Violence (Project SERV)**
Project SERV was created by Congress and implemented by ED in 2001 to help schools restore the learning environment as quickly as possible after experiencing an event that disrupts teaching and learning. Based on our past work with schools, we know that events such as school shootings or natural disasters, such as hurricanes, can have a traumatic effect on students and faculty and that additional services are often needed, such as mental health counseling, security assistance, or substitute teachers.

While Project SERV was developed in direct response to a series of school shootings that occurred in the 1990's, it has been used since its inception to support the needs of children affected by and recovering from a variety of traumatic events. Since the establishment of Project SERV, ED has made 74 awards to school districts and states. Thirty-eight of these awards were made to schools after a shooting or other violent event; 16 were made to districts after a suicide or series of suicides; 2 were made to deal with the aftermath of an accident; and the remaining 18 were made to deal with other significant disruptive events.

Immediately following the events of 9/11, we recognized that children could be affected not only by events that directly touched their individual schools, but also by circumstances beyond the borders of their school. To help those children that were affected by the events of 9/11, we provided Project SERV awards to the states of New York, New Jersey, Connecticut, Maryland, and Virginia. In addition, separate awards were made to support the efforts of the Washington D.C., and New York City schools. These grants–totaling $13,425,000—were used by State Education Agencies (SEAs), the New York City Board of Education, and Washington, DC Public Schools for activities such as mental health counseling, grief counseling, and professional development for staff.

In September 2005, shortly after Hurricane Katrina struck the Gulf Coast, we reached out to the SEAs in Alabama, Mississippi, Louisiana, and Texas to offer assistance through Project SERV. We made grants totaling $7 million to each of the States that were directly impacted by the hurricane. SERV funds were used for a variety of efforts, including hiring additional counselors and social workers, providing supplemental educational services for students who had missed school, offering teacher professional development on recovery-related topics, and providing support to families.

In February 2008, after shootings at Virginia Polytechnic Institute (Virginia Tech) and Northern Illinois University (NIU), Project SERV was expanded so funds could be awarded to institutions of higher education (IHEs). The first institution to receive such funds was NIU. It received $396,919 in September 2008 to hire additional counselors, develop a threat assessment protocol, and identify alternate classroom space. While Virginia Tech did not receive funds under Project SERV, it did receive $960,685 from ED to help respond to the mass shooting that occurred there on April 16, 2007. The funds were provided under the Safe and Drug-Free Schools and Communities Act National Programs grant authority (Title IV, Section 4121 of the ESEA), and were used to establish a sustainable institutional infrastructure for identifying, assessing and responding to students who are more likely to commit violent acts. Virginia Tech has also used grant funds to support national discussions on assessing and responding to at-risk individuals in a higher education setting as part of efforts to create a replicable model.

**Readiness and Emergency Management for Schools (REMS)**

The Readiness and Emergency Management for Schools (REMS) initiative was created by Congress and implemented by ED in FY 2003. The program is designed to provide funds to LEAs to create, strengthen, or improve emergency management plans at the district and school-building levels. Funds from this initiative can be used by LEAs to train school personnel in emergency management procedures; to coordinate with local community partners, including local government, law enforcement, public safety or emergency management, and public health and mental health agencies; and to improve local capacity to sustain emergency management efforts. Since the initiative's inception, ED has awarded over $200 million in grants to 717 school districts in 47 of the 50 States. In 2009, ED awarded $26.7 million to 111 districts.

**Emergency Management for Higher Education (EMHE)**

In FY 2008, Congress appropriated funds for IHEs to develop and implement emergency management plans to prevent campus violence (including assessing and addressing the mental health needs of students) and for responding to threats and incidents of violence or natural disaster in a manner that ensures the

safety of campus communities. Since that time, ED has provided over $18.4 million in grant funding to 43 IHEs across the country. Funds from EMHE are being used by IHEs to implement a variety of activities, including writing and enhancing emergency management plans, providing training to campus stakeholders, conducting vulnerability assessments, collaborating with State and local community partners, and developing campus-based threat assessment teams.

**Elementary and Secondary School Counseling Programs**

While not primarily a disaster recovery program, the Elementary and Secondary School Counseling (ESSC) Program supports enhanced access to mental health services for students and helps schools provide a comprehensive counseling program to meet students' needs, including recovering from a crisis. The ESSC program is designed to provide funds to Local Educational Agencies (LEAs) to develop promising and innovative approaches for initiating or expanding counseling programs in elementary and secondary schools. Since 2000, the program has provided over $350 million to 410 schools. Grantees use funds to support the hiring and training of qualified school counselors, school psychologists, and social workers for elementary and secondary schools and to provide greater student access to counseling services by reducing the ratio of students to counselors, social workers, and school psychologists. ED plans to hold a competition for new awards under this program early in Fiscal Year (FY) 2010 and make awards during the summer, pending enactment of ED's fiscal year FY 2010 appropriation.

**Training and Technical Assistance**

Aside from these various grant programs, ED also provides training and technical assistance focused on emergency management to assist schools in their efforts to plan for and recover from disasters. The framework for our emergency management guidance can be found in our 2003 publication, *Practical Information on Crisis Planning: A Guide for Schools and Communities,* which provides school officials with information on the critical concepts and components of good crisis planning and provides examples of promising practices. The guide has been distributed to every school district in the country and is available at www.ed.gov, along with numerous other publications on crisis planning and emergency management in schools.

ED also supports a REMS Technical Assistance Center that hosts a web site, develops training materials, and coordinates training sessions. The Center has collaborated with ED on a variety of publications related to children and disasters. In addition to developing publications, ED and the Center have created a series of training sessions for educators and emergency management personnel on various aspects of emergency management. In addition, we have developed a series of advanced training sessions on specific issues such as "Responding to Bereavement and Loss" and "Continuity of Operations Planning", both of which are critical issues for disaster recovery. All this information is available for educators and others involved in emergency management activities on the REMS TA Center web site: http://rems.ed.gov.

**Collaboration with Other Federal Agencies**

ED has also collaborated with other federal agencies on numerous activities that are related to one or more of the four phases of emergency management planning. For example, in collaboration with the U.S. Secret Service (USSS), we conducted research on elementary and secondary school shootings. The findings from that study, published in a report entitled *The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States*, are available at http://www.ed.gov/admins/lead/safety/ preventingattacksreport.pdf and provide educators and law enforcement personnel with key information about how to prevent school shootings. A similar study is being conducted on targeted shootings at IHEs, and we expect it to provide administrators at colleges and universities with similar findings.

As a result of our research on school shootings, we have also developed a guide to managing threatening situations in schools. The guide is available at http://www.ed.gov/admins/lead/safety/threatassessmentguide.pdf and served as the basis for the development of a Threat Assessment Training Program. Since 2002, ED and the USSS have provided several hundred of these threat assessment trainings to educators, law enforcement personnel and mental health staff.

ED has also worked with the Department of Homeland Security (DHS) and the Centers for Disease Control and Prevention (CDC) to respond to the recent H1N1 influenza outbreak. Because children and youth are disproportionately affected by the virus, schools and school policies were of paramount importance and became a focal point in responding to this emergency. Since April 2009, when the virus was first reported, we have worked with the CDC to publish common-sense guidelines to help schools—from pre-K to higher education—manage the risk of the disease while also maintaining a stable learning environment for students. Together, we created a nationwide reporting mechanism to track school dismissals in real time, allowing decision makers and scientists to understand how communities were affected by and responded to the threat of H1N1 influenza and how the disease spread across the country.

ED has also collaborated with the National Oceanic and Atmospheric Administration (NOAA) and DHS to provide all public and private elementary, secondary, and postsecondary schools with NOAA all-hazards radios. These radios, which were provided to schools free of charge, are an effective and inexpensive tool for communicating both weather-related and other public safety alerts to local communities and schools so they can be better prepared to respond to a crisis.

**Response to Hurricanes Katrina and Rita**

In addition to our broad and ongoing efforts to address emergency management in all schools, ED engaged in numerous activities designed specifically to support the recovery effort following Hurricanes Katrina and Rita.

In the days, weeks, and months following the hurricanes, Department officials maintained contact with the affected states to continually assess their needs and provide assistance where possible. ED staff conducted numerous conference calls, meetings, and training sessions with local and state officials and provided written guidance as needed to respond to concerns. We created a brochure full of practical tips for educators, school support staff, parents, and students to help students cope with the aftermath of disaster. In addition, we developed a web site to serve as a resource clearinghouse for persons who wanted to help students displaced by the hurricane.

ED also granted waivers to various provisions of fiscal and administrative requirements of the Education Department General Administrative requirements (EDGAR), as well as ESEA. We worked closely with affected SEAs to permit greater flexibility on provisions related to carry over funds and transfer of funds, as well as maintenance of effort and matching requirements, and supplement not supplant restrictions.

In addition to our extensive outreach efforts to affected states, ED also implemented several specific programs created by Congress to respond to the needs of displaced students, including grant programs to assist homeless youth, charter schools, teacher recruitment, and IHEs in the Gulf Coast region. Three of the our most expansive efforts involved the Emergency Impact Aid program, the Immediate Aid to Restart School Operations (Restart) program, and the provision of Federal Student Aid for displaced college students.

***The Emergency Impact Aid Program for Displaced Students***

The Emergency Impact Aid Program (EIAP) was signed into law on December 30, 2005, as section 107 of the Hurricane Education Recovery Act (HERA). The legislation authorized formula payments to

LEAs and eligible nonpublic schools to assist with costs associated with the education of children who were displaced by Hurricanes Katrina and Rita. The original appropriation provided $645 million, and a supplemental appropriation signed by the president on June 15, 2006, increased the total funding to $880 million. The authority and funding were available only during fiscal year 2006. Forty-nine States and the District of Columbia applied for the program and all that applied received funding.

Under EIAP, LEAs could use funds for a wide range of allowable costs incurred during school year 2005-2006, the year in which the children were initially displaced. Authorized uses of funds included compensation of personnel, curricular materials, classroom supplies, mobile educational units, transportation costs, health and counseling services, and education and support services. In addition, Emergency Impact Aid could be used for basic instructional services including tutoring, mentoring or academic counseling.

Funds were distributed on the basis of student count data supplied by SEAs and LEAs. The LEAs were required to make counts of displaced students enrolled in their schools on four quarterly dates during the school year. They reported this information to their SEAs, which combined the counts in their initial applications to ED and in amendments made later in the year.

The law stipulated short time periods for the implementation of the program in order to move the funds to the LEAs as quickly as possible. In January 2006, ED published in the Federal Register a notice of availability of funds and published an electronic application on the Internet. Under the statute, LEAs were required to apply to their SEAs for funds no later than 14 calendar days after the date of the Federal Register notice, and the SEAs were required to submit their initial applications to the ED no later than 21 calendar days after the publication of the notice. ED also published policy guidance through two Frequently Asked Questions documents in January and March because there was insufficient time for the rule-making process. ED made a series of payments to SEAs based on the initial applications and the amendments that were submitted later; the SEAs then made payments to the LEAs.

The formula in the law specified a maximum amount per displaced student, and specified that payments be made based on four quarterly counts of displaced students in the LEAs. When the initial payments were made, ED prorated the amount paid per student because it was unclear whether the appropriation would cover the maximum amount. After receiving all amendments and after the passage of the supplemental appropriation, ED determined that the maximum amount per student could be paid. Final payments were made in the summer of 2006, and the LEAs were able to use those funds for costs that had been incurred during the 2005-2006 school year.
ED staff conducted multiple conference calls with SEAs, LEAs, and nonpublic schools, as well as education coordinators for homeless students, between January and June. The program staff conducted technical assistance and monitoring trips to several SEAs, including the three that reported the most displaced students, Texas, Louisiana, and Mississippi. Monitoring trips also were made to the SEAs of Arkansas, Maryland, Michigan, Missouri, North Carolina, Tennessee, Virginia, and Washington, D.C.

The primary challenges for the EIAP related to fiscal oversight and management of the program. While ED was able to make initial payments within two months of receiving the appropriation, the most heavily impacted school districts and States were not prepared to administer these funds within the prescribed timeframes. Recordkeeping was also an area that proved challenging, as applicants for Emergency Impact Aid were allowed to adjust their data as they received more accurate student counts. Finally, in some cases, States were hesitant to move forward when the "normal" rules did not apply, which resulted in unnecessary delays. For example, instead of drawing down available funds immediately, as EIAP allowed, some States first required LEAs to submit expenditure reports, which was unnecessary. Some of

the States needed assurances from ED officials that they were not violating rules prohibiting excessive fund draws that are often imposed on grantees under other programs.

An important factor in the success of the program was the ability to launch a grant program in an exceptionally short period of time. Although ED had been preparing for the passage of this legislation, certain steps, such as approval of application forms by the Office of Management and Budget (OMB), could not occur until the legislation had been signed. The OMB approval moved very quickly because OMB and ED made this project their highest priority, and each office was ready to respond to the needs of the other. The very short timeframes created challenges for the SEAs, which had to develop their own applications and procedures and coordinate new activities with their LEAs. In planning for future emergency programs such as this one, it will be imperative to establish strong lines of communication between each level of government as quickly as possible.

***Immediate Aid to Restart School Operations***

The Immediate Aid to Restart School Operations (Restart) was signed into law on December 30, 2005, as section 102 of the Hurricane Education Recovery Act (HERA). The $750 million program was designed to provide immediate services and assistance to LEAs and non-public schools in Alabama, Louisiana, Mississippi, and Texas that served an area in which a major disaster had been declared as a result of Hurricane Katrina or Rita. In an effort to assist states in their recovery efforts, the Department made initial awards under Restart within just six days after the passage of HERA. The remainder of the grant funds was awarded less than two months later.

Although Restart funds were awarded in FY 2006, they are available to the states until expended. Louisiana and Mississippi still have active grants and continue to use Restart funds in their recovery efforts. Restart funds may be used for a variety of activities, including, but not limited to: recovery of data, rental of mobile units, replacement of instructional materials and information systems, curriculum development, transportation costs, and initiating and maintaining education and support services.

Since the program's inception, Department staff has stayed in close contact with SEA staff, particularly from Louisiana and Mississippi, to provide technical assistance and to monitor program implementation. This close contact continues today, and will continue until the Restart funds have been completely expended.

***Federal Student Aid for the Education of Displaced Postsecondary Students***

While most postsecondary education institutions in the Gulf region re-opened quickly after Hurricane Katrina, 42 institutions had to suspend operations, many for at least the fall semester. Other institutions throughout the region and across the nation opened their doors to these nearly 70,000 displaced students. ED moved quickly, issuing guidance to institutions in the days immediately following the storm so that displaced students could quickly receive Federal student aid.

Our Federal Student Aid office (FSA) convened a higher education Katrina taskforce to ensure that our response addressed all aspects of FSA's service delivery and business functions that touch students, parents, borrowers, schools, lenders, guaranty agencies, servicers, and our other business partners. We reached out to affected schools to assist them in assessing the damage. FSA representatives were dispatched to the region to provide on-site guidance and assistance. ED extended application and reporting deadlines for a number of higher education programs.

We established a Hurricane Katrina call center group to field calls from students, parents, borrowers, schools and partners impacted by the storm. Any question posed to any FSA call center or received

through email was immediately routed to this group of specially-trained customer service representatives. In the months immediately following the storm, FSA received over 6,000 requests for information.

FSA developed a Web site to inform affected higher education students, parents, schools, lenders, loan servicers and business partners about the assistance that was available to them. The site was linked to our primary website, www.ED.gov, as well as all of FSA's primary sites, and it served as our key tool for communicating with those impacted by the storm.

**Recommendations of the National Commission on Children and Disasters**

In its Interim Report released on October 14, 2009, the National Commission on Children and Disasters made two recommendations specifically related to elementary and secondary schools. Those recommendations were:

*Recommendation 7.1:* Establish a school disaster preparedness program and appropriate funds to the U.S. Department of Education (ED) for a dedicated and sustained funding stream to all state education agencies (SEAs). Funding should be used for state-and district-level disaster response planning, training, exercises and evaluation that are coordinated with state and local plans and activities.

*Recommendation 7.2:* Enhance the ability of school personnel to support children who are traumatized, grieving or otherwise recovering from a disaster.

ED appreciates the Commission's work and believes that the activities discussed earlier in this testimony have helped schools be better prepared to plan for, respond to, and recover from disasters. We are currently reviewing the recommendations to determine what actions we can take to provide schools with the most effective emergency management support possible.

With regard to Recommendation #7.1, ED stands ready to work with SEAs to implement programs and activities created by the Congress in a timely way, and with an emphasis on the growing body of knowledge available about effective emergency management planning, response, and recovery.

With regard to Recommendation #7.2, ED has already developed and implemented a training program on bereavement as part of an advanced training curriculum developed for its REMS grantees. We are prepared to explore ways in which this and other important content can be made more available to a broader range of school personnel.

We look forward to continuing to work with the Commission as it develops a final report, and to working with Congress as it reviews the interim recommendations and considers possible action in this area. We believe that, by working together, we can continue to help ensure that all schools are prepared to respond effectively to traumatic incidents and minimize disruptions to teaching and learning.

**Hearing Testimony of Louisiana State Superintendent of Education Paul G. Pastorek**
**U.S. Senate Ad Hoc Subcommittee on Disaster Recovery**
**December 10, 2009**

Good Afternoon.

I am Paul G. Pastorek, Louisiana State Superintendent of Education. I would like to thank Senator Landrieu and the members of the Ad Hoc Subcommittee on Disaster Recovery for exploring opportunities to more effectively support students and families who are impacted by disasters. Unfortunately, in recent years, Louisiana has experienced several events that have led to displacing our students for an extended period of time, and in some cases permanently. With that in mind, I appreciate the opportunity to share our perspective on what is working and what challenges we continue to face under such circumstances.

Having served as State Superintendent of Education since March 2007, coupled with my eight-year role as a member of our state Board of Elementary and Secondary Education and one of the founders of a statewide educational nonprofit, I have worked closely with state leaders around the country, particularly in the Gulf South, as well as extensively with state, local and school leaders in Louisiana as we attempted to respond to the numerous and diverse challenges that disrupt the education and quality of life of children when disaster strikes their homes and communities.

Today I will focus on the systematic strengths, deficiencies and resulting changes and needs that we have encountered primarily due to our experiences after Hurricanes Katrina and Rita. I would like to share with you what worked well, the adjustments we've made to improve since that time and our existing needs to adequately equip the education community to respond to disasters.

**Student Information Systems**

About 700 schools in Louisiana and Mississippi were damaged or destroyed and over 370,000 students in the two states were displaced after Katrina. In Louisiana, the storm displaced about 200,000 public school students—more than 26 percent of our state's pre-storm enrollment.

By September 2005, every state in the nation had received at least one hurricane-displaced student and 12 states had received more than 1,000. A large number of students, 45,000, relocated to Texas or to other parts of Louisiana. While the Texas and Louisiana education communities welcomed these students with open arms, we were unprepared to transition such a large number of students to other communities in such a short time-frame.

Monitoring and transitioning displaced students after a crisis requires excellent planning, effective communication, and high-quality data. School leaders need accurate data to inform student placement, deliver appropriate educational services, adjust school management practices, allocate disaster-relief funding and track student performance. Fortunately, in Louisiana, some student information, such as testing data, grade level, course history and program participation, was housed at the state level, but in several different pieces in various offices. We did not have

files that linked all of the relevant information for each individual student. During the first few days immediately following the storms, our offices received thousands upon thousands of telephone calls from receiving districts and others states who were requesting demographic and other important student information that simply did not exist in an easily accessible format. Within a few days, we were able to utilize existing data that had been collected at the state level to create a temporary information database. This allowed us to provide receiving administrators with access to basic student demographic information. But at that point, we recognized a critical need for our state to have appropriate mechanisms in place to address these kinds of emergencies, especially considering that many of our districts were not operational for months.

An even bigger challenge surfaced around the lack of specific student information. For example, the Individualized Education Plans (IEPs), which outline the prescribed needs of exceptional students, were not stored electronically at the state level. Therefore, receiving districts and states were forced to do new evaluations and IEPs for thousands of students. In the meantime, these students went without the services until their needs could be appropriately identified. You might imagine how that could make a tragic event in the life of a child even more tragic.

Although Louisiana was already working toward implementing an electronic data management system for all student records, Katrina and Rita highlighted the need to maintain electronic files of student records, such as IEPs, ensuring accessibility and portability of crucial student information.

**Emergency Impact Aid**

School districts across Louisiana and other states quickly responded to enroll displaced students into their schools, but many struggled to offset the costs of absorbing these students. The USDOE and Congress responded with the Hurricane Education Assistance Act (HERA). This Act included federal funding through the federal Emergency Impact Aid Program, which was established to offset the cost of educating displaced students after the storms. Louisiana received a total of $148,641,500 in Emergency Impact Aid funds. This was the first funding released after the storms and required that students be identified and accounted for by receiving entities, who would then request federal funding from the Louisiana Department of Education (LDOE) as the fiscal agent for the program. Both public and nonpublic schools took in these displaced students, and both were eligible for funding.

Additionally, HERA provided for aid to restart schools in severely impacted communities. The Immediate Aid to Restart School Operations provided $340 million of funding to Louisiana schools for the purchase of equipment, supplies, books and other contract services necessary to re-open schools.

At the time, there was no mechanism in place to support these kinds of recovery programs for either receiving districts and states or severely impacted communities. In fact, all HERA funds have been utilized and therefore, there is no permanent source of funding in place should such a disaster occur again. State, districts, schools and even more importantly, students and their

families, need to know there is a permanent and instantaneous funding source in place if their lives are disrupted by tragedy.

**Moving forward and lessons learned**

Through the devastation of these two storms and their tumultuous aftermaths, Louisiana, particularly the Department of Education, has identified necessary supports and systems that should be in place in the event of a crisis.

First, we require individual districts and schools to develop their own crisis management plans.

And student and teacher data systems across the region should be maintained electronically to ensure that the information systems are compatible, eliminate the risk of paper files being lost or damaged and permit information-sharing between schools and states. It would be extremely beneficial to implement statewide data systems, not only for Louisiana students, but students in Texas, Alabama, Mississippi and others who may be impacted by natural disasters. We want to be able to have the ability to provide up-to-date student data instantaneously. These systems would greatly assist education officials when deciding student placement and delivering appropriate educational services during severe times of crisis and displacement.

Perhaps most importantly, we would like to see a permanent fund established that parallels HERA. The Impact Aid and Restart programs process were extremely beneficial to our recovery efforts. If a permanent fund were to be established, it would accelerate financial support to receiving districts and states and would provide instantaneous funding to help educators support displaced students who are in great need of high quality services.

The State of Louisiana and other states along the Gulf have undergone tremendous challenges over the past few years in their efforts to recover from Hurricanes Katrina and Rita. We are fortunate for the generosity of the American people and even people throughout the world, as well as for the support of leadership advocates such as Senator Landrieu and others who have consistently voiced the needs of our children in committees such as this. Please allow me to convey our gratitude to you all, and rest assured that our aim is to leverage the resources and aid you have extended to us to transform Louisiana's education programs. While, our student enrollment has not returned to pre-storm levels—of the nearly 200,000 students that were displaced in 2005-06, about 143,000 have returned to our state. But we are coming back, and we are coming back strong – but not ignoring our charge to better prepare our state and our region for future disasters.

I appreciate the willingness of this Committee to hear some of our concerns around the needs of children impacted by these unfortunate events. It has been an honor and privilege to speak with you today, and I thank you for your time.




Statement of

Matt Salo
Director of the Health and Human Services Committee
National Governors Association

before the

Committee on Homeland Security and Governmental Affairs
Ad Hoc Subcommittee on Disaster Recovery

United States Senate

on

"Children and Disasters: A Progress Report on Addressing Needs"

December 10, 2009

Chairman Landrieu, Ranking Member Graham and distinguished members of the Committee, on behalf of the nation's governors, thank you for the opportunity to testify today regarding the state role in meeting the health care needs of children during disasters. My name is Matt Salo and I am the Director of the Health and Human Services Committee at the National Governors Association (NGA).

**State Role in Ensuring Public Safety and Well-Being**

While there is nothing that states can do to completely prevent major events such as public health emergencies, natural disasters, and terrorist attacks, there is much we can do to ensure that we are prepared to deal with them should they arrive. One of the key functions of state and local governments is to maximize our ability to prepare for, react appropriately to, and recover from any type of disaster.

We appreciate the clarity achieved by the National Commission on Children and Disasters when they categorized the key issues relevant to supporting our children during such emergencies: health, child care, child welfare, education, housing and shelter, transportation, juvenile justice, evacuation, and emergency management). Governors take these issues very seriously, and states have strong traditional roles in these areas, particularly for children. Today, I will discuss the state role (through Medicaid and the State Children's Health Insurance Program) in ensuring the health of children during these emergencies.

It is clear that states and the federal government must both do more to plan and prepare for catastrophic disasters, and that the unique needs of children must be emphasized. Although they are not just little adults, they are part of families, and preparedness must recognize that their protection and well being is achieved in the context of their family unit.

**The Role of Medicaid and SCHIP**

Medicaid is the state-federal partnership program that provides health and long-term care services to millions of low-income pregnant women, children, individuals with disabilities, and seniors. It has a long history of providing important services to those who cannot obtain care from any other source. As such, it must be functional and provide reliable and sustained service during and after an emergency.

The Congressional Budget Office recently estimated that the Medicaid program provided services to over 68 million individuals at some point in time in 2009, and as a result, Medicaid now consumes 21 percent of the average state budget. Medicaid spending has continued to rise as a result of increased caseloads and increases in costs per beneficiary, and total costs in the program are projected to increase an average of 8 percent per year for the next decade.

Although governed by a common set of federal minimum standards, the Medicaid program was designed with enough state flexibility that the programs in each of the states and territories operate quite differently with respect to who is covered, what benefits are provided (and how they are delivered), and how providers are reimbursed.

The State Children's Health Insurance Program (SCHIP) was created by the Balanced Budget Act of 1997 and provides states with the option of providing health insurance (either through Medicaid, or through a stand-alone program designed to look more like private insurance) to children in families who earn too much to qualify for Medicaid. While Medicaid covers far more children than SCHIP, they are both vitally important in the nation's health care safety net.

Governors have worked well with The U.S. Department of Health and Human Services (HHS) over the years to help ensure that Medicaid and SCHIP's role as critical components of the safety net is not jeopardized during disasters (natural or otherwise). The experiences of New York City in the aftermath of the September 11, 2001 terrorist attacks, and those of states and counties hit hardest by hurricanes, floods and other natural disasters bear out this testament to a solid foundation, but also highlight areas that clearly need focused attention.

**Hurricanes Katrina and Rita**

The devastation that was wrought in the aftermath of Hurricanes Katrina and Rita was tragic, and of a magnitude that few could have predicted. The entire governmental infrastructure was reduced to rubble in large swaths of the affected states, and in the hours immediately following the disaster, the crisis reactions were not always effective or sufficient. The shock that the hurricane winds and subsequent flooding delivered to the area's health care and safety net systems was equally catastrophic. In light of that, states fully acknowledge that mistakes were made and the system did not operate as well as we may have hoped.

But the entire story cannot be told based on the first few hours immediately post-impact. Once the initial brunt had been withstood, it became much clearer what needed to be done, and where the flaws in the nation's health care preparedness system were. On a positive note, the outpouring of generosity from state and local governments, and from individual citizens, from areas both near and far was as heartwarming as the disaster was heart wrenching. The host states were so proactive, that they assumed a considerable risk by providing services to displaced individuals well before any waivers were approved, in an effort to sustain continuity of care.

Beginning the next day after the largest and fastest mass human migration in this country's history, Governors and state Medicaid Directors in the Southern region were working together on a constant basis to ensure the transitions occurred as smoothly as possible. In the states most directly impacted by Katrina and Rita, Medicaid eligibility employees were working seven days a week taking Medicaid applications while simultaneously negotiating with CMS on how to process them. Armed with laptop computers and wireless internet cards, and working either out of FEMA tents, or directly in the hundreds of shelters that had been established, they worked to complete Medicaid and SCHIP applications, immediately enrolling kids into the programs and updating mailing addresses.

Providers in the host states were granted expedited enrollment in the respective home state Medicaid programs so that displaced beneficiaries could quickly and effectively access services across state lines and those providers could get paid for their services. Louisiana's Department of Health and Hospitals expedited Medicaid enrollment for over 7,500 out of state providers in all 50 states to ensure the continued provision of health care services to evacuated and displaced Louisiana residents. Out of state providers, especially hospitals, showed a great willingness to take on patients in need of inpatient care, and worked closely with the home states to facilitate care and payment for those services provided.

The affected states were also able to put into place provisions that suspended Medicaid's prior authorization requirements for services such as inpatient hospitalizations and removed timely filing requirements to ensure that preventive screenings were available with fewer barriers for out of state children.

Resolving issues between states whose Medicaid programs function quite differently can indeed be a challenge, as providers may be paid different amounts for the evacuees than for their normal patients, and may be required to charge different levels of cost sharing. There were even concerns about the perception of fairness in states that operate capped waiver programs who opened their doors unconditionally to new beneficiaries, while current residents looked on in frustration.

In addition to the many short term emergencies that were addressed, there were also ongoing and long term challenges such as ensuring the health and safety requirements for enrollees in home and community based waiver programs, and ensuring prolonged access to those providers willing to enroll and participate in the host state's Medicaid program.

While these were challenges, they were not insurmountable, and states were able to pick up the shattered pieces of the safety net and quickly rebuild. We can and should learn from these experiences. The following are some recommendations based on those experiences. Governors from affected states have provided us the following guidance, that I now pass on to you as lessons learned to help ensure that we – states and the federal government in partnership – provide for children during emergencies with minimal disruption.

**Recommendations**

Funding

There is clearly an important ongoing federal role in helping states plan for and respond to disasters. While every state that was affected (and every state was) stepped up to the plate to ensure constant communication and coordination, it was the promise of time-limited but full federal funding for impacted populations that made a critical difference. CMS's response was timely and crucial, but it was Congressional action that provided 100% federal match for Medicaid and for uncompensated care services provided to non-Medicaid populations that made the biggest difference in ensuring their continuity of care.

The neighboring states like Texas and Arkansas could not have been expected to pay the full cost of this enormous influx of evacuees, often with complex, expensive medical conditions. Just as importantly, with much of its tax base crippled, the states of Louisiana and Mississippi were in no position to pay for the ongoing care of its citizens who were forced to leave. The current federal rules and regulations regarding state residence simply do not envision the possibility of indefinite or multi-year evacuations. The federal government's promise of funding through the Medicaid program and the uncompensated care pools was critical, but it took time to develop this federal legislation. Should there be similar events that warrant an equivalent response in the future, these funding mechanisms can serve as a model for activating a simple, effective, more immediate response.

Health Information Exchange

Despite the efforts of the states involved and the federal government, we know that not everything worked to perfection. No amount of hands-on coordination could ensure that patients whose only health records were in metal filing cabinets submerged under six feet of dirty water would be able to quickly and effectively interface with providers hundreds of miles away. Some of the most commonly reported problems had to do with patients' medication histories. If the only hard copy of which prescription drugs an evacuee was currently taking was destroyed or lost, there was no mechanism in place for any provider to learn that information. In this case, residents were forced to verbally describe the multiple medications they were currently taking, and often had to resort to describing them by how the pills looked.

In fact, in every state we talked to, the top federal recommendations invariably revolved around ensuring interoperable health information exchange and a greater reliance on reliable electronic medical records. Life-critical data must be able to survive a catastrophe and travel with the person to safety, outside of a physical filing cabinet. In fact, the Southern states have been meeting regularly around the current HIE grants to ensure interoperability between systems for situations like this.

This is not an easily achievable task even in perfect conditions, and states are hard at work trying to build the infrastructure to ensure accessibility of information when necessary, while ensuring that appropriate steps are taken to protect patient privacy.

There are examples of approaches that worked. KatrinaHealth.org was an online database of patient pharmaceutical information established by drug stores and pharmacists working together to share data. It enabled, on a limited basis, patients and providers to be able to access some information about their medication history. One of its challenges was that it did not provide access to important information on mental health drugs, for various privacy and security reasons. Unfortunately, we know that this is one of the areas that is MOST critical to patients attempting to recover from the shock of a disaster of this magnitude.

Similarly, Louisiana discovered that its online immunization network for kids, called LINKS, allowed authorized users to access the immunization records for children. This was immediately important as it allowed these children to enroll quickly into schools no matter where they ended up. It was also important to show that broader application and adoption of the technology could be the backbone for ensuring continuity of care despite the hardships otherwise encountered.

While the HITECH Act set in motion a national process to ensure interoperable health information exchange by 2014, we must continue to be vigilant until such time as these networks are operational. Additional funding steered towards providing up front financial incentives for primary care providers to adopt the hardware and software would be an improvement and could make the nation more prepared more quickly than the current trajectory.

Supporting the Existing System of State and Local Response

There are two important themes to remember. First is that health care delivery systems, public health infrastructures and preparedness/planning activities are local by nature. The second is that every disaster is different. Hurricanes that impact multiple states are very different from wildfires or localized floods that primarily impact only one state. Both of these are different from events such as the terrorist attacks of 9/11.

States have now had years of experience conducting so called "table top exercises", with the assistance of the Department of Homeland Security. Often conducted regionally, they have made states, and the nation more prepared for various contingencies, such as terrorist attacks, potential pandemic outbreaks such as the avian flu, and natural disasters such as floods or hurricanes. This concept has worked and should be continued. These exercises could be expanded to include issues specific to children, such as the interaction of schools and the health care and social services safety nets. However, while the unique needs of children must be addressed in the planning for and response to disasters, it is important to recognize that children are members of families, and we must be careful not to disrupt the family unit.

The ability of states to work together and with their federal partners is the underpinning of a successful disaster response system. With the various templates in place now and the lessons we have learned over the past decade, we are better equipped to handle the fundamentals of most disasters in a more timely manner. Overly prescriptive rules and regulations will only impede this function, and not make our citizens safer or more prepared.

Improving the State-Federal Partnership

The need for federal support to be flexible is highlighted by the fact that the experiences of the various states directly impacted by hurricanes are very different. The Centers for Medicare and Medicaid Services (CMS) worked extremely well with most of the impacted states to develop

waivers that could be tailored to the specific needs of both the home and host states, and streamlined to minimize unnecessary bureaucracy. The various templates took into account various scenarios such as 1) people displaced from a disaster area, but still within their home state; 2) people displaced to other states and the host state had to ensure compliance between their providers and the home state's program; 3) states that saw some residents displaced into neighboring states AND who also were accepting evacuees from other states; and 4) variations on those themes.

Louisiana, however, which saw New Orleans devastated by flooding, and saw the greatest number of citizens evacuated across state lines, was forced to make significant commitments to critical programs and other state Medicaid agencies with no guarantee that sufficient federal assistance would come. In many ways, Louisiana officials were on the vanguard of the response effort and were flying blind with little consistent federal guidance at the onset. Both federal guidance and flexibility in the initial moments of any disaster is critical to fully meet the unique challenges of every disaster and every state's situation.

In the wake of Hurricanes Katrina and Rita, impacted states took financial risks by temporarily waiving program integrity rules to ensure that people affected by the disasters got immediate access to health care services. It is important that otherwise appropriate bureaucratic safeguards do not jeopardize the provision of emergency health care services, and states should not have to simultaneously focus on protection of their citizens and fear of penalties or disallowances while trying to respond to the disaster. As states make preparedness plans, they need more certainty (either with legislation, or clear regulatory guidance) on the availability of emergency funding and what types of program rules can be waived, and for how long.

**Conclusion**

Ultimately since disasters cannot be entirely prevented, it is our duty to ensure that we do our best to prepare for the unexpected. This can best be achieved with a renewed partnership between states and the federal government that recognizes the tools states need to ensure the well being of their citizens.

The clearest way that the federal government can help ensure this is through 1) the certainty of adequate funding; 2) continued assistance in the development of interoperable health information exchanges; 3) timely support for states as they prepare for and react to these unfortunate events; and 4) working with states to improve the state-federal partnership.

**Hearing Testimony of Melissa Reeves, PhD, NCSP**
**U.S. Senate Ad Hoc Subcommittee on Disaster Recovery**
**December 10, 2009**

Good afternoon. I am Dr. Melissa Reeves, a school psychologist and faculty member in the school psychology program at Winthrop University. I want to thank Senator Landrieu and the members of Ad Hoc Subcommittee on Disaster Recovery for taking the lead in shining a light on the needs of children impacted by crises and disasters. It is a privilege to be here today on behalf of the National Association of School Psychologists (NASP), and to share my view of the critical role schools must play in crisis response and recovery.

In addition to being a graduate educator and a consulting school psychologist, I am also a licensed special education teacher, licensed professional counselor, and lead developer of the PREPaRE School Crisis Prevention and Intervention Training Curriculum with more than 15 years of direct experience helping schools prevent, prepare for, and respond to crisis events.

My remarks today focus on the significant role of schools in keeping our children safe and healthy in the event of a crisis. After both 9/11 and the Gulf Coast hurricanes, we saw America's schools thrust into the center of the nation's crisis response. Not only did schools respond in the immediate aftermath of these tragedies, but they have been, in many cases, the sole source of ongoing support for children and their families during recovery. In fact, I think it is safe to say that the country would have been unable to meet the needs of children and youth, even to the extent we have, without our schools.

## Impact on Children

This support is vital, since trauma can have significant psychological consequences for children and youth if we fail to provide the appropriate services needed for full recovery. In working with a variety of students and age levels in the aftermath of crises, I have seen firsthand their impact on both the physical and psychological safety of students. Immediate reactions can be profound and include fear, anger, grief, anxiety, loss, and hopelessness. Children also often have trouble eating, sleeping, concentrating, or interacting with others; crying; regression; and/or withdrawal. As children grow, their reactions may change and new emotions emerge as they process the crisis event at different stages of their lives. Therefore, recovery takes time. In schools, trauma reaction can manifest itself in declines in grades; inattentiveness in class; increased social, emotional, and behavior problems (such as interpersonal conflicts or increased aggression); physical complaints; and risks from serious mental health problems like posttraumatic stress disorder (PTSD), major depression, anxiety, or suicidal ideation.

The aftermath of Hurricane Katrina illustrates many of these negative and concerning outcomes. For example, a study of children living in FEMA subsidized housing found 44% (at 6 months) and 55% (at 1 year) experienced new emotional or behavioral difficulties (Abramson & Garfield, 2006; Abramson et al., 2007). Additionally, a study of individuals from households that were displaced by Katrina, conducted 21 months after the hurricane, found that up to 37% had been diagnosed with depression, anxiety, or a behavior disorder (Abramson et al., 2007). Further, the lifetime prevalence rate of PTSD (a serious and dehabilitating mental disturbance generated by exposure to extreme traumatic stressors) is estimated to be 6–10% for children and adolescents in the general population (Dyregrov & Yule, 2006) and as high as 30% among some urban populations (Buka, Stichick, Birdthistle, & Earls, 2001). Finally, there is considerable evidence that youth with trauma exposure and PTSD are at increased risk for low academic achievement, depression, aggressive or delinquent behaviors, and substance abuse (Kilpatrick, Saunders, Resnick, Best, & Schnurr, 2000). Despite these alarming findings, the good news is that when we meet the needs of children affected by a crisis with timely and appropriate services, we minimize traumatic effects and increase the odds that children will continue to learn and grow despite their crisis experience.

## Schools Are Critical to Providing Services

Schools are uniquely positioned to support this process and the President's New Freedom Commission on Mental Health (2003) recommended that one way to enhance the utilization of mental health

services is to deliver them in schools. Supporting this recommendation, it has been found that referrals for school-based mental health services are far more successful than referrals to agencies in a community-based setting (Evans & Weist, 2004). There are multiple reasons for this. First and foremost, schools are where children reside for a significant amount of time each day. The learning environment provides daily structure and support, and opportunities for building coping skills. Second, school personnel know the students. They have the opportunity to monitor the residual and emerging effects of the crisis and provide a continuity of supports over time. And third, schools are familiar and accessible to families. This increases the likelihood that they will seek and accept help for their children. Schools can help support the parents as well, and in my personal experience, this also leads to more parent engagement with their child's learning and recovery.

This need is especially great in New Orleans, as documented by *The State of Public Education in New Orleans Reports* (BCG, 2007, 2008). Both reports documented teacher and support staff shortages, and the 2007 report indicated that students often did not receive the services they needed, especially counseling services. In addition, the 2007 Report noted that students, families, and community members all voiced the need for improved mental health support for students in the public schools. Many schools report that they lack sufficient numbers of mental health professionals (such as school psychologists), which they believe has led to a growing difficulty engaging students in learning and an increase in disciplinary incidents.

## Direct Interventions Provided by School Psychologists and Other School-Based Mental Heath Professionals

Community-based services are also critical to meeting the full continuum of children's needs and are invaluable in cases where children require intensive long-term therapeutic support. However, these services need to be supplemental and complementary to those provided by school-employed mental health professionals (such as school psychologists, school counselors, school social workers, and school nurses). Ensuring the ongoing presence of school-employed mental health professionals is important because of our specialized training with children, knowledge of schools, and our familiarity with students. I saw this firsthand as a crisis responder following the Columbine High School shooting. While there were many mental health professionals offering their assistance, some lacked the special knowledge and training needed for work in schools and with traumatized youth. Those that lacked this knowledge were not particularly helpful, and in some cases they did more harm than good.

This brings me to a key point: crisis response is *not* a matter of choice for schools. When a crisis occurs, the school can be immediately transformed from an environment focused on learning to a triage center, emergency shelter, evacuation site, counseling center, communication depot, and/or liaison between families and community services. I can tell you from firsthand experience that the entire school staff (including secretaries, teaching assistants, and custodial staff) become caregivers who provide a critical sense of normalcy and structure for children in an otherwise chaotic, sometimes frightening world.

The problem is that very few schools today are adequately prepared to perform this role in a comprehensive, cohesive, and sustained manner. It is critical that any proposed legislation addressing children and disasters explicitly link schools to policies and funding to ensure all phases of emergency response are efficient and effective.

## What Does This Look Like? PREPaRE Curriculum & Professional Training Opportunities

Effective school crisis response requires planning and strategies appropriate to the learning environment that encompass both physical and psychological safety, school–community collaboration, a designated school crisis response team, and staff training. In training professionals across the country, I have often seen some or part of these things addressed, but rarely all. For example, a crisis plan may address physical safety with minimal focus on psychological safety. Or staff training may focus on plan development, but not staff skill development. Effective crisis training must use a comprehensive approach.

As a leader with NASP, I have had the privilege to help develop the *PREPaRE School Crisis Prevention and Intervention Training Curriculum* (PREPaRE) designed to help schools build this capacity at the local level. NASP has long been a leader in school crisis response, providing direct support in schools,

training, research, and free public resources in the aftermath of major crises. The PREPaRE curriculum is a comprehensive crisis prevention and intervention curriculum developed by school-based professionals who have extensive direct experience in school crisis for school professionals. The curriculum integrates the U.S. Department of Education's four crisis phases (prevention/mitigation, preparedness, response, and recovery), and makes use of the National Incident Management System (NIMS) and its Incident Command Structure. Specifically, PREPaRE combines the important aspects of crisis team and crisis plan development with extensive training on the mental health implications for children and how to minimize traumatic impact within the school context. To date, PREPaRE has trained close to 5,000 school and community professionals from more than 38 states and several foreign countries. We have also trained local trainers to offer PREPaRE workshops within their school communities in order to foster long-term sustainability at a reasonable cost. As one district administrator put it, "PREPaRE has provided the continuity amongst providers that we have striven to reach for years." In addition, I recently had a high school science teacher who had completed a PREPaRE crisis training workshop say that what made the training important to her was that it helped her better understand the traumatic stress reactions displayed by many of her students.

In addition, the school psychology program at Tulane University in New Orleans is one of the first school psychology programs in the country to offer a specialty PhD training program in Trauma Focused School Psychology. It is important to note that this program is made possible through funding provided by the U.S. Department of Education Preparation of Leadership Personnel training grant. Their doctoral students and faculty directly work with students in New Orleans area schools that were impacted by Hurricane Katrina. In addition, they are also working collaboratively with Project Fleur-de-lis (PFDL), which is a collaborative program linking local social service agencies, schools, and nationally recognized researchers, program developers, and clinicians in a coordinated effort to provide evidence-based mental health services within 64 New Orleans area schools. This special focus on specialized school-based crisis response training that emphasizes the importance of school–community collaboration is exactly the kind of training that needs to be emphasized in policy and practice.

## How Can Congress Help Schools Build This Capacity?

We need clear policies that recognize the importance of schools in disaster and crisis response. These policies must give schools the mandate and funding to develop crisis plans and teams, train school staff, strengthen the school's capacity to deliver short- and long-term mental health services, and sustain these supports over time. We need national school crisis response standards and a national repository for best practice resources, technical assistance, and research to evaluate the efficacy of school crisis training and strategies. Immediate streamlined access to emergency funds in the event of a major crisis with the goal of restoring learning environments as quickly as possible is critical. And we need a clearly defined mechanism for school–community collaboration that lays out roles, responsibilities, and the use of resources. Lastly, schools need an adequate number of school-employed mental health professionals, such as school psychologists, who can provide the ongoing expertise and support to students, teachers, and families before, during, and following a crisis. These are the professionals trained to link services and interventions to learning, not just in the event of a major disaster, but through daily challenges that affect children's academic achievement and well-being.

Again, I'd like to thank you for your leadership on these issues and the opportunity to contribute today.

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NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

# Effective School Crisis Preparedness and Response: Policy Recommendations

There is growing awareness in the United States about the critical need to improve schools' capacity for crisis prevention, preparedness, response, and recovery. In the past decade alone, we have seen America's schools thrust to the center of the nation's response to major disasters such as the terrorist attacks on September 11, 2001 and the Gulf Coast hurricanes in 2006. Not only did schools respond in the immediate aftermath of these tragedies, but they have been, in many cases, the sole source of ongoing support for children and their families during their long road of recovery. Many schools were unprepared and inadequately resourced to do so.

The importance of school crisis response capacity goes beyond disasters. Children and schools are affected far more frequently by severe family crises, suicide, violence, or the death of a loved one, fellow student, or staff member. We know that children's psychological as well as physical health can be affected by trauma and that children respond differently than adults. Mental health supports must be integral to school crisis response capacity. Children who experience trauma generally recover when the response is organized, comprehensive, and sufficient to meet their immediate and long-term physical and mental health needs.

Despite this clear need, public policies directing schools to engage in effective crisis planning lag behind. Schools throughout the country need policies that support a cohesive, comprehensive approach to the four elements of effective crisis response (prevention, preparedness, intervention, and recovery), include crisis team development and staff training, and facilitate the necessary collaboration with community-based emergency response and relief agencies.

The National Association of School Psychologists (NASP) has been providing leadership in the area of school crisis planning and response for more than a decade. From this work, several policy priorities have emerged in response to specific needs encountered by schools following a variety of school and community-based traumatic events. This document summarizes NASP policy recommendations.

## NASP Public Policy Recommendations

**1. Public policies need to emphasize the importance of school-based crisis preparedness, prevention, response, and recovery.** Schools have many competing priorities but, in general, school leaders prioritize according to explicit directives contained in statutes and regulations. To ensure that school personnel are ready and able to handle a crisis when it occurs, public policies should guide school administrators by delineating expectations for crisis planning, prevention, and response. These policies need to take into consideration the unique developmental needs and responses of children and recognize that both short- and long-term services and supports are necessary for recovery. Additionally, policies must recognize that when children are struggling with mental health issues following a disaster or traumatic event, their academic performance often declines. A critical component to schools placing priority on school crisis preparedness and response is for policy to emphasize the positive correlation between academic achievement and mental health. Research shows that school mental health programs, prevention services, and social-emotional supports improve educational outcomes by decreasing absences and discipline referrals and improving test scores (Collaborative for Academic, Social, and Emotional Learning, 2008; Jennings, Pearson, & Harris, 2000).

**2. Public policies need to provide schools with opportunities to help build the capacity of school-based teams to plan for and respond to crises.** Schools' capacity to develop crisis plans and prepare staff for crisis response is directly related to the funding and leadership opportunities presented by the state and federal government. Building the capacity of school-based teams is important for a variety of reasons. (a) School-based personnel have an ongoing relationship with, and knowledge of, students, their families, and the school community. This familiarity is essential when assessing the degrees to which individuals have been affected by a traumatic event. (b) School-employed mental health personnel remain in the school community throughout the recovery period and can monitor and respond to emerging and residual effects of the crisis on the system, faculty, and students. (c) School-employed mental health personnel understand the processes of teaching and learning and how these relate to crisis recovery. (d) School-employed personnel are trained in school systems and law. (e) School-employed personnel have existing relationships with families, thereby increasing the ease and comfort level for which parents or guardians are willing to access crisis intervention support. Leadership provided by state governmental agencies can help promote consistent professional development, planning, and school-based response models. Importantly, professional development and planning are ongoing activities, not one-time static endeavors.

**3. Public policies need to encourage the development of a centralized repository of information, materials, and resources where proven practices in school crisis preparation, prevention, and response could be disseminated and easily accessed by the public.** A national technical assistance center or similar entity whose charge it is to gather, evaluate, and disseminate school-based crisis resources, programs, activities, training, and supports related to all phases of school crisis response would provide significant assistance to state and local governments in preparing for and responding to a crisis. No such central source of information about best practices focused on school crisis response and youth currently exists. Without a centralized source of resource information, materials, and training, incomplete information, fragmentation of services and supports, and inconsistent practices persist. Additionally, a national technical assistance center should also review existing school-based crisis preparedness and response research and identify and promote new areas for research that are needed.

**4. Public policies need to provide immediate access to emergency funding for schools for the purpose of comprehensive short- and long-term crisis response and recovery activities that include both physical and mental health supports.** Current legislation provides "state and local governments" with access to emergency funding for the purpose of restoration of physical structures, replacement of materials and resources, and for individual emergency care such as medical, dental, or mental health supports. Displacement of children from their homes and their neighborhood schools can result in additional trauma as they struggle to cope without their normal sources of stability and support. Occasionally, schools report delays in receiving funding created by funding silos and bureaucratic structures that impede the swift delivery of funds. Policies should streamline how funds filter down to individual schools and students so that the recovery work can begin quickly.

**5. Public policies need to explicitly direct community and school responders to work collaboratively for comprehensive crisis response services to children and their families.** Schools are integral to an overall community crisis response on many levels (providing a safe haven, disseminating information, identifying individuals at risk, providing mental health services, supporting teachers and administrators, linking individuals with community services, tracking displaced families, supporting long-term recovery, serving as a source of normalcy and structure). However, much of the existing legislation emphasizes the role of community responders in crisis planning and intervention. Such legislation needs to be explicit about the role of schools in providing crisis response services, while jointly collaborating with local community agencies and organizations (public and private). Collaboration needs to establish clear communication and response protocols, expectations for information and resource sharing, and for the efficient use and dissemination of goods and services. Additionally, public policies need to predict potential areas of conflict that may arise based upon differences in organizational and system functioning (i.e., FERPA vs. HIPAA).

**Project Fleur-de-lis™:**

**An Intermediate and Long-Term School-based Mental Health Service Model for Youth Exposed to Disasters**

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Hurricane Katrina, which ravaged the Gulf Coast on August 29, 2005, was amongst the most devastating natural disasters in our country's history. The traumatic experiences of youth and families who endured the storm, the flooding that resulted from the break of the levees, the evacuation, and the aftermath of Katrina were unprecedented. The aftermath of the storm also exposed longstanding problems that continue to afflict many of our nation's cities and states, especially their poorest communities: lack of jobs, proper housing, and quality education. In the days following Hurricane Katrina, it became clear that jobs, homes, and schools, were three inter-related factors that would dictate the immediate recovery of New Orleans. These three factors make up the "trinity" that has driven the recovery of New Orleans over the past four years.

For those of us providing the long-term child and adolescent-oriented mental health care post-Katrina, it has been the New Orleans area schools which have provided the best opportunity to introduce not only examples of treatment best-practice in the field of child and adolescent trauma, but new and innovative ways to link youth and families with mental health services. Project Fleur-de-lis was designed only days after Hurricane Katrina to address the intermediate and long-term mental health issues of students as they re-entered school and endured a post-Katrina landscape that evoked for many mixed feelings of grief, hope and fear.

Project Fleur-de-lis

Project Fleur-de-lis is a collaborative program linking local social service agencies, schools, and nationally recognized researchers, program developers, and clinicians in a coordinated effort to provide state-of-the-art mental health services within 58 New Orleans-area schools. Project Fleur-de-lis entered into the National Child Traumatic Stress Network in October 2008 as a Community Treatment and Services (CTS) Center within the National Child Traumatic Stress Network (NCTSN). A grant award of $1.4 million dollars by the Substance Abuse and Mental Health Services Administration (Grant #1U79SM058776-01) will help maintain Project Fleur-de-lis as a NCTSN member until 2012.

The goals of Project Fleur-de-lis are to 1) implement school intervention services to students exposed to trauma; 2) establish a mechanism for identification of and services to students with all mental health and psycho-educational needs beyond what can be addressed or identified in the school setting; 3) partner with national leaders to provide increased access to mental health care and effective trauma treatments for students in schools and the community; and 4) provide evidence that treatments for traumatized youth can be effectively delivered in a three-tiered stepped approach model of care utilizing school-based interventions, classroom-based interventions and specialized community-based interventions in communities significantly impacted by natural or man-made disasters.

Project History

For every school reopening along the Gulf Coast following Hurricane Katrina, significant logistical and clinical factors impacted the type and structure of school-based mental health interventions. These factors included the time at which an intervention could be introduced into a recovering school, the vast number of youth that needed to be served, and the varying severity of post-trauma symptoms of youth identified as being in need of more intensive care outside the school setting. Project Fleur-de-lis was designed around the invaluable knowledge possessed by school teachers, counselors, and administrators of schools rebuilding after the hurricane. This knowledge, combined with evidence-based practices, innovative pathways of care, and integrated electronic records has created an intermediate and long-term school-based mental health response to Hurricane Katrina that has addressed not only trauma related issues in youth, but the myriad of other psychological and educational problems that occur in the general child and adolescent population (e.g., anxiety, depression, learning disorders).

For every school reopening along the Gulf Coast in the weeks and months after Hurricanes Katrina and Rita, a hierarchy of needs had to be satisfied before mental health services could be introduced to the students, faculty, and administration. Focus groups with principals and counselors from 42 area schools in the spring of 2006 revealed that many could not even consider allowing comprehensive mental health programming in their schools because they were still overwhelmed with overcrowded classrooms, lack of teachers, damaged physical plants, and meeting the needs of individualized education plans of new students whose educational records had been destroyed by the storms. Project Fleur-de-lis began its first school-based interventions in March of 2006 within a Catholic school in Orleans Parish and by the start of the 2006 – 2007 academic year, 45 other schools had arrived at a time in their post-storm recovery that allowed the introduction of this school-based mental health program. Project Fleur-de-lis has grown to include 58 participating schools which include 25,000 students eligible for free in-school trauma-focused treatment. Participating schools are made up of Catholic, public, public charter, and private schools that are located across seven civil parishes in the Greater New Orleans area.

Project Fleur-de-lis' Pathways of Care

The Project Fleur-de-lis stepped model of care relies on two intervention pathways. The first pathway is comprised of the three core trauma-informed practices termed the Stepped Trauma Pathway. The second pathway is the classroom to community referral system, which is called Classroom-Community Consultation ($C^3$). Both pathways utilize a stepped approach to intervention where students receive a higher level of care if necessary, but the goal is to be able to address signs and symptoms early so a higher level of care/intervention is not necessary. Each pathway is described in more detail below.

Innovative Design: Stepped Trauma Pathways

The goal of the Stepped Trauma Pathway (Figure 1) is to provide appropriate mental health interventions to all students that are appropriate for each individual's level of need based on their trauma history and/or presenting symptoms. The Stepped Trauma Pathway is a combination of trauma informed treatments that are designed to provide care to varying numbers of children (classroom, group, individual) for varying degrees of need (mild, moderate, severe). Project

Fleur-de-lis has worked collaboratively over the past three and a half years with the authors of these interventions to promote training and implementation of these programs in southeast Louisiana and the gulf-coast region.

*Tier One: Classroom-Camp-Community-Culture Based Intervention.*
*Note: This intervention has been recently replaced by Psychological First Aid (Brymer, Jacobs, Layne, et al., 2006).*

The problem of serving large numbers of youth in the schools was answered with the help of Save the Children which instituted a psycho-social program in the United States Gulf Coast to provide support to young youth affected by Hurricane Katrina and its aftermath. Having been extensively field tested, Classroom-Camp-Community-Culture Based Intervention (CBI) (Macy, Macy, Gross, and Brighton, 2006), was attractive as a psycho-social intervention post-Katrina because of its use all over the world in addressing various types of traumatic exposures including ongoing armed conflict, post-conflict environments, refugee camps, and mass casualties as a result of natural disasters (tsunami, earthquakes, floods). This model of intervention is based on the premise that immediate, short-term interventions for trauma-exposed youth are beneficial in reducing the harmful effects of traumatizing experiences.

Within Project Fleur-de-lis, CBI was used to blanket an entire school so that every student had the opportunity to benefit from the stabilization program, and be formally (using standardized instruments) or informally screened for psychological distress throughout the CBI programming. Making up the first-tier of intervention within the Stepped Trauma Pathway, CBI provided the best opportunity to supply the most appropriate mental health intervention, at the most appropriate time post-disaster, to the most youth. As the sole sponsor of CBI in the Gulf Coast region, Save the Children trained 1,113 implementers and intervened with approximately 11,500 youth in the Gulf Coast, many of whom were enrolled in schools affiliated with Project Fleur-de-lis (Save the Children, 2007).

*Tier Two: Cognitive Behavioral Intervention for Trauma in Schools (CBITS)*

The Stepped Trauma Pathway model was designed to then move students identified throughout CBI into more intensive intervention. This more intensive and "intimate" trauma focused intervention was provided by CBITS, (Jaycox, 2004). CBITS is the most thoroughly tested trauma-focused school intervention program at present, having undergone two controlled trials (Kataoka et al, 2003; Stein et al, 2003). CBITS is listed within SAMHSA's National Registry of Evidenced-based Programs and Practices (NREPP). It includes 10 group sessions and 1-3 individual sessions designed specifically for use in schools where youth have been exposed to traumatic events.

The application of CBITS to post-Hurricane trauma was a natural choice given its proven efficacy with diverse populations and the relative ease of its dissemination and implementation. Also considered was its usefulness in addressing exposure to community violence, which for many youth in the New Orleans area was a daily occurrence prior to, and after, the storm. Because of the timing of the training for CBITS in the New Orleans area, formal referrals from tier one (CBI) to tier two (CBITS) were not possible, but future implementation of the Stepped Trauma Pathway post-evacuation in New Orleans would include this type of triage. There have

been many successful cases within Project Fleur-de-lis of youth being referred "up" from the Tier Two CBITS intervention to Tier Three, Trauma Focused – Cognitive Behavioral Therapy (TF-CBT) when CBITS was not completely successful in relieving trauma related symptoms.

*Tier Three: Trauma Focused – Cognitive Behavioral Therapy(TF-CBT)*

Finally, the issue of serving the most severe traumas in youth was answered with the help of Trauma Focused – Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino & Deblinger, 2006). TF-CBT, a SAMHSA model program, is a psychotherapeutic intervention designed to assist youth, adolescents, and their caregivers overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school or community violence; or exposure to disasters or war. TF-CBT is designed as a 10-session treatment program that mixes individual student sessions with parent-only and parent-student sessions.

TF-CBT is a components-based intervention model that incorporates trauma sensitive treatments with cognitive behavioral, family, and humanistic principals and methods for children ages 3 – 18. During the 2006 – 2007 school year, several youth in Project Fleur-de-lis were identified as having direct exposure to the storm and/or the traumatic experience of being evacuated to the Super Dome or the Morial Convention Center. Beyond helping with traumas of youth who were directly exposed to the storm, over forty youth from participating schools were referred for TF-CBT for other types of traumas (domestic violence, sexual abuse, accidents) during the same school year, making this intervention invaluable for our community-based clinicians.
Classroom-Community Consultation ($C^3$)

The goal of the $C^3$ pathway of care is to provide an efficient and barrier-free triage system for students in need of intensive interventions and services that cannot be provided within their school setting (See Figure 2). This collaborative process also allows for the provision of guidance to school counselors in their day-to-day interventions with students so as to catch school related problems early and often, and as a result avoid referrals for more intensive community based interventions. $C^3$ also functions as a clearinghouse of information and resources for those schools and communities who have been stripped of their social service assets. This collaborative referral process has also benefited the school-based counselors by increasing their knowledge of trauma related issues in youth, and strengthening relationships among participating members.

The strength of $C^3$ lies in its utilization of school mental health resources that were in place prior to Hurricane Katrina. Each week throughout the school year counselors submit names of students they believe are in need of community based services such as psychiatry, psychotherapy and psycho-educational testing. The school based counselor is required to gather information from parent, teacher and child prior to presenting their case (which includes subjective data, and data derived from standardized screening instruments). This meeting is often made up of over thirty members who include the school based counselors, Mercy Family Center psychologists, social workers and psychiatrists, and other invited community based mental health professionals. In a collaborative process, members in attendance offer questions and feedback with the goal of determining if a student is need of more intensive services. An electronic records system is used to collect and organize $C^3$ referrals and daily counselor encounters with students. If a student is

determined to be in need of services, a referral form is created from the electronic records system that assists parents in understanding their child current symptoms and how they will be linked with psychological or psychiatric care at Mercy Family Center or community mental health partner.

Impact

To date, Project Fleur-de-lis has provided intervention recommendations for 1,360 students who have been triaged during weekly $C^3$ meetings since September 1, 2006. These $C^3$ meetings have provided professional and emotional support to over 80 school based counselors in the past three and a half years. This project's Stepped Trauma Pathway has provided over 5,000 students with trauma informed interventions appropriate to their level of need since its introduction into New Orleans area schools in the spring of 2006. Douglas Walker, the architect and Project Director of Project Fleur-de-lis became a CBITS "certified" trainer in the spring of 2008, and along with his staff have trained 192 school-based counselors in CBITS over the past year and a half. See Figure 3 for a summary of Project Fleur-de-lis' service delivery since September 2006.

Lessons Learned

The first lesson learned was the unexpected demand for psycho-educational testing for students identified within Project Fleur-de-lis during the 2006 – 2007 school year. Of the 268 children staffed at the $C^3$ meetings, 116 (43%) were recommended for psycho-educational testing to rule out the existence of Attention Deficit Hyperactivity Disorder, learning disorders, or psychological issues (such as trauma) that were interfering with the student's ability to perform in school. The reason for the amount of these types of referrals might someday be explained by way of a complex algorithm, but some initial theories are as follows: First, Project Fleur-de-lis and Mercy Family Center were seeing the "typical" number of new incidences expected with the prevalence of Attention Deficit Hyperactivity Disorder (estimated at 3% to 7%) and learning disorders (2% to 10%), according to the *Diagnostic and Statistical Manual of Mental disorders* (*DSM*; American Psychiatric Association, 2000). Second, the students being recommended for psycho-educational testing had pre-existing conditions prior to the storm, but were not identified or recognized by their school as having significant deficits in learning and/or attention (15% of students referred for assessments had previously failed a grade but had not been tested to determine the cause of the learning problems). The third theory, which opens a potentially volatile discussion, is that many of the students referred for psycho-educational testing were being underserved by their former school and that they were significantly delayed academically when they entered into their new post-Katrina school and curriculum. These percentages have been persistent throughout the 2007 – 2008 and the 2008 – 2009 academic years.

The second lesson came by way of the unexpected use of our weekly $C^3$ meetings as a social support network where all participants could express their fear, doubt, and hope regarding the future of their schools and communities. It was overlooked by those of us employed within outpatient mental health treatment centers that the school counselors were often isolated in their schools, not having other mental health professionals in the next office to trade peer consultations or rely on for emotional support. By way of its own group process our weekly $C^3$ meetings have become "care for the caregiver" reconstituting each professional's fortitude and

making it possible for them to go back to "the trenches" where they continue to exert their best effort in the face of overwhelming need in our community.

*Project Fleur-de-lis Research*

Through collaborations with various centers within the National Child Traumatic Stress Network, Project Fleur-de-lis has been able to examine its system design and impact upon children suffering from trauma related symptoms. Below are brief summaries of the studies findings:

Cohen, J.A., Jaycox, L.H., Mannarino, A.P., Walker, D.W., Langley, A. K. & DuClos, J. (2009). Treating Traumatized Children after Hurricane Katrina: Project Fleur-de Lis™. *Clinical Child and Family Psychology Review*, 12(1), 55-64.

Results of this research study supported the vision that Project Fleur-de-lis could be a prototype for providing stepped care mental health screening and treatment for large numbers of significantly affected children after a community-wide disaster, although empirical data is still needed to back up its components. This stepped care approach makes inherent sense in post-disaster communities that are significantly lacking in the ability to provide adequate intermediate and long-term mental health care because it creates timely access to appropriate levels of mental health care, with a relatively small amount of professional resources. It is a comprehensive approach to identifying, triaging, and providing needed care to children, regardless of the reasons for their mental health needs, and attentive to finding the appropriate level of care for each. Our work conducted within the research project demonstrated a clear need for service among students exposed to this disaster, and attention to the varying mental health needs, moving beyond the singular focus on disaster-related symptoms, will be important in future disasters. This research project shed some light on how interventions can work post-disaster, but we already know a good deal about how to help children who face trauma, and must find new ways to toll out such programs in the weeks, months, and years to affected communities. This includes finding ways to fund such efforts so that sustained and effective programs can be implemented. (Full journal article is attached to this document).

Jaycox, L.H., Cohen, J.A., Mannarino, A.P., Walker, D.W., Langley, A. K., Gegenheimer, K. L., Scott, M., & Schonlau, M. Children's Mental Health Care Following Hurricane Katrina: A Field Trial of Trauma -Focused Psychotherapies. *Journal of Traumatic Stress.* (In Press).

This field trial indicated the ongoing need for intervention in a sample of school children who were not seeking mental health treatment more than a year following the hurricanes of 2005 in New Orleans. Not only were students experiencing symptoms related to the disaster, but many had experienced more devastating traumas and deaths prior to August 2005, and had diagnoses other than PTSD when evaluated. Future responses to natural disasters should include not only child-focused, long-term and traditional mental health services, but should take an even broader vision by taking into account previous trauma and pre-existing mental health disorders. When interventions were offered to comparable groups, access to those interventions turned out to be extremely important. The differences in access between the otherwise similar treatments, offered free of charge, shows that treatment must be available in convenient locations and at convenient

times. While schools' mission is to educate, schools may offer many children's only window of opportunity to recover from the negative effects of trauma on learning.

Conclusion

Project Fleur-de-lis grew out of the destruction and despair in the months following Hurricane Katrina to become the largest school-based mental health program in the New Orleans area (Princeton University – Woodrow Wilson School of Public and International Affairs, 2007). Lessons learned from the Project could someday assist New Orleans and other cities across the United States that experience similar disasters by informing public policy in disaster preparedness and immediate/long-term mental health responses for youth exposed to similar disasters. We expect Project Fleur-de-lis to grow beyond our current 58 schools (Figure 4) as administrators, teachers and parents find the value in combining the knowledge and expertise of school-based counselors with the knowledge and expertise of community-based providers in a coordinated effort to provide early and rapid identification and intervention of psychological and psycho-educational problems in New Orleans area students. The creation of Project Fleur-delis has been a daunting task when taking into account the adverse environment in which it was created. But in the years to come we hope to continue expanding Project Fleur-de-lis in order to assist youth and families in the Greater New Orleans area in their long-term recovery from Hurricane Katrina and provide consultation to communities across the United States who may benefit from this innovative system of intermediate and post-disaster care.

Recommendations

1. Provide Federal funding to support intermediate and long-term mental health services. Current FEMA and SAMHSA funding for crisis services a) prohibit mental health services from being offered and b) require that only disaster-specific services be provided (Stafford Act restrictions). As Project Fleur-de-lis has documented, many children exposed to disasters have previous trauma exposure and significant mental health problems that require mental health treatment. While short-term disaster-related services might help minimally impacted children, they do little for the most severely impacted children, who continue to have significant problems in the absence of mental health interventions months and years after the disaster has occurred.
2. Initiate immediately a coordinated nation-wide training program for mental health professionals (community and school-based) in Psychological First Aid, and evidence-based NREPP approved cognitive behavioral interventions such as CBITS and TF-CBT. A coordinated training program would allow communities to receive training in trauma-informed interventions before disaster strikes. Communities would also gain the knowledge to address more traditional and persistent traumas in their communities (e.g., community violence, physical and sexual abuse, neglect). Mental health professionals trained in these interventions could be placed on a national registry so as to create a coordinated tiered approach to community trauma intervention that could be formulated quickly post-disaster.

3. Build upon proven stepped models of post-disaster mental health care like Project Fleur-de-lis to address signs and symptoms early so more intensive and costly levels of care/intervention may not necessary. Stepped levels of care by way of school-based trauma interventions and coordinated triage for treatment outside the school setting addresses trauma related to the disaster, pre-existing trauma, pre-existing mental and learning disorders. Enhanced school-based

interventions and systems of care also supplement the loss of mental health care in the community, and allow for easy access to services within the school setting.

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Figure 1: Project Fleur-de-lis' Stepped Trauma Pathway
Designed for intermediate and long-term treatment of post-disaster trauma.

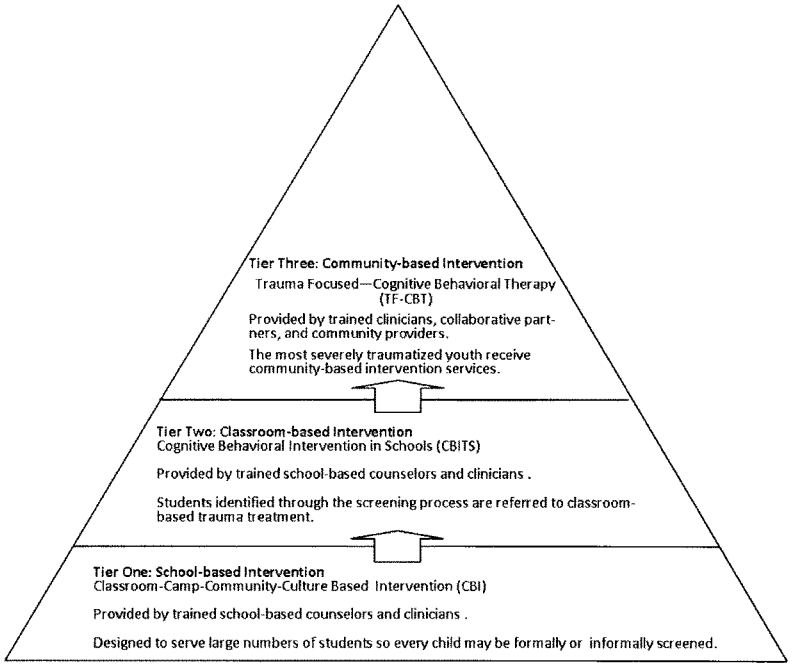

Figure 2: Classroom-Community Consultation Triage Model ($C^3$)

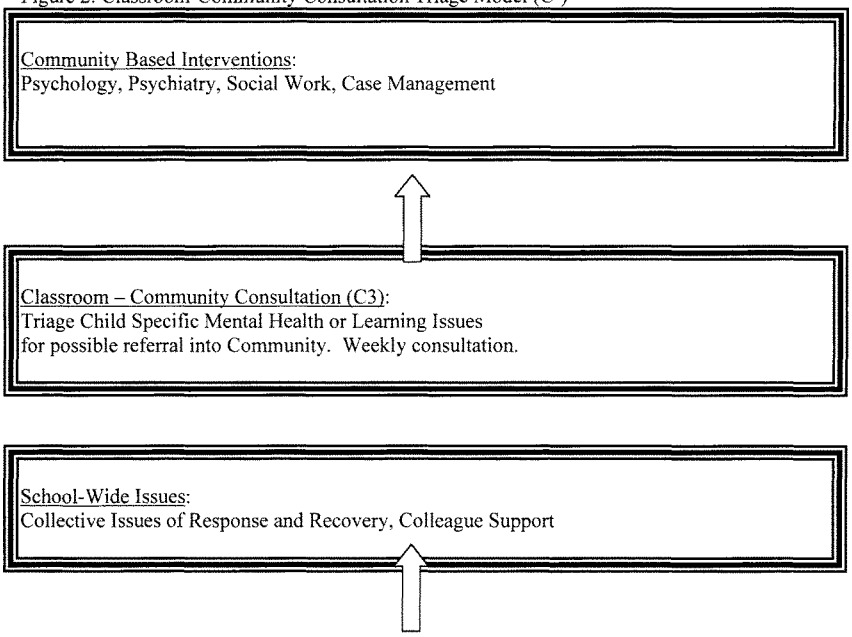

Figure 3: Project Fleur-de-lis (PFDL) Service Summary Table 2006 – 2009 academic years
PFDL Service Summary Table

| | 2006 – 2007 | 2007-2008 | 2008-2009 |
|---|---|---|---|
| Number of Schools | 45 | 56 | 58 |
| Students Receiving CBI © | 5,000* | 0† | 0† |
| Students Receiving CBITS | 53 | 0 | 137 |
| Students Receiving TF-CBT | 6** | 0*** | 0*** |
| $C^3$ | | | |
| Number of Students Triaged | 268 | 549 | 543 |
| Total # of Triaged Students Who Sought No-Cost Community Mental Health Services | 153 | 368 | 400 |
| Total # of counselors trained in CBITS | 0 | 0 | 192 |
| Number of PFDL Staff (FTEs) | 2.5 | 4.5 | 7.0 |

*Estimated number of children as reported by Save the Children
**Students who underwent TF-CBT during 2006 – 2007 academic year were treated within a PFDL research project. Over 40 students in the same year were treated within Mercy Family Center
***Students that were referred for TF-CBT were treated by Mercy Family Center
† CBI © is considered an immediate intervention to be used in the weeks and months after a disaster, therefore it has not been utilized since the 2006-2007 academic year

Figure 4: Current 2009-2010 Project Fleur-de-lis participating schools.

Catholic Schools

Academy of Our Lady
Archbishop Rummel
Ascension of Our Lord
Cathedral Academy
Chapelle High School
Christ the King
De La Salle
Good Shepherd
Holy Name of Jesus
Holy Rosary
St. Benedict
St. Clement of Rome
St. Scholastica
St. Anthony (Gretna)
St. Angela Merici
St. Benilde
St. Charles Borromeo
St. Christopher
St. Cletus
St. Joan of Arc
St. Mary's Dominican High School
St. Mary Magdalen
St. Matthew the Apostle
St. Philip Neri
St. Rita – Harahan
St. Rosalie
Our Lady of Divine Providence
Our Lady of Perpetual Help – Belle Chasse
Our Lady of Perpetual Help – Kenner
Our Lady of Prompt Succor
Ursuline Academy Elementary
Visitation of Our Lady

Charter Schools

Accelerated Academy at Booker T. Washington
Alice Harte Charter School
Algiers Technology Academy
Arthur Ashe
Behrman Charter School
Edna Karr High School
Eisenhower Charter School
Excel Academy High School (Welcome School)

Fischer Charter School
Harriett Tubman
Hope Academy
International School of Louisiana
KIPP Believe
KIPP Central City Academy
Langston Hughes
Lusher Charter School
McDonough 32 Charter School
New Orleans College Prep Charter School
O' Perry Walker
Samuel Green
Sojourner Truth Academy
Success at Schwartz

Public Schools

John James Audubon
G.W. Carver High School

Private Schools

St. George's Episcopal School
St. Paul's Episcopal School


# Fiscal Year 2010

# HOMELAND SECURITY GRANT PROGRAM

## SUPPLEMENTAL RESOURCE: CHILDREN IN DISASTERS GUIDANCE

U.S. DEPARTMENT OF HOMELAND SECURITY

# CHILDREN IN DISASTERS GUIDANCE

## A. Children in Disasters Background and Mission

Specific planning guidance on children is addressed in FEMA's *Interim Emergency Management Planning Guide for Special Needs Populations: Comprehensive Planning Guide 301*. Although children are considered as a population among "at risk," "vulnerable" or "special needs" populations, children under the age of 18 comprise nearly 25 percent of the U.S. population and have important and often complex planning and emergency response needs. Congress established the National Commission on Children and Disasters in 2008 to identify gaps in capabilities to meet the unique needs of children in Federal, State and local emergency preparedness, mitigation, response and recovery activities. The FY10 HSPG guidance includes specific language on children, with the objective of establishing a focused national effort to close the gap in planning and response deficiencies and ensure specific entities in communities that provide care for children, such as schools, child care facilities, child welfare and juvenile justice systems, are integrated into State and local disaster planning and exercising.

Children have unique needs that must be addressed in emergency preparedness, mitigation, response and recovery operations. For example:

- Children require different dosages of medications and different forms of medical and mental health interventions than those used by adults.
- Decontamination of children is more time and resource intensive than adults.
- Children's developmental and cognitive levels may impede their ability to escape danger. Young children may not be able to communicate enough information to be identified and reunited with parents or caregivers.
- Children may experience increased psychological effects as they may have difficulty comprehending disasters within the context of normal every day events. This may leave children unable to cope long after disasters and result in later consequences including depression, lack of focus and poor school performance
- Children have specialized care requirements and equipment that limit the number of hospital facilities that may be prepared to handle an influx of pediatric disaster victims.
- Critically sick or injured children may have specialized transportation needs.
- Children's safety in a disaster and their individual recovery is dependent on the preparedness, response and recovery capabilities and resources of a network of institutions, including schools, child care providers and other congregate care settings.

FEMA Administrator Craig Fugate announced the creation of an internal "Children's Working Group" in August 2009, which will explore and implement planning and response strategies specific to children throughout DHS and ensure that the unique needs of children are not only considered, but fully integrated into FEMA's emergency

preparedness and response operations and activities. This emphasis aligns with the *Interim Report* recommendations of the National Commission on Children and Disasters found at *http://www.childrenanddisasters.acf.hhs.gov*.

This supplement provides resources for grantees to incorporate children into their planning and purchase of equipment and supplies; provide training to a broad range of child-specific providers, agencies, and entities; and exercise capabilities relating to children, such as evacuation, sheltering and emergency medical care.

### B. Federal, State, Local, and Tribal Partnerships

Partnerships are needed to effectively address critical gaps in tribal, local, state, and federal capabilities to address the needs of children in disasters. These partnerships must occur across numerous disciplines and include subject matter experts with knowledge on the physical health, mental health, nutrition, education and human services needs of children and families. Annex A illustrates the breadth and depth of projects and partnerships reflected in current national planning efforts surrounding children in disasters.

### C. Building Capabilities: Allowable Costs and Available Resources

Funding from the State Homeland Security Grant Program (SHSP), Urban Area Security Initiative (UASI), and Metropolitan Medical Response System (MMRS) programs can be used to enhance existing or establish new children-specific planning and preparedness initiatives.

- **Planning and Protocols**: There are a number of resources to help grantees prepare for the unique needs of children:
    - *Interim Emergency Management Planning Guide for Special Needs Populations: Comprehensive Planning Guide 301*. Available from: http://www.fema.gov/pdf/media/2008/301.pdf.
    - *The Unique Needs of Children in Emergencies, a Guide for the Inclusion of Children in Emergency Operations Plans*: An emergency management guide prepared by Save the Children. Available from: http://www.savethechildren.org/publications/emergencies/Children-in-Emergencies-Planning-Guide.pdf
    - *Standards and Indicators for Disaster Shelter Care for Children* (Annex B): This resource was developed through a collaborative effort including the National Commission on Children and Disasters, the American Red Cross and FEMA. The document is currently being piloted and will be revised, finalized and disseminated by Summer 2010, for adoption by the American Red Cross, National Voluntary Organizations Active in Disasters and the state and local emergency management communities.

- *Supplies for Infants and Toddlers in Mass Care Shelters and Emergency Congregate Care Facilities* (Annex C): This resource was developed through a collaborative effort including the National Commission on Children and Disasters, American Academy of Pediatrics, Save the Children, American Red Cross and FEMA.

- *Equipment for Ambulances*: A pediatric equipment list for Basic Life Support and Advanced Life Support vehicles, developed by American College of Surgeons Committee on Trauma, American College of Emergency Physicians, National Association of EMS Physicians Pediatric Equipment Guidelines Committee, Emergency Medical Services for Children Partnership for Children Stakeholder Group, and American Academy of Pediatrics. Available from: http://www.childrensnational.org/files/PDF/EMSC/PubRes/Equipment_for_ambulances_FINAL.pdf

- *Decontamination of Children: Preparedness and Response for Hospital Emergency Departments.* Available from: http://www.ahrq.gov/research/decontam.htm

- *Lessons Learned Information Sharing (LLIS.gov)* also has a number of resources specific to children.

- **Training**—FEMA is piloting a classroom/independent study course *Mobile Course L366: Planning for Children in Disasters* that can be delivered as G course by states, as an E course by the Emergency Management Institute (EMI).

- **Exercises**— Exercises and drills should include objectives that test the jurisdiction's ability to address the proportion of the jurisdiction's population that is under the age of 18. For example, decontamination exercises should test the jurisdiction's capability to decontaminate children in addition to adults, and address issues such as unaccompanied minors, protocols for toddlers and infants, children requiring acute care, children with limited English proficiency and disabled children, among others.

DHS/FEMA will provide assistance with developing, designing and conducting exercises in compliance with Homeland Security Exercise and Evaluation Program (HSEEP) methodology. The purpose of exercises support is to test equipment, training, polices and procedures. It is critically important that children be incorporated into exercise plans and target capabilities.

During FY 2010, FEMA's Children's Working Group will continue to refine and expand program offerings and technical assistance, as well as expand its State, local and tribal stakeholder partnerships to coordinate the incorporation of children into base plans, programs and services to enhance our capabilities to meet the needs of families and children.

## Annex A: Child- and Family-Centric Preparedness, Planning, Training, Exercise, and Equipment Procurement Activities

| | Preparedness | Planning | Training | Exercise | Equipment |
|---|---|---|---|---|---|
| **EMERGENCY MANAGEMENT**<br>**Overarching activities and those that build on existing child-centric planning, response, and recovery efforts** | | | | | |
| **Comprehensively integrate the needs of children into disaster planning activities and operations. Plans should be based on specific demographics of the child population and their age-based needs** | x | x | x | x | |
| • Develop an accurate assessment—an informed estimate of the number and types children residing in the jurisdiction. Emergency planners should base their assessments on lists and information collected from multiple relevant sources wherein children are represented, such as schools, day care centers, summer camps, juvenile detention facilities, child welfare facilities, and homeless shelters, among others. (CPG 301) | x | x | | | |
| • Incorporate children into EOP and other base plans | | x | | | |
| • Train and exercise EOP and other base plans | | | x | x | |
| **Develop local and state recovery strategies addressing the immediate and long-term health, mental health, educational, housing and human services recovery needs of children** | x | x | x | x | |
| • Increase public awareness and education efforts to inform families about resources available for children after disasters | x | | | | |
| **MENTAL HEALTH**<br>**Activities that promote overall resilience and address disaster-specific mental health needs** | | | | | |
| **Integrate mental and behavioral health for children into public and medical preparedness and response activities** | x | x | x | x | |
| • Incorporate mental and behavioral health principles into communication strategies | x | x | | | |
| • Develop special messages targeted to parents and other caregivers to support children coping with a disaster | x | | | x | |
| • Conduct joint exercises that include realistic mental and behavioral health challenges to the exercise scenario | | | | x | |

| | Preparedness | Planning | Training | Exercise | Equipment |
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| **Provide pediatric disaster mental and behavioral health training for professionals and paraprofessionals** | | | x | | |
| • Provide specialized education and training in disaster mental health and/or psychological first aid to emergency responders and other professionals, including disaster relief personnel and volunteers, faith-based professionals, and school and child care personnel. | | | x | | |
| • Work with state and local providers and professional associations to train mental health professionals to serve as master trainers, community supervisors, and cultural consultants in psychological first aid for their graduate training and continuing education programs | x | | x | | |
| **Promote psychological resilience for individuals, families and communities** | x | x | | | |
| • Use mental and behavioral health education, training, and intervention to bolster community resilience. | x | | | | |
| **CHILD PHYSICAL HEALTH AND TRAUMA**<br>**Planning, training, exercise, and equipment procurement to increase pediatric medical capacity** | | | | | |
| **Ensure availability and access to pediatric medical countermeasures at the state and local level for chemical, biological, radiological, nuclear and explosive threats** | x | x | x | x | x |
| • Test capabilities to mass distribute and individually administer pediatric medical countermeasures at the state and local level for chemical, biological, radiological, nuclear and explosive threats | | | x | x | x |
| **Ensure all health care professionals who may treat children during an emergency have adequate pediatric disaster medicine training specific to their role** | | | x | | |
| • Develop and/or provide continuing education to health care professionals such as EMS providers | | | x | | |
| **Create a regional planning group to develop a formal regional pediatric system of care, prepared for disasters** | x | x | | x | |
| • Assess pediatric surge capacity at local, regional, and/or state levels (MMRS) | x | x | | | |

| | Preparedness | Planning | Training | Exercise | Equipment |
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| **Develop and implement comprehensive state and regional plans for pediatric patient surge capacity in conjunction with hospitals, EMS and emergency management agencies (MMRS)** | | x | | | |
| • Develop local and regional disaster response plans that anticipate need and fully integrate trauma systems, children's hospitals, EMS, and other institutions with pediatric critical care and pediatric surgical sub-specialty care capabilities (MMRS) | | x | | | |
| • Practice disaster drills that include *all* staff that may be called on to deliver care to children in scenarios with sufficient pediatric survivors to test pediatric surge capacity | | | | x | |
| • Ensure that adequate, up-to-date stocks of pediatric supplies are on site (MMRS) | x | | | | x |
| **Conduct planning activities to ensure access to physical and mental health services for all children during recovery from a disaster** | x | x | | | |
| • Develop and exercise Continuity of Operations Plans for physical and mental health services entities | | | x | x | x |
| **EMERGENCY MEDICAL SERVICES AND PEDIATRIC TRANSPORT**<br>**Planning, training, exercise, and equipment procurement to increase pediatric medical capacity** | | | | | |
| **Improve the capability of Emergency Medical Services (EMS) to transport pediatric patients and provide comprehensive pre-hospital pediatric care during daily operations and disasters** | x | x | x | x | x |
| • Acquire and train with pediatric equipment in accordance with national guidelines for equipment for BLS and ALS vehicles (see *Equipment for Ambulances* above) | | | x | x | x |
| • Establish statewide, territorial, or regional standardized systems that recognize hospitals that are able to stabilize or manage pediatric medical emergencies and trauma. | x | x | | | |
| • Establish written pediatric inter-facility agreements, including a categorization process and inter-facility transfer guidelines to facilitate EMS transfer of children to appropriate levels of resources. | x | x | | | |
| **CHILD CARE**<br>**Planning, training, exercise activities specific to child care services and providers** | | | | | |
| **Increase disaster planning capabilities of** | x | x | | | |

| | Preparedness | Planning | Training | Exercise | Equipment |
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| **child care providers in all settings** | | | | | |
| • Assist child care operators through guidance or direct assistance in the development of comprehensive disaster plans | x | x | x | x | x |
| • Work with child care facilities to designate site and evacuation routes in the event of a disaster | x | x | | | |
| • Work with child care facilities to develop reunification plans for children and families in the event they become separated during an emergency | | x | | | |
| **Improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster** | x | | | | |
| • Develop child care disaster plans at the state level that establish guidelines for recovery addressing the continuation of child care services and provision of temporary child care services | | x | | | |
| • At the state level, develop temporary disaster child care operating standards that permit disaster child care in non-traditional settings | X | x | | | |
| • Increase capacity to provide support services to parents, guardians, employees, and employers in the aftermath of a disaster | x | | | | |
| **ELEMENTARY AND SECONDARY EDUCATION**<br>**Planning, training, exercise activities specific to early education, elementary and secondary education** | | | | | |
| **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** | | x | | | |
| • Integrate planning among school districts, SEAs, local government, local public health and emergency response officials, and parents | | x | | | |
| • Execute regular disaster preparedness exercises and drills that involve local emergency management, school personnel, and other stakeholders | | | | x | |
| • Develop state, regional, and local school district continuity of operations plans to ensure academic continuity for all students affected by a disaster | | x | | | |

| | Preparedness | Planning | Training | Exercise | Equipment |
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| • Develop integrated plans for coordinated state and regional school closures in the event of a pandemic or other event | | x | | | |
| **Enhance school personnel's abilities to support children who are traumatized, grieving, or otherwise recovering from a disaster** | | x | | | |
| • Train teachers, school administrators, and other school personnel to understand the impact of trauma and loss and to provide basic supportive services and basic bereavement services following a disaster | | | x | | |
| • Develop initiatives that both support and promote emergency preparedness and crisis response training for teachers and other school staff | x | | x | | |
| **CHILD WELFARE AND JUVENILE JUSTICE**<br>**Planning, training, exercise activities specific to child welfare and juvenile justice agencies** | | | | | |
| **Activities at the state and local level, in collaboration with state and local emergency management, courts, and other key stakeholders, to meet current applicable disaster planning requirements** | | x | | | |
| • Review state child welfare plans to ensure they meet or exceed current requirements, including identification of personnel to implement plans at the local level and collaboration with courts and other key stakeholders | | x | | | |
| • Train and exercise child welfare/juvenile justice plans at the local level | | | x | x | |
| • Develop or update juvenile justice system 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 service agencies | | x | | | |
| **EVACUATION**<br>**Develop local and regional evacuee tracking and family reunification strategies** | | | | | |
| **Develop, train, and exercise local and regional strategies for evacuee tracking and family reunification strategies** | | x | x | x | |
| • Develop plans to track and reunify families during and after a disaster. The system should take into account adults and children who are | | x | | | |

| | Preparedness | Planning | Training | Exercise | Equipment |
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| wounded, nonverbal, or have limited English proficiency, as well as potential legal issues regarding custody (in the case of children). (CPG 301) | | | | | |
| • Include family reunification planning as part of individual and family preparedness activities | x | | | | |
| • Establish alternative agreements for evacuation transportation beyond school buses. If an evacuation takes place during a school day, school bus drivers may not be available to assist with the evacuation because they will be driving children to or from home. Additionally, these drivers are typically not trained or contracted for emergencies and may not be available to provide assistance to some special needs individuals. (CPG 301) | x | x | | | |
| • Work with agencies and businesses to incorporate family reunification plans for employees as part of Continuity of Operations Planning | x | x | | | |
| **SHELTERING STANDARDS, SERVICES, AND SUPPLIES**<br>**Ensure safe, secure mass shelter environments for children** | | | | | |
| **Planning, training, and exercising to ensure a safe and secure mass care shelter and emergency congregate care environment for children, including appropriate access to essential services and supplies.** | x | x | x | x | |
| • Adopt and implement the ***Standards and Indicators for Disaster Shelter Care for Children*** for all mass shelter operations (Annex B) | | | | | |
| • Create caches of essential age-appropriate shelter supplies for infants and children in accordance with ***Supplies for Infants and Toddlers in Mass Care Shelters and Emergency Congregate Care Facilities*** (Annex C) | | | | | x |
| • Develop plans that mitigate risks unique to children in shelters including child abduction and sex offenders | | x | | | |
| **HOUSING**<br>**Prioritize disaster housing assistance and permanent housing for families, especially those with critical health, mental health, or educational needs** | | | | | |
| • Develop state plans that ensure that all disaster survivors are sheltered safely and securely, with access to food and other necessary life- | | x | | | |

| | Preparedness | Planning | Training | Exercise | Equipment |
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| sustaining commodities and resources | | | | | |
| • Create or expand a standing state-Led Disaster Housing Task Force at the state level, including persons with subject matter expertise related to children and the programs that serve their health, mental health, nutrition, education, and social services needs | x | x | | | |

## Annex B: Standards and Indicators for Disaster Shelter Care for Children*

### A. 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.

### B. 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.

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*This document was approved by the National Commission in Children and Disasters, June 2009*

- 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.

## C. 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.

## Annex C: Supplies for Infants and Toddlers in Mass Care Shelters and Emergency Congregate Care Facilities

This document was facilitated by the National Commission on Children and Disasters in September 2009 with guidance from subject matter experts in emergency management and pediatric care. The document identifies basic supplies necessary to sustain and support 10 infants and children up to 3 years of age for a 24 hour period. The guidance is "scalable" to accommodate 10 or more children over a longer period of time.

The National Commission on Children and Disasters recommends state and local jurisdictions provide caches of supplies to support the care of children in mass care shelters and emergency congregate care facilities for a minimum of 72 hours. The amount of supplies cached in an area should be based upon the potential number of children up to 3 years of age that could be populating the local shelters and facilities for a minimum of 72 hours, as determined by an assessment of current demographic data for the jurisdiction.

Depending on the nature of the event, a 24-72 hour supply of essential child-specific supplies should be on site prior to the opening of a shelter or facility. However, in situations where this is not possible, supplies should still be available for immediate deployment and delivered on site within 3 hours. Such a level of preparedness is critical due to the high vulnerability of this population.

| Required Supplies | | |
|---|---|---|
| **Quantity** | **Description** | **Comment** |
| **Perishable Supplies** | | |
| 40 Jars | Baby Food - Stage 2 (jar size is 3.5 - 4 oz) | Combination of vegetables, fruits, cereals, meats |
| 1 box (16oz) | Cereal - single grain cereal preferred (e.g. rice, barley, oatmeal) | Rice, barley, oatmeal or a combination of these grains |
| See Note | Diaper wipes - fragrance free (hypoallergenic) | Minimum of 200 wipes |
| 40 | Diapers - Size 1 (up to 14 lbs.) | Initial supply should include one package of each size, with no less than 40 count of each size diaper |
| 40 | Diapers - Size 2 (12 - 18 lbs.) | |
| 40 | Diapers - Size 3 (16 - 28 lbs.) | |
| 40 | Diapers - Size 4 (22 - 37 lbs.) | |
| 40 | Diapers - Size 5 (27 lbs. or +) | |
| 40 | Pull Ups 4T - 5T (38 lbs. +) | |
| 320oz | Formula, milk-based, ready to feed (already mixed with water) ++ | Breastfeeding is the best nutritional option for children and should be strongly encouraged. |

| Required Supplies | | |
|---|---|---|
| **Quantity** | **Description** | **Comment** |
| 64oz | Formula, hypoallergenic-hydrolyzed protein, ready to feed (already mixed with water) ++ | |
| 320oz | Formula, soy-based, ready to feed (already mixed with water) ++ | |
| 1 Quart | Oral Electrolyte solution for children, ready-to-use, unflavored (e.g. Pedialyte) - *Dispensed by medical/health authority in shelter* ++ | Do not use sports drinks. The exact amount to be given, and for how long, should be determined by an appropriate medical authority (doctor or nurse). To be use in the event an infant/child experiences vomiting or diarrhea, and the degree of dehydration. |
| See Note | Nutritional Supplement Drinks for Kids/Children, ready-to-drink (e.g., Pediasure, Kids Essential/Kids Boost) - *Dispensed by medical/health authority in shelter* | ** Not for infants under 12 months of age ** Requirement is a total of 40-120 fl. oz per day; in no larger than 8 oz bottles. |
| **Non-Perishable Supplies & Equipment** | | |
| 25 | Infant feeding bottles (plastic only) ++ | 4 - 6 oz. size preferred (to address lack of refrigeration) |
| 30 | Infant Feeding Spoons ++ | Specifically designed for feeding infants with a soft tip and small width. Can be used for younger children as well. |
| 50 | Nipples for Baby Bottles (non-latex standard) ++ | 2 per bottle |
| 25 | Diaper Rash Ointment (petroleum jelly, or zinc oxide based) | Small bottles or tubes |
| 100 pads | Disposable Changing Pads | At least 13x18 in size. Quantity is based on 8-10 diaper changes per infant per day |
| 10 | Infant bathing basin | Thick plastic non-foldable basin. Basin should be at least 12" x10" x 4" |
| See Note | Infant wash, hypoallergenic | Either bottle(s) of baby wash (minimum 100 oz.), which can be "dosed out" in a disposable cup (1/8 cup per day per child) or 1 travel size (2oz) bottle to last ~48 hrs per child. |
| 10 | Wash cloths | Terry cloth/cotton - at least one per child to last the 72 hr period |
| 10 | Towels (for drying after bathing) | Terry cloth/cotton - at least one per child to last the 72 hr period |
| 2 sets | Infant hat and booties ++ | Issued by medical/health authority in shelter |

| Required Supplies | | |
|---|---|---|
| Quantity | Description | Comment |
| 10 | Lightweight Blankets *(to avoid suffocation risk)* | Should be hypoallergenic, (e.g., cotton, cotton flannel, or polyester fleece) |
| 5 | Portable Crib | To provide safe sleeping environments for infants up to 12 months of age |
| 2 | Toddler potty seat | That can be placed on the seat of an adult toilet, with handles for support. One each should be located in both a Men's and Women's restroom |
| 1 pack | Electrical Receptacle Covers | Minimum 30 (Note: Prioritize covering outlets in areas where children and families congregate (family sleeping area, children's areas, etc.) |

| Recommended Supplies | | |
|---|---|---|
| Quantity | Description | Comment |
| **Perishable Supplies** | | |
| | Baby Food – Stage 1 (jar size ~ 2.5 oz) | Combination of vegetables, fruits, cereals, meats |
| | Baby Food - Stage 3 (jar size ~ 6 oz) | Combination of vegetables, fruits, cereals, meats |
| | Diapers - Preemie Size (up to 6 lbs.) | As needed for shelter population |
| | Healthy snacks that are safe to eat and do not pose a choking hazard *(intended for children 2 year and older)* | Should be low sugar, low sodium: (Yogurt, Applesauce, Fruit dices (soft) (e.g., peaches, pears, bananas), Veggie dices (soft) (e.g., carrots), 100% real fruit bite-sized snacks, Real fruit bars (soft), Low sugar/whole grain breakfast cereals and/or cereal bars, crackers (e.g., whole grain, "oyster"/mini) |
| **Non-Perishable Supplies & Equipment** | | |
| | Sip Cups (support for toddlers) ++ | |

| Supplemental Information | |
|---|---|
| Description | Supplemental Notes |
| Formula | Use of a powered formula is at the discretion of the jurisdiction or shelter operator. If using powdered preparation of the formula should be conducted by appropriately trained food preparation workers. Water used should be from an identified potable water source (bottled water should be used if there is any concern about the quality of tap or well water).<br><br>Hypoallergenic hydrolyzed formula can be provided in powdered form—(1) 400 gram can—but only if potable water is accessible. |

| Supplemental Information | |
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| **Description** | **Supplemental Notes** |
| Infant Feeding Bottles and Nipples | Each time nutritional fluids, formula and/or other infant feeding measures (including breast milk in a bottle) are distributed by trained, designated shelter staff and/or medical professionals, clean, sterilized bottles and nipples must be used. Note: After use, bottles are to be returned to the designated location for appropriate sterilization (and/or disposal). Bottle feeding for infants and children is a 24/7 operation and considerations must be in place to provide bottle feeding as needed (On average, infants eat at minimum 5-8 times daily).<br><br>Sterilizing and cleaning:<br><br>Sterilize bottles and nipples before you use them for the first time by putting them in boiling water for 5 minutes. Nipples and bottles should be cleaned and sterilized before each feeding. If disposable bottles and nipples are not available and more durable bottles and nipples will be re-used they must be fully sterilized each feeding. To the greatest extent possible bottles and nipples should be used by only one child.<br><br>In the event parents want to use their own bottles and nipples, shelter staff should provide support for cleaning these items between feedings. Support such as access to appropriate facilities for cleaning (not public restrooms). |
| Note regarding all feeding implements for Infant/Children | There is a specific concern with cleaning and sanitizing of all feeding implements associated with infants and children (infant feeding bottles/nipples, spoons, sip cups, etc), these items will require additional attention by food preparation staff to ensure they are sanitary as a means of reducing food borne illness. Staff medical/health staff should be consulted on best means of raising awareness among shelter residents and enlisting their support for these extra sanitary measures.<br><br>Feeding implements such as spoons and sip cups should be cleaned using hot soapy water provided potable water is available. When the item is being cleaned to give to another child the item must be sterilized. |
| For the following items: Infant bathing basin, Lightweight blankets, Diaper rash ointment, Wash cloths, and Towels | Consider pre-packaging the listed items together and providing one package to each family with children Note: additional blankets and towels will be necessary for families with more than one child. |

**Project Fleur-de-lis™:**

**An Intermediate and Long-Term School-based Mental Health Service Model for Youth Exposed to Disasters**

**Overview of Program's Electronic Records System (ERS)**

*Douglas W. Walker, Ph.D.*
*Clinical Director – Mercy Family Center*
*Project Director – Project Fleur-de-lis*
*New Orleans, Louisiana*

Project Fleur-de-lis utilizes a customized version of the TexTALK MD ERS system for behavioral health professionals. TexTALK MD was chosen for use within Project Fleur-de-lis because it is a multimodal ERS and document management system that is easy to learn and simple to use with little or no computer knowledge. Customized templates for school-based mental health professionals where created to meet their needs of tracking their student's progress in the months and years following Hurricane Katrina. Although not used within Project Fleur-de-lis, TexTALK MD has the capacity to provide state-of-the-art speech recognition technology with intuitive speech commands to automate complex tasks.

**Structure and Function**

Students who are registered within Project Fleur-de-lis initiate their electronic record with three documents that have been completed by their parent/caregiver which include: the informed consent, general demographics form and the Hurricane Assessment Instrument. There are currently over 5,400 students represented within the ERS. Twenty-five custom-made document templates provide consistency in reporting across all school-based mental health professionals and their schools. The two most used templates are the standard Counselor Progress Note and the Consultation/Referral Note (see Appendix A) which is completed during $C^3$ (see original written testimony "Project Fleur-de-lis™: An Intermediate and Long-Term School-based Mental Health Service Model for Youth Exposed to Disasters" for description of $C^3$ triage meetings) for every student referred for community-based care. Embedded within each ERS template is the Pediatric Symptom Checklist (Jellinek, Murphy, Robinson, Feins, Lamb, & Fenton, 1988) which is used as a subjective measure of the student functioning and provides data for use in quality improvement initiatives within the project.

Students needing school-based mental health services are seen by their school's mental health professional. All school-based mental health professionals have access to the Project Fleur-de-lis secure electronic records system via web based encrypted access. School-based mental health professionals maintain an electronic record for their students in accordance to their school's policies and those held by their professional licensing board. School-based mental health professionals and school principals have access to only their own school's electronic records.

A student's electronic record within Project Fleur-de-lis is considered a school record; not a medical record. At the school level, school-based mental health professionals and principals have the ability to gain access to the electronic records system (ERS) via password access given out to participating school school-based mental health professionals. Electronic school records are available to parents via their school school-based mental health professional in accordance with their school policies regarding parent access to school records. At the system level, access to electronic school records is determined by necessity. The following individuals have complete access as "Super Users" based upon their function within Project Fleur-de-lis: Clinical Director, Intervention Coordinator, Data Base Management Coordinator, local technology consultant manager, and the engineer/creator of the ERS system: TextTalk MD. This ERS system is fully compliant with the Health Insurance Portability and Accountability Act of 1996, with particularity to the Privacy Rule and the Security Rule. (Kontonassios, 2004).

**Long-Term Monitoring**

Because the school-based mental health professional's notes on each student are stored within the ERS permanently, school-based mental health professionals can easily access past electronic records to re-access a student's information. School-based counselors have the ability to view what the student's hurricane experience was in addition to prior traumatic experiences they may have faced. It is also an efficient and accurate way to keep track of patterns or symptoms that may develop over time. We expect that over time the current Project Fleur-de-lis data base can be studied so as to identify individual and cohort trends that demonstrate the long-term psychological effects of Hurricane Katrina and its aftermath.

**Technical Information**

A Windows Server 2003 with SQL Server 2005 is utilized to securely store the records in a centralized TexTALK MD SQL Database. A Citrix Virtualization Server is utilized to provide secure remote access. PCs, running TexTALK MD Client application are used to access the records remotely. The TexTALK MD SQL Database stores structured and free text information regarding student encounters. Data mining is performed, utilizing SQL 2005 free text capabilities. Researchers can search the data to identify specific symptoms or create reports to identify problems. Reports can be exported in the form of Excel spreadsheets for further scientific analysis. The TexTALK MD client application utilizes a one screen design that makes it easy to learn and use. All pertinent information regarding a student encounter is readily available without further navigation. Pulling charts, filling new materials in charts, and re-filling is eliminated.

**References**

Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S. & Fenton, T. *Pediatric Symptom Checklist; Screening school-age children for psychosocial dysfunction.* 1988, *Journal of Pediatrics*, 112: 201-209.

Kontonassios, Thanos. (2004). TexTALK MD, Alma Information Systems, Inc., Houston, TX 77059, (281) 488-7016, thanos@speech-pro.com.

**Appendix A**

**CONSULTATION/REFERRAL FORM**
**Project Fleur-de-lis**
**{School}**

**Name**: {FirstName} {LastName}
**Parent(s)/Caregiver(s):** {ParentName}
**Contact Numbers**: Home -{HomePhone}/ Work - {WorkPhone}
**Date**: {Date}
**DOB**: {DOB}
**AGE**: {Age}
**Grade:** {Grade}
**School:** {School}
**Pre-Katrina School:** {PreKatrinaSchool}
**Pre-Katrina Zip Code:** {PreKatrinaZipCode}
**Current Zip Code**: {ZipCode}
**StudentNumber**: {Account}
**Counselor:**

**Key Issues:**

**Symptoms**: <<|None>>
<<|1. Complains of aches and pains
>><<|2. Spends more time alone
>><<|3. Tires easily, has little energy
>><<|4. Fidgety, unable to sit still
>><<|5. Has trouble with teacher
>><<|6. Less interested in school
>><<|7. Acts as if driven by a motor
>><<|8. Daydreams too much
>><<|9. Distracted easily
>><<|10. Is Afraid of new situations
>><<|11. Feels sad, unhappy
>><<|12. Is Irritable, angry
>><<|13. Feels hopeless
>><<|14. Has trouble concentrating
>><<|15. Less interested in friends
>><<|16. Fights with other children
>><<|17. Absent from school
>><<|18. School grades dropping
>><<|19. Is down on him or herself
>><<|20. Visits the doctor with doctor finding nothing wrong
>><<|21. Has trouble sleeping
>><<|22. Worries a lot

>><<|23. Wants to be with parents more than before
>><<|24. Feels he or she is bad
>><<|25. Takes unnecessary risks
>><<|26. Gets hurt frequently
>><<|27. Seems to be having less fun
>><<|28. Acts younger than children his or her age
>><<|29. Does not listen to rules
>><<|30. Does not show feelings
>><<|31. Does not understand other people's feelings
>><<|32. Teases others
>><<|33. Blames others for his or her troubles
>><<|34. Takes things that do not belong to him or her
>><<|35. Refuses to share>>

**Referred for:** <<|Case Management,
>><<|No Referral Necessary At This Time
>><<|Individual Therapy
>><<|Family Therapy
>><<|Developmental Evaluation (Infant Mental Health Services or Similar)
>><<|Psychological Testing: >><<|Comprehensive Evaluation| Comprehensive Evaluation with Projectives | Educational Evaluation | Neuropsychological Evaluation
>><<| Behavior Management/Parent Training
>><<| Group Therapy
>><<| School Consultation
>><<| Psychiatric Evaluation
>><<| Medication Management>>

As a parent you have a choice in securing a mental health provider in our community to address the issues outlined in this consultation/referral note. A Project Fleur-de-lis representative will be contacting you to help locate a mental health provider for your child within the Greater New Orleans area.

If you have any immediate questions regarding this referral process, please contact Daphne Beers, Project Fleur-de-lis' Clinical Services Coordinator:

Daphne Beers
Project Fleur-de-lis Clinical Services Coordinator
110 Veterans Memorial Blvd.; Suite 425
Metairie, LA 70005

**COUNSELING NOTE**
**Project Fleur-de-lis**
**{School}**

**Name**: {FirstName} {LastName}
**Parent(s)/Caregiver(s):** {ParentName}
**Date**: {Date}
**DOB**: {DOB}
**AGE**: {Age}
**Grade:** {Grade}
**School:** {School}
**Pre-Katrina School:** {PreKatrinaSchool}
**Pre-Katrina Zip Code:** {PreKatrinaZipCode}
**Current Zip Code:** {ZipCode}
**StudentNumber**: {Account}
**Counselor:**

**Type of Encounter:** <<| Counseling Session - 15 minutes | Counseling Session - 30 minutes | Counseling Session - 60 minutes | Parent/Child Session | Other: |>>

**Frequency of Intervention**: <<|As necessary |Once a week |Twice a week |Once every two weeks |Once every three weeks |>>

**Symptoms**:

<<|1. Complains of aches and pains
>><<|2. Spends more time alone
>><<|3. Tires easily, has little energy
>><<|4. Fidgety, unable to sit still
>><<|5. Has trouble with teacher
>><<|6. Less interested in school
>><<|7. Acts as if driven by a motor
>><<|8. Daydreams too much
>><<|9. Distracted easily
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>><<|12. Is Irritable, angry
>><<|13. Feels hopeless
>><<|14. Has trouble concentrating
>><<|15. Less interested in friends
>><<|16. Fights with other children
>><<|17. Absent from school
>><<|18. School grades dropping
>><<|19. Is down on him or herself
>><<|20. Visits the doctor with doctor finding nothing wrong

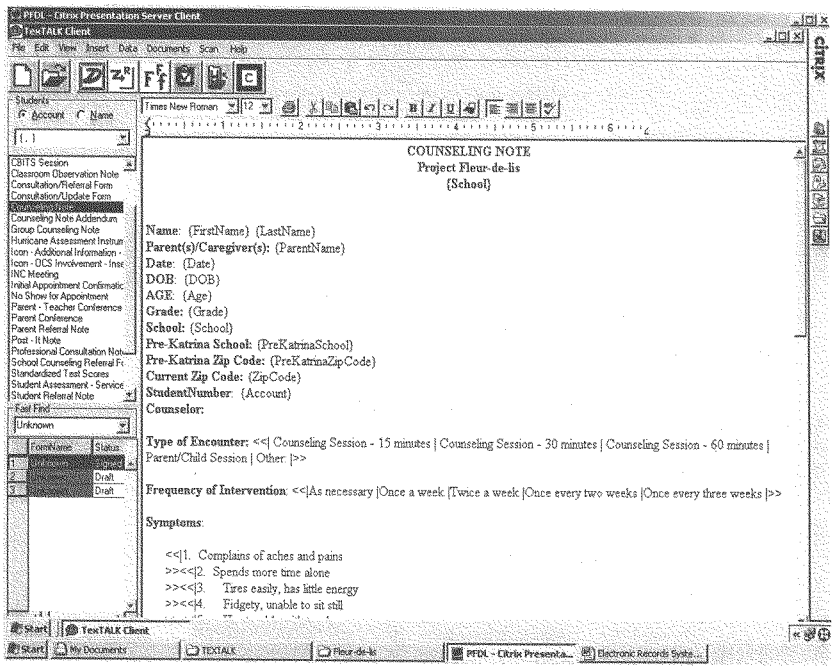
>><<|21. Has trouble sleeping
>><<|22. Worries a lot
>><<|23. Wants to be with parents more than before
>><<|24. Feels he or she is bad
>><<|25. Takes unnecessary risks
>><<|26. Gets hurt frequently
>><<|27. Seems to be having less fun
>><<|28. Acts younger than children his or her age
>><<|29. Does not listen to rules
>><<|30. Does not show feelings
>><<|31. Does not understand other people's feelings
>><<|32. Teases others
>><<|33. Blames others for his or her troubles
>><<|34. Takes things that do not belong to him or her
>><<|35. Refuses to share>>

**Progress to Date**:

**Intervention Plan**: <<| Counseling Session - 15 minutes | Counseling Session - 30 minutes | Counseling Session - 60 minutes | Parent/Child Session | Refer to outside agency for evaluation and or treatment | Other: |>>

**Frequency of Intervention**: <<|As necessary |Once a week |Twice a week |Once every two weeks |Once every three weeks |>>

**Screen Shot of TexTALK MD / Project Fleur-de-lis User Screen**



Journal of Traumatic Stress

# Children's Mental Health Care following Hurricane Katrina: A Field Trial of Trauma-Focused Psychotherapies

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| Keyword - Special Populations: | Children/Adolescents |
| | |

# Children's Mental Health Care following Hurricane Katrina: A Field Trial of Trauma-Focused Psychotherapies

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Running title: Intervention for Children after Disaster

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**Abstract**

New Orleans school children participated in an assessment and field trial of two interventions 15 months after Hurricane Katrina. Children (N=195) reported on hurricane exposure, lifetime trauma exposure, peer and parent support, PTSD, and depressive symptoms. Teachers reported on behavior. At baseline, 60.5% screened positive for PTSD symptoms and were offered a group intervention at school, or individual treatment at a mental health clinic. Uptake of the mental health care was uneven across intervention groups, with 98% beginning the school intervention, compared to 37% beginning at the clinic. Both treatments led to significant symptom reduction of PTSD symptoms but many still had elevated PTSD symptoms at post treatment. Implications for future post-disaster mental health work are discussed.

**Key words: mental health services, children, PTSD, depression, disaster, intervention**

A significant proportion of children develop posttraumatic stress disorder (PTSD) symptoms related to natural disasters (Bokszczanin, 2007; Hoven et al., 2005; LaGreca, Silverman, Vernberg, & Prinstein, 1996; Thienkrua et al., 2006). It is therefore of critical importance to identify affected children early and provide them with effective treatment for PTSD in order to prevent these negative outcomes.

Communities affected by disasters often face multiple challenges and child mental health treatment resources may be particularly limited. Typically, affected communities do not have enough therapists trained in evidence-based treatments (EBT) to be able to provide every child with individual therapy. Thus, it is usually necessary to triage children according to severity of need, with the most intensive services being provided to the most severely affected children and less impaired children receiving less intensive services (e.g., group therapy). While some efforts have been made along these lines in post-disaster settings to demonstrate feasibility of the approach (e.g., Hoagwood & The CATS Consortium, in press), there remains little data to guide the decisions about who should be offered which types of services. In addition, there is no data to inform intervention-providers about what services are desired, feasible, or acceptable to those affected by disaster.

The current project attempted to gather additional information to inform post-disaster mental health efforts for children. Specifically, we aimed to identify students with elevated symptoms of distress in the form of PTSD symptoms. We conducted a field trial to observe the impact of two trauma-specific interventions as delivered under real-world conditions, with the goal of examining predictors of how students fared in each intervention, in order to inform future efforts at allocation of resources following disaster. The project was conducted within Project Fleur-de-lis (PFDL; Cohen et al., 2009), a program run by Mercy Family Center to provide a

tiered system of trauma intervention including two evidence-based interventions: Cognitive-Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2003) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006).

Specifically, the project aimed to identify students with elevated symptoms, offer them either TF-CBT or CBITS, and observe how students fared in each intervention according to their risk and resilience factors, including symptoms of PTSD and depression, social support from friends and family, and their exposures to the hurricanes and to other lifetime traumas. We included measures of social support due to their relationship with treatment outcome in earlier studies of TF-CBT (Cohen & Mannarino, 1998 & 2000), and measures of trauma exposure due to their hypothesized salience in recovery from PTSD following disaster. In order to have roughly comparable groups in each of the two intervention arms, we randomized students to be offered one of the two interventions, and monitored their use of services and how they fared during the field trial. We expected that students who took part in each intervention would improve in symptoms, based on earlier demonstration of effects of the interventions (e.g., Stein et al., 2003; Cohen, Deblinger, Mannarino & Steer, 2004), that students with additional trauma exposure would show more modest improvement, and that those with social support would show more robust improvement.

## METHODS

Three schools participating in PFDL were selected to represent schools participating in PFDL (e.g., diverse size, racial and socioeconomic makeup, and diversity of hurricane, evacuation and post-hurricane experiences) and based on their willingness to participate (see Table 1).

We sent home an introductory letter and consent forms during the fall term of the 2006-2007 school year to 609 4th - 8th graders at the three schools. We received 438 consent forms (72%), and 202 (33%) gave permission for participation. At the time of the baseline assessment, child assent was requested: six students declined and one student had moved. Thus, 195 students (32%) participated (see Figure 1). This rate of consent varied by school: in School 1 41% consented to participate, in School 2 27% consented, and in School 3 46% consented.

Of the 195 children who agreed to participate, 118 (61%) screened positive for elevated PTSD symptoms. In order to obtain representative groups within each intervention arm, these children were randomized within strata to receive each intervention, resulting in 58 students offered CBITS and 60 students offered TF-CBT. These numbers also varied by school: 16 were eligible and randomized in School 1, 57 in School 2, and 45 in School 3.

*CBITS.* CBITS is a 10-group session and 1-3 individual session intervention designed specifically for use in schools. It has demonstrated effectiveness in two controlled trials (Kataoka et al., 2003; Stein et al., 2003) and has been successfully implemented with children of many different cultural groups and who have suffered multiple forms of trauma.

*TF-CBT.* TF-CBT is a 12- session individual intervention that includes child and parent and typically is delivered in clinics. TF-CBT has demonstrated effectiveness in improving PTSD and other symptoms in children experiencing sexual abuse, multiple trauma and disaster in multiple randomized trials (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004).

Both CBITS and TF-CBT include cognitive-behavioral skills, including: psycho-education, relaxation skills, affective modulation skills, cognitive coping skills, trauma narrative, in vivo mastery of trauma reminders, and enhancing safety. However, there are also significant differences between these two models, including that TF-CBT is provided in conjoint sessions

(with parent and child) whereas CBITS is provided in a group format (children only), that TF-CBT may be optimal for developing a multiple trauma narrative and for addressing avoidance symptoms, since the therapist can tailor the intervention to each child, and that CBITS may offer a more acceptable and feasible approach by overcoming some logistical barriers and stigma.

Treatment was provided free of charge to participants. Therapists received training from the developers of the CBITS and TF-CBT models and participated in a regional Learning Collaborative conducted in Mississippi for TF-CBT, as well as receiving ongoing phone consultation for both CBITS and TF-CBT. Therapists, assessors, and intake workers were trained in family engagement strategies (McKay & Bannon, 2004), in order to enhance their ability to draw children at risk and their parents into services.

After randomization, parents and students assigned to be offered CBITS were informed about when and where the group meetings would take place, and given an opportunity to opt-out. CBITS groups started in schools about two weeks later, and were provided at students' home schools during their regularly scheduled school days, with students pulled from class to attend the groups. Three of the usual components of CBITS were not delivered in this study due to resource and timeline constraints: individual interviews with students prior to beginning the groups, teacher inservice meetings, and parent meetings in two of the three schools.

Calls to parents to schedule intakes for TF-CBT began immediately after randomization and continued until all parents were reached or deemed unreachable. As per usual clinical practice, the intake procedure included a diagnostic interview to confirm a diagnosis of PTSD, TF-CBT was provided at Mercy Family Center's Metairie, Louisiana clinic. Round trip taxi fare and free babysitting for siblings were also offered.

Measures

Students were assessed at baseline (December 2006-January 2007), at 5-months (April-May 2007) and at 10-months (September- October 2007). CBITS groups ran March to May, 2007 and TF-CBT was implemented February to September, 2007. This paper only reports on the 10 month follow-up assessment results.

Demographics. Demographic information about the sample was obtained via parent report for 90 children or via school records with parents' permission. We also calculated the distance between each child's home and the Mercy Family Center's Metairie clinic.

Hurricane exposure. We adapted the Disaster Experiences Questionnaire (Scheeringa, 2005) for use with students via self-report. For an overall exposure to hurricane experiences measure, we tallied experiences listed in Table 2, for a total number of experiences per student.

Trauma Exposure. The UCLA PTSD Reaction Index for DSM-IV (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) contains a 12-item exposure questionnaire used in this study (Table 2), which asks the child to identify types of trauma experienced. Reliability (.90) and validity (.87) of this instrument are high (Pynoos et al., 1998). At baseline, participants were asked about lifetime experiences; at follow-up they were asked about experiences since the prior assessment. Due to school concerns, we modified one item about experience of sexual abuse.

PTSD Symptoms. PTSD symptoms in the past month were assessed using the CPSS; (Foa, Johnson, Feeny & Treadwell, 2001). This measure has good convergent ($r = .80$) and discriminant validity and high reliability (Cronbach's alpha = .89; Foa et al., 2001). Children who met a score of >11, indicating elevated symptoms, were randomly assigned to receive one

of the two treatments. We used a score of 15 as a clinical cut off for this instrument (E. Foa, personal communication, February 3, 2009).

Depressive Symptoms. The Children's Depression Inventory (CDI; Kovacs, 1981) was used to assess depressive symptoms. This 27-item measure assesses children's cognitive, affective and behavioral depressive symptoms and has high internal consistency (alpha = .94), moderate test-retest reliability, and correlates in the expected direction with measures of related constructs (e.g. self-esteem, negative attributions, and hopelessness; Kendall, Cantwell, & Kazdin, 1989). A score of 12 or less on the CDI is considered normal.

Peer and Family Support. We included the Social Support Scale for Children (Harter, 1985) subscales for support from friends (4 items, Cronbach's $\alpha$ = .68) and from family (4 items, Cronbach's $\alpha$ = .80). This scale has demonstrated construct validity, ranging from .28 to.49 (Harter, 1985).

Behavior Problems at School. Teacher reported behavior problems were assessed using the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997; Goodman, Meltzer, & Bailey, 1998). This questionnaire contains 20 items assessing problem areas (emotional symptoms, conduct problems, hyperactivity/inattention, and peer relationship problems; Goodman, 1999). The scale compares favorably to other behavior scales (Goodman, 1997; Goodman & Scott, 1999), distinguishing well between clinical and non-clinical samples.

PTSD Diagnosis. As part of the normal TF-CBT protocol, children assigned to TF-CBT were scheduled for an clinic intake consisting of the PTSD section of a diagnostic interview (K-SADS-PL-PTSD; Kaufman et al., 1996) to determine whether they met PTSD criteria. Children whose responses did not indicate PTSD were not included in TF-CBT treatment.

## Analysis

We imputed missing items 5 times separately for each treatment group and timepoint using Proc MI in SAS (Version 9.2; SAS Institute, 2002-2008). We conducted descriptive statistics at baseline, and compared groups who were randomly assigned to CBITS or to TF-CBT. We present differences in PTSD and depressive symptoms over time within each group (adjusting for clustering within CBITS intervention groups for those in the CBITS arm. As will be discussed below, our plan to examine predictors of improvement within each group was not possible, due to limited numbers of children who participated in TF-CBT. Thus, we examined predictors of improvement within the CBITS group only, via regressions controlling for baseline PTSD levels and adjusting for clustering within CBITS intervention groups. In the TF-CBT group, we examined predictors of uptake of TF-CBT via logistic regressions predicting intake attendance. Analyses without clustering were conducted in SAS and those requiring clustering were conducted in R (Version 2.9.1; R Development Core Team, 2005).

## RESULTS

Students who participated in the assessments consisted of slightly more girls than boys (girls 55.9%; boys 44.1%), with average age 11.6 years old (SD=1.4). Forty-eight percent of children were non-Hispanic White, 46% were African American or Black, 5% were Hispanic, and 2% were from other racial/ethnic backgrounds. Of those determined to be "at-risk" based on PTSD symptoms scores, there were more girls (63%) than boys (37%), with an average age of 11.5 (sd = 1.5; median = 11.3; range 9.0-15.5). Fifty-two percent of students were African American or Black, 42% were non-Hispanic White, 4% were Hispanic, and 2% were from other racial / ethnic backgrounds.

Students in the study reported a median of 1 hurricane exposure (range 0-7). As seen in Table 2, the most common experiences were having seen something very upsetting (75%), or being separated from parent or caregiver (29%). Rates of being trapped, rescued, or stranded in New Orleans were much lower, around 5%.

Lifetime trauma exposure was common, with students reporting a median of 4 traumatic events (range 0-10) at the baseline assessment. As seen in Table 2, the most common traumatic events reported were vicarious traumas (learning about the death or injury of a loved one, witnessing violence) but personal exposures to trauma (car accident, victim of violence, medical procedure) were also common. At the 10-month assessment, students reported on exposure to traumatic events since the last assessment. During this time, students reported a median of 3 additional recent traumatic exposures (range 0-8; mean 3.31, sd = 2.13).

Mean scores for PTSD, depression, and behavior problems are shown in Table 3. With regard to PTSD symptoms, all had scores of 12 or higher by definition, with 82.2% in the clinically significant range (scores of 15 or higher). For depression, 52.5% of students reported clinically significant symptoms (scores of 13 or more on the CDI). Teachers reported behavior problems indicative of the "borderline" range (a score of 12-15) for 11.9% of students and problems in the "abnormal" range (a score of 16 or above) for 15.3% of students. The two groups of children were comparable to one another, as shown in Table 3, as intended following the randomization procedure.

Of children randomized to be offered CBITS in schools, 57/58 (98%) began treatment, and 53 (91%) completed treatment. For children randomized to be offered TF-CBT at Mercy Family Center, therapists began calling parents immediately after randomization to schedule the intake, including confirming PTSD. Twenty-two of the 60 (37%) attended the initial assessment,

which occurred weeks to months after the baseline assessment. Of this number, seven (32%) did not meet PTSD criteria on the K-SADS and were not provided with TF-CBT treatment, most commonly because distress was not linked to a specific traumatic event. Instead, these children were offered a different form of therapy within Mercy Family Center. Another child had a pervasive developmental disorder that precluded inclusion in the study. Thus, 14 (23%) began TF-CBT, and 9 (15%) completed treatment by the time of the 10-month follow up (4 dropped out of treatment, and 1 began late and had not completed treatment; See Figure 1). These rates of uptake varied by school: in School 1, 9 of 9 students began CBITS and 2 of 7 attended the TF-CBT intake appointment, in School 2, 28 of 28 began CBITS and 17 of 29 attended the TF-CBT intake, and in School 3, 20 of 21 began CBITS and 3 of 24 attended the TF-CBT intake.

As seen in Table 4, PTSD scores at 10 months improved in both interventions including all students that began treatment, as compared to baseline scores. Mean PTSD scores for the TF-CBT group had moved to the normal range while mean scores in the CBITS group were in the low clinical range. Sixty-five per cent of the children (37/57) in the CBITS group remained in the "at-risk" range ($\geq$ 12) on the CPSS at the 10-month follow-up, whereas 43% (6/14) of the children who received TF-CBT remained at-risk. A Fisher's Exact test revealed these two rates of clinical change were comparable across the two groups (2-tailed p-value = 0.22). According to the KSADS, only 1/9 (11%) children completing TF-CBT treatment met criteria for PTSD at the end of treatment. Changes in depressive symptoms also improved for both groups, but this improvement was only statistically significant for the CBITS group. Mean depression scores moved to the normal range for both groups. Thus both statistically and clinically significant gains were achieved by students in both interventions.

Since few children took part in TF-CBT, we could not evaluate predictors of treatment response. Instead, we examined predictors of attending the intake for TF-CBT (see Table 5). Baseline trauma exposure, severity of symptoms, and social support were not predictive of attending the intake. Boys and younger children had higher odds of attending the intake appointment. African American students had lower odds than Caucasian students, as also reflected in the higher odds of students in School 3 (with a largely Caucasian student body) attending the appointment. Rates of attendance also differed by distance between home and clinic. School, race/ethnicity, and distance were confounded (with students at School 2 living the shortest distances and students at School 1 the longest), but school and race were too highly confounded in the TF-CBT group to examine separately. When school as well as distance were used in the same regression, school remained a significant predictor of attendance (Wald's Chi-squared = 7.38, p = .03) while distance did not (Wald's Chi-squared = 2.22, p = .14).

Predictors of treatment outcome for the CBITS group were examined, predicting PTSD symptoms at 10 months while controlling for baseline PTSD. Baseline PTSD was a strong predictor of PTSD at 10 months (See Table 6). Support from family predicted lower PTSD scores, whereas higher baseline depressive symptoms and additional exposures to traumatic events as reported at follow-up predicted higher PTSD scores. Gender, school, teacher reported behavior problems at baseline, hurricane exposures, and social support from friends were unrelated to PTSD at follow-up.

## DISCUSSION

This study evaluated the prevalence and correlates of PTSD and depressive symptoms in students in three New Orleans schools 15 months after Hurricane Katrina. Students reported significant levels of mental health symptoms. More than 60% of children screened positive for elevated PTSD symptoms and were included in the intervention field trial. These results highlight the importance of long-term support for mental health needs of children following disaster.

Of note were the high rates of previous lifetime trauma exposure, in addition to hurricane exposure, that were present among these students with elevated PTSD symptoms. This finding has both clinical and policy implications. Clinically, therapists who serve children affected by disasters should be aware of the impact of previous trauma on children's mental health functioning. Disaster exposure can trigger past trauma memories, which for individual children may have been much more traumatic than the disaster itself. Alternatively, earlier trauma may increase vulnerability to a new traumatic event such as a disaster. This was reported by children after the September 11th terrorist attacks (Mullett-Hume et al., 2008) and was again seen after Hurricane Katrina (Salloum et al., 2009). Thus, assessment of previous traumas as well as the specific disaster exposures is needed to fully evaluate PTSD and other mental health impact of trauma in children's lives.

Results indicate that both treatments led to significant improvement in PTSD symptoms, but CBITS was far more accessible to families who may not have been willing or able to participate in individual, clinic-based treatment that required parental participation and initiative to attend appointments outside of the child's regular school attendance. It is notable that despite starting with significant adversity, including exposure to traumatic events during the intervention

period, these non-treatment seeking children experienced significant gains. Since there was no control group, however, it is difficult to gauge whether students symptoms may have improved without treatment. We expect that symptoms would be relatively stable during the period of 15 months to 24 months post-disaster, but there is no empirical data to guide this conjecture.

This project found that most families did not access therapy at community clinic settings but did access similar services through their children's schools. In fact, some families asked whether they could receive the TF-CBT at school instead of the clinic, suggesting that co-locating all mental health treatment services in or adjacent to children's schools is desirable post-disaster. Families who attended the clinic intake were not reporting more severe problems, in contrast to other community-based findings (e.g., Leaf et al., 1996). Rather, demographics (age, race, and gender) as well as school and distance to the clinic predicted attendance. Families with younger, male, Caucasian students at certain schools were more likely to be able to access care. Since school and race/ethnicity were so highly confounded in this study, it was not possible to tease apart the contributions of school culture and community from race/ethnicity of the student, and this remains an important question for future research.

We encountered two important measurement issues in this project. If the results of the K-SADS-PL are representative, approximately one third of these children who were identified as "at-risk: may have been reporting general distress symptoms or another mental health problem rather than specific PTSD symptoms, since the most common reason for not meeting criteria for PTSD was that their distress symptoms were not linked to a specific traumatic event. Thus, the measures used for screening may be overly general for a trauma-focused intervention. Importantly, teachers reported lower rates of child problems than did the children themselves, as often observed in studies of anxiety (e.g., Collishaw, Goodman, Ford, Rabe-Hesketh, & Pickles,

2009). Although schools can be an ideal setting for meeting the mental health needs of children after disasters, teachers may not be ideally positioned to judge which children need these services.

There were several important limitations to note in this study, as seems to be the rule rather than an exception in post-disaster research. First, recruitment proved more difficult than anticipated, resulting in a smaller field trial and limited ability to utilize complex regression models. Although these types of consent rates are common in other school-based studies in inner city settings (e.g, Stein et al., 2003), we had expected recruitment at these smaller parochial schools, all attuned to the recent hurricane exposures, would be more productive. Thus, we conducted several different analyses to explore relationships, inflating the possibility of Type 1 error. Second, the results reported here on access to care were unanticipated, and thus the analysis had to shift from the original aims of examining predictors of intervention response to predictors of uptake of the therapy for TF-CBT. As an unexpected finding, we had not measured the full array of factors that would be desired for this analysis. Our choice to randomize children to one of the two intervention arms proved to be fortuitous, however, since it allowed a fair examination of access and uptake of intervention services across equivalent groups. In addition, we maintained the two interventions as they are normally delivered, rather than trying to make them more equivalent to one another, including the extra intake assessment in the group assigned to TF-CBT. Thus, the validity of the results was not threatened and the study can provide valuable information for future mental health efforts following disaster.

In conclusion, this field trial indicated ongoing need for intervention in a sample of school children who were not seeking mental health treatment more than a year following the hurricanes of 2005 in New Orleans. Not only were students experiencing symptoms related to

the disaster, but many had experienced more devastating traumas and deaths prior to August 2005, and had diagnoses other than PTSD when evaluated. Future responses to natural disasters should include not only child-focused, long-term and traditional mental health services, but should take an even broader vision by taking into account previous trauma and pre-existing mental health disorders. When interventions were offered to comparable groups, access to those interventions turned out to be extremely important. The difference in access between the otherwise similar treatments, offered free of charge, shows that treatment must be available in convenient locations and at convenient times. While schools' mission is to educate, schools may offer many children's only window of opportunity to recover from the negative effects of trauma on learning (Garbarino, Dubrow, Kostelny, & Pardo, 1992; Hurt, Malmud, Brodsky, & Giannetta, 2001; Saigh, Mroueh, & Bremner, 1997; Schwab-Stone et al., 1995).

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**Table 1: Description of School Sites**

| | School 1 | School 2) | School 3 |
|---|---|---|---|
| **Size** | 158 students (85 4th-8th grade) | 796 students (397 4th - 8th grade) | 261 students (127 4th - 8th grade) |
| **Location** | New Orleans, LA | Metairie, LA | New Orleans, LA |
| **Hurricane Damage** | Moderate damage to roof and part of the school could not be used during the 2005 – 2006 school year. | No damage to school, but surrounding neighborhood damaged by wind. | Four to six feet of flooding, water damage to first floor, replaced furniture and books. |
| **Race and ethnicity** | Predominately African American (74%) | Predominately Caucasian (90%) | Predominately African American (97%) |
| **Participation in free/reduced lunch program** | 75% | 11% | 80% |
| **Student living situations** | Many students did not evacuate and lived in trailers, hotels and cruise ships immediately after the hurricane. | Many students lived in FEMA trailers for months after returning to school. | Many students travel nearly an hour to get to school, having relocated to other towns outside New Orleans after the storm. |

**Table 2: Exposure to Hurricanes and Other Traumas Among "At-Risk" Students (N=118)**

| Hurricane Experiences | Percent |
|---|---|
| Trapped in a flooded house | 5.98 |
| Walked or swam through floodwater to escape | 7.63 |
| Got out by boat | 4.24 |
| Got out by helicopter | 3.39 |
| Stayed in the Superdome or Convention Center | 3.39 |
| Slept overnight on a street (including the I-10) | 5.08 |
| Saw something really upsetting, like dead bodies | 74.58 |
| Separated from parents or usual adult caretakers | 28.81 |
| **Other Traumatic Experiences** | |
| Earthquake | 0.00 |
| Other disaster (fire, tornado, flood or hurricane) | 53.39 |
| Bad accident | 31.62 |
| Been in a warzone | 5.93 |
| Victim of violence at home | 26.72 |
| Witness to family violence | 29.31 |
| Victim of community violence | 26.72 |
| Witness to community violence | 53.04 |
| Seen a dead body | 42.61 |
| Adult touch or treatment that made you feel uncomfortable | 14.91 |
| Learned about death or serious injury of a loved one | 71.19 |
| Painful and scary medical treatment | 41.88 |

**Table 3: Exposures and Symptoms among "At-risk" Students at Baseline (15 months post-Katrina)**

| | Overall (N=118) | | CBITS (N=58) | | TF-CBT (N=60) | | t-statistic | p-value |
|---|---|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | Mean | SD | | |
| Exposure to Hurricane-related Trauma | 1.33 | 1.13 | 1.22 | 1.11 | 1.43 | 1.16 | -0.99 | 0.32 |
| Exposure to Lifetime Traumatic Events | 3.98 | 2.12 | 3.81 | 2.08 | 4.15 | 2.15 | -1.01 | 0.31 |
| Self-reported PTSD Symptoms | 22.27 | 8.04 | 21.93 | 7.88 | 22.60 | 8.24 | -0.53 | 0.60 |
| Re-experiencing symptoms | 6.63 | 3.11 | 6.86 | 2.74 | 6.40 | 3.44 | 0.74 | 0.46 |
| Avoidance symptoms | 6.95 | 3.68 | 6.71 | 3.89 | 7.18 | 3.48 | -0.79 | 0.43 |
| Arousal symptoms | 8.69 | 3.52 | 8.36 | 3.49 | 9.02 | 3.56 | -1.02 | 0.31 |
| Self-reported Depressive Symptoms | 13.37 | 7.90 | 13.47 | 8.39 | 13.28 | 7.46 | 0.14 | 0.89 |
| Teacher Reported Behavior Problems | 7.95 | 7.29 | 9.00 | 7.77 | 6.93 | 6.70 | 1.32 | 0.19 |

**Table 4: Changes Observed Among Intervention Starters**

| | Baseline | 10-months | Difference | |
|---|---|---|---|---|
| | Mean (sd) | Mean (sd) | t-statistic | p-value |
| CBITS Starters[1] (N=57) | | | | |
| PTSD Score | 21.98 (7.94) | 15.81 (9.31) | -4.85 | <.001 |
| Depression Score | 13.40 (8.45) | 9.72 (8.97) | -4.30 | <.001 |
| TF-CBT Starters (N=14) | | | | |
| PTSD Score | 22.86 (8.33) | 12.00 (10.36) | -3.07 | <.01 |
| Depression Score | 15.43 (7.63) | 11.14 (10.52) | -1.37 | 0.17 |

[1] Changes within the CBITS group control for clustering within the CBITS intervention groups.

**Table 5: Odds of Attendance at TF-CBT Intake (N=60)**

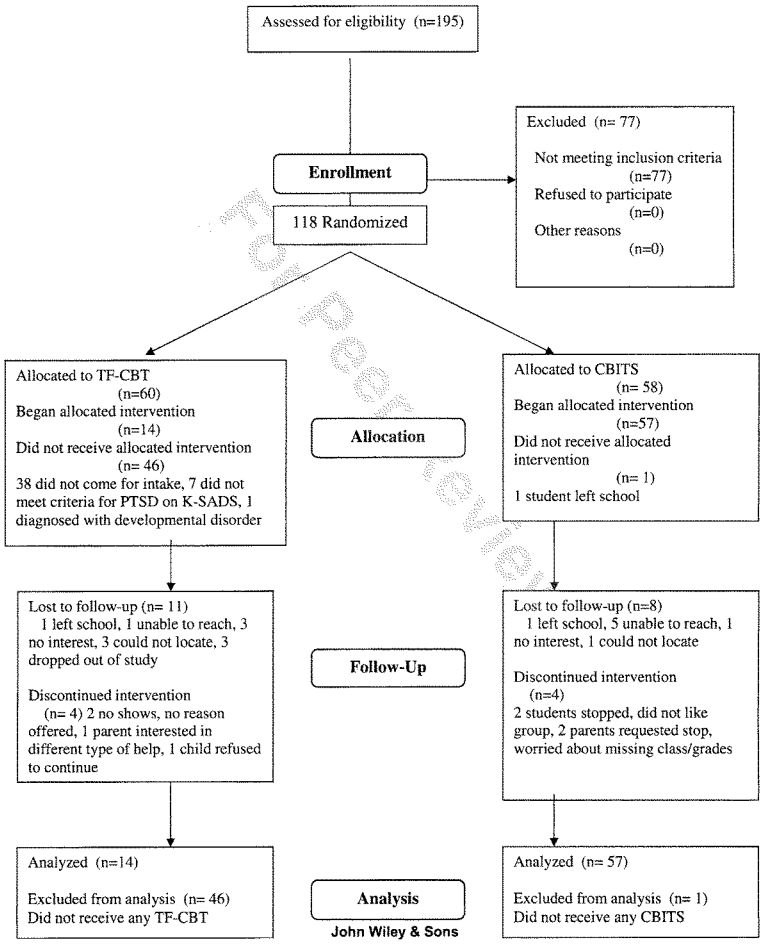
| Categorical Variables | OR | 95% CI | |
|---|---|---|---|
| School | | | |
| School 1 | 1.00 | | |
| School 2 | 2.80 | 0.37 | 21.49 |
| School 3 | 9.92 | 2.40 | 40.93 |
| Male | 3.55 | 1.18 | 10.67 |
| Race/Ethnicity | | | |
| White (non-Hispanic) | 1.00 | | |
| Black (non-Hispanic) | 0.10 | 0.03 | 0.36 |
| Hispanic | 0.65 | 0.04 | 11.45 |
| **Continuous Variables** | **OR** | **95% CI** | |
| Age | 0.59 | 0.38 | 0.91 |
| Exposure to Hurricane-related Trauma | 1.34 | 0.84 | 2.14 |
| Exposure to Lifetime Traumatic Events | 1.11 | 0.87 | 1.42 |
| Self-reported PTSD Symptoms | 1.00 | 0.94 | 1.07 |
| Self-reported Depressive Symptoms | 1.00 | 0.93 | 1.07 |
| Teacher Reported Behavior Problems | 1.01 | 0.93 | 1.09 |
| Social Support - Family | 1.06 | 0.89 | 1.27 |
| Social Support - Friends | 0.92 | 0.79 | 1.07 |
| Distance Home-Clinic | 0.81 | 0.68 | 0.97 |

**Table 6: Predictors of 10-month Follow-up PTSD within the CBITS Group[1] (N=57)**

| | Standardized Coefficient | Standard Error | t-statistic | p-value |
|---|---|---|---|---|
| Baseline PTSD Symptoms | 4.18 | 0.15 | 3.65 | <.001 |
| Baseline PTSD Symptoms | 4.31 | 0.14 | 3.76 | <.001 |
| Female Gender | 1.60 | 2.62 | 1.36 | 0.18 |
| Baseline PTSD Symptoms | 4.24 | 0.15 | 3.64 | <.001 |
| School 1 vs. 3 | 0.58 | 3.87 | 0.41 | 0.68 |
| School 2 vs. 3 | -1.77 | 2.67 | -0.88 | 0.38 |
| Baseline PTSD Symptoms | 2.23 | 0.19 | 1.52 | 0.13 |
| Baseline depression symptoms | 3.01 | 0.17 | 2.06 | .04 |
| Baseline PTSD Symptoms | 4.32 | 0.15 | 3.67 | <.001 |
| Hurricane exposures | -0.82 | 1.52 | -0.67 | 0.50 |
| Baseline PTSD Symptoms | 3.25 | 0.15 | 2.73 | 0.006 |
| Social Support from Family | -2.82 | 0.34 | -2.28 | 0.02 |
| Baseline PTSD Symptoms | 3.46 | 0.16 | 2.8 | 0.005 |
| Social Support from Friends | -1.83 | 0.33 | -1.47 | 0.14 |
| Baseline PTSD Symptoms | 4.32 | 0.15 | 3.66 | <.001 |
| Teacher report of behavior problems | -0.59 | 0.17 | -0.47 | 0.64 |
| Baseline PTSD Symptoms | 4.77 | 0.16 | 3.66 | <.001 |
| Lifetime trauma exposures at baseline | -1.32 | 0.63 | -1.00 | 0.32 |
| Baseline PTSD Symptoms | 3.34 | 0.15 | 2.79 | 0.005 |
| Trauma exposures between baseline and 10 month follow-up | 2.57 | 0.62 | 2.03 | 0.04 |

[1] Regressions adjust for clustering within the CBITS intervention group

## Figure 1: Flow of Study Participants



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# Treating Traumatized Children after Hurricane Katrina: Project Fleur-de Lis™

**Judith A. Cohen · Lisa H. Jaycox · Douglas W. Walker · Anthony P. Mannarino · Audra K. Langley · Jennifer L. DuClos**

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**Abstract** Project Fleur-de-lis™ (PFDL) was established to provide a tiered approach to triage and treat children experiencing trauma symptoms after Hurricane Katrina. PFDL provides school screening in schools in New Orleans and three tiers of evidence-based treatment (EBT) to disaster-exposed children utilizing a public health approach to meet the various needs of students referred to the program, some stemming from the disaster itself, some related to prior exposure to violence, and some relating to preexisting conditions and educational delays. The National Institute of Mental Health (NIMH) is funding a research project conducted in collaboration with PFDL, to examine two evidence-based practices for child PTSD in order to guide child treatment decisions after future disaster situations. This article describes the need for mental health services for children following disaster, the structure and purpose of PFDL, design of the NIMH project, two case descriptions of children treated within the project, and preliminary lessons learned.

**Keywords** Children · CBITS · Disaster · PTSD · TF-CBT · Violence

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## Introduction

Emergency disaster responders focus on medical and other basic needs rather than children's psychological distress. This is a reasonable allocation of acute resources since the majority of children have transient signs of distress after disaster exposure. As structure, routine, and order return, many children are resilient, regaining their previous level of psychological functioning. However, a significant minority of children who are more vulnerable will have ongoing difficulties.

Recent studies have identified factors that increase children's risk for developing PTSD and related symptoms such as depression after disasters. Greater exposure to the disaster itself increases risk. Children with greater personal exposure to life threat or danger, those who witnessed others in life-threatening situations or whose family members' lives were in danger are at greater risk than children who did not experience or witness such things

(Pine and Cohen 2002). Similarly, having a family member die in the disaster is a risk for greater symptoms post-disaster. After the Asian tsunami, delayed evacuation was found to predict the development of PTSD in children 9 months later (Thienkrua et al. 2006). After the September 11th terrorist attacks and the Asian tsunami, children's peri-traumatic panic symptoms predicted later PTSD symptoms (Pfefferbaum et al. 2006; Thienkrua et al. 2006).

Factors unrelated to disaster exposure also predict risk and resilience. Demographic factors (female gender, younger age) (Pine and Cohen 2002) genetic vulnerabilities (Caspi et al. 2002), family variables (parental support and parental PTSD) (Pine and Cohen 2002), and existing mental health problems such as anxiety (La Greca et al. 1998) are all associated with symptom development in children after disaster exposure. Of particular note are the facts that children in disaster zones have often experienced previous traumas, and that these prior traumatic events may be identified by children as being more traumatic than the disaster itself. Children with past trauma histories of sexual abuse, domestic violence, traumatic deaths, or other serious traumas may experience a "retriggering" of previous PTSD symptoms upon exposure to a new trauma such as a disaster. These children may be at increased risk for manifesting PTSD symptoms post-disaster (Hoven et al. 2005; Pine and Cohen 2002). In addition, community-wide disasters may allow for new exposures to violence, during evacuation or amidst post-disaster crowding and difficult living conditions, and thus may exacerbate recovery. These exposures to violence can be considered "secondary" traumas, caused in part by the disaster but with a different meaning and a different context for children.

Given the long-term deleterious effects associated with PTSD in children who have PTSD symptoms, including the development of chronic PTSD (American Academy of Child & Adolescent Psychiatry in press), cognitive and educational impairments, relationship problems, significantly increased health care usage, substance abuse, suicide attempts, and completed suicide (La Greca et al. 1996), it is of critical medical and societal importance to identify affected children, and provide them with effective treatment for PTSD in order to prevent these negative outcomes. This article describes one approach to meeting the mental health needs of children following disaster, the 2005 Hurricanes Katrina and Rita. In this article, we describe Project Fleur de Lis™, a school-centered program addressing children's post-hurricane mental health needs, and a small research project launched 15 months after Hurricane Katrina struck. In this project, the importance of addressing children's exposure to past traumas along with exposure to disaster was apparent.

## Project Fleur-de-lis™ (PFDL)

Hurricane Katrina was one of the worst natural disasters to ever impact the United States. On August 29, 2005 it made landfall, with subsequent flooding of New Orleans secondary to the breach of several levees and canals. There was a mandatory evacuation of the entire city plus the destruction of the living environment of over 500,000 people and the loss of over 1,000 lives. Although the majority of families escaped prior to the breach of the canals, thousands of the city's citizens, including the poor, elderly, and hundreds of children, had no means of evacuating and were forced to seek refuge in the attics or roofs of their homes or in two large emergency shelters (the Super Dome and the New Orleans Convention Center). These are the same families most likely to be exposed to previous traumas prior to the hurricanes (Stein et al. 2003a). Many had to wade through flood waters, experienced separation from family members, or viewed dead bodies during the journey to these shelters. Others had to be rescued from rooftops or make other precarious journeys to safety. Both emergency shelters lost electricity, leaving their inhabitants without air conditioning, working toilets, water or food during the days before they were rescued. There were a number of incidents of violence in the shelters, including reported sexual assaults. During the evacuation many children were separated from family members; by the time of the evacuation, many young children and elderly had become seriously ill and had to be hospitalized. Most families were subsequently evacuated to the Astrodome in Houston where more separations, waiting, uncertainty, and ethnic tensions occurred as predominantly African American children were temporarily integrated into a predominantly Latino community. Hurricane Rita struck the Gulf Coast on September 24th, delaying the reopening of New Orleans and causing further damage and displacement. Upon return to New Orleans, families were faced with life in FEMA trailers, and discovery that all of their possessions and homes were destroyed, and family members, friends, and pets had died or moved away and their schools had closed. Many children had relocated multiple times by the start of the 2006–2007 school year. Many were still living in FEMA trailers, under over-crowded conditions. Anecdotal reports gathered during Project Fleur-de-lis (PFDL) (described below) detail the high stress conditions and children being exposed to more adult behaviors (drinking, sexual activity, and violence) than would be the case if they were living in their own homes.

After the immediate disaster response, when "first responder" volunteers who had provided mental health care left the New Orleans area, the daunting task of providing intermediate and long-term trauma-informed

treatment to the thousands of children exposed to trauma before and after Hurricane Katrina was left to those mental health professionals who remained. PFDL was created by Mercy Family Center in the fall of 2005. It has been funded by a consortium of corporations, foundations, individual donations, and non-profit agencies over the last 3 years. PFDL was designed as an intermediate and long-term school-based mental health service model for children who have been exposed to traumatic events as a result of natural and man-made disasters. PFDL is a collaborative program linking local social service agencies, schools and nationally recognized researchers, program developers, and clinicians in a coordinated effort to provide state-of-the-art mental health services within schools in the greater New Orleans area. PFDL was designed to: (1) implement school-based intervention services to children exposed to trauma; (2) establish a mechanism for identification of and provision of services to children with mental health and psycho-educational needs beyond what can be addressed or identified in the school setting; (3) partner with national leaders to provide increased access to mental health care and effective trauma treatments for children in schools and the community; and (4) provide evidence that treatments for traumatized children can be effectively delivered in a three-tiered model of care utilizing school-based interventions, classroom-based interventions, and specialized community-based interventions in communities significantly impacted by natural or man-made disasters.

PFDL's "Stepped Trauma Pathway" was designed to address three major factors that impact mental health intervention post-disaster, including the time when a school-based intervention can be implemented after a community disaster, the number of children served, and the severity of post-trauma symptoms of identified children. PFDL's Stepped Trauma Pathway focuses on children who have been exposed to trauma through a combination of (1) direct exposure to Hurricane Katrina and its immediate destruction in the greater New Orleans area; (2) the persistent and pervasive secondary traumas endured by way of living in the greater New Orleans area, including violence exposure and; (3) complex trauma that many financially disadvantaged and ethnic minority children have experienced prior to Hurricane Katrina.

Treatment studies of childhood PTSD have grown in numbers and empirical rigor in the past decade. Several empirical reviews and treatment guidelines (e.g., American Academy of Child & Adolescent Psychiatry 1998; Chadwick Center for Children and Families 2004; Foa et al. 2008; SAMHSA Model Programs, www.modelprograms.gov,) have recognized Trauma Focused-Cognitive Behavioral Therapy (TF-CBT; Cohen et al. 2006a) as the treatment with the strongest evidence of efficacy in treating traumatized children, and have recognized Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox 2003; Stein et al. 2003b) as a "promising" or "proven" school-based intervention. In addition, the Classroom-based Intervention (CBI ©; Macy et al. 2006) was being implemented in many schools in New Orleans by Save the Children, and is also a promising practice (Jaycox et al. 2008). Thus, these three interventions had been selected for use in PFDL based on their evidence-base: CBI offered as a universal intervention, CBITS as a selected intervention for those with lingering symptoms, and TF-CBT for children with PTSD who did not respond to the school-based interventions.

In response to constraints in school priorities, timing, and staffing issues, however, the full-stepped care model was not the norm. In the months following Hurricane Katrina, PFDL offered free multidisciplinary consultation to school-based mental health professionals and free psychological and psychiatric services to students identified as needing mental health care in excess of what could be provided in the school setting. During weekly "Classroom–Community Consultation"($C^3$) meetings, children who were identified as being in need of psychological services in participating schools were discussed at weekly meetings attended by other participating school-based mental health professionals and the social workers, psychologists, and psychiatrists of Mercy Family Center, a non-profit community mental health center funded by the Sisters of Mercy Health System. Forty-five schools and 22,000 students were under the PFDL "umbrella of care" during this period. (PFDL model of care and free services continue to the present time with more schools being added on an ongoing basis.)

During the 2006–07 school year, 268 students were triaged within weekly $C^3$ meetings, 116 students were referred for psychoeducational testing, 114 students were referred for therapy, 20 students were referred for psychiatric services, and 18 were determined to be in no need of services. Of the 114 students referred for psychotherapy, 70 referrals (61%) were trauma related (half of these were related to Hurricane Katrina by way of either direct exposure or secondary loss such as damaged home, neighborhood, death of family member and pet).

The 70 referrals for trauma related events in the 2006–2007 school year were directly referred for individual, outpatient "third tier" services (TF-CBT) since "second tier" trauma focused groups were not up and running in the 45 participating schools as originally intended. Significant progress has been made in establishing a sustainable stepped-care model among the 65 participating schools during the current 2008–2009 school year by way of 13 PFDL schools now providing CBITS groups and TF-CBT interventions on their campuses. And although current trauma exposure for our PFDL student population receiving

interventions tend to be related to community/domestic violence and abuse/neglect, this stepped model is becoming established to address trauma related to future natural and manmade disasters.

## The NIMH Project: Implementation of Two Interventions

In many disaster scenarios, detection of children in need of services is challenging, and few trained mental health providers are available to provide individual treatments to all symptomatic children. Thus, triaging children to the optimal level and intensity of care is essential, and PFDL, described above, provides a good model for how to do this. Although there are many examples of tiered programs in school settings (Smith et al. 2007), empirical data to provide information about how best to operationalize them are still lacking. Although data are being collected from children at pre- and post-treatment to assess clinical improvement, these data do not address the question as to which treatment was optimal for which children. The authors believed that an opportunity existed within the structure of PFDL to conduct such a study, whether funding could be obtained to "piggyback" this study onto the existing structure. However, a mechanism had to be found to obtain funding quickly enough to meet children's post-hurricane mental health needs during the 2006–2007 school year (one year after Hurricane Katrina occurred).

Most federal funding mechanisms after disasters do not provide for actual treatment, but only for outreach and education. Other mechanisms for conducting research, such as RAPID (Rapid Assessment Post Impact of Disaster) grants, require applicants to go through an expedited review process which still might delay receipt of funding for many months, as do competitive grant supplements. An alternative was to obtain Administrative Supplements to existing federal grants, though these funds are very modest. Three of the authors were Principal Investigators on two existing grants from the National Institute of Mental Health (NIMH), which were aimed at evaluating the effectiveness of TF-CBT when delivered in a community setting, and an adaptation of CBITS for delivery by school personnel, respectively. We proposed to NIMH to develop joint Administrative Supplements which would aim to help inform efforts to triage children to needed levels of intervention after exposure to community trauma, while also being consistent with the goals of each of the parent grants, and received funding in the fall of 2006 to conduct a small research project.

This project focused on schools for the identification of students in need of mental health services, in three small parochial schools. We proposed to provide universal screening at these schools among children whose parents consented/children assented to participate. Through screening, we planned to identify children meeting minimal criteria for PTSD symptoms who were potentially "in need" of intervention. Early on in discussion with NIMH, we considered whether to screen for PTSD symptoms related to the hurricane only, or whether to identify children with PTSD symptoms related to any past trauma. Taking the public health viewpoint that following disaster, all of disaster victims' health needs, regardless of their source, must be met, we decided to assess PTSD related to any type of trauma. This broad approach is in line with the empirical studies of risk factors for PTSD, reviewed earlier in this article, as well. Thus, the screening would examine not only trauma symptoms but also trauma history, including both subjective and objective exposures to hurricane traumas (Thienkrua et al. 2006) and to past traumas and violence exposure. This broad and inclusive approach was validated by information gathered during the course of the interventions—both in terms of what the children identified as the "worst" trauma they had experienced, and in relation to our study with specific children within the interventions, as will be illustrated by two case presentations.

In order to capitalize on the small funding and still be able to inform triage efforts, the project was designed to randomize students to either CBITS or TF-CBT, and examine which factors successfully predicted positive response to which treatment.

CBITS was provided in the children's schools during regular school hours, while TF-CBT was provided at Mercy Family Center and required that a parent or other caretaking adult bring the child to therapy and actively participate in treatment. Data stemming from this project are forthcoming.

### CBITS

CBITS is a 10-group session and 1–3 individual session intervention designed specifically for use in schools. It is the most thoroughly tested school program at present, having undergone two controlled trials (Kataoka et al. 2003; Stein et al. 2003b). CBITS has been successfully implemented with children as young as 4th grade students and as old as 12th grade students, with many different cultural groups (including Native Americans and African Americans as well as Hispanics), and with populations who have suffered multiple forms of trauma. Although most of the school projects have screened and identified children based on exposure to community violence, the students focus on whichever traumatic experience is most upsetting to them, and thus the groups themselves address diverse traumatic experiences.

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TF-CBT

TF-CBT is a 12–16 session intervention that includes child and parent, and typically is delivered in a clinical setting. Until the last 5 years, the evidence for TF-CBT was based primarily on studies of sexually abused children, all demonstrating superior outcomes for those treated with TF-CBT (Cohen and Mannarino 1996, 1997, 1998; Cohen et al. 2005). More recent evidence indicates that TF-CBT is also effective for multiply traumatized children (Deblinger et al. 2006). TF-CBT has also been evaluated for traumatized children following a community-level disaster within the Child and Adolescent Trauma Treatment and Services (CATS) Project following the September 11, 2001 terrorist attacks on the World Trade Center (WTC) in New York City. This study involved more than 580 children (445 with significant PTSD symptoms) and 80 therapists at nine community sites coordinated by Columbia University. Children receiving TF-CBT experienced significantly greater reliable decrease in PTSD symptoms than children receiving community treatment as usual according to a regression discontinuity analysis (Hoagwood et al. 2006).

## Importance of Prior Violence Exposure in the Lives of Participants

Early in each intervention, children discussed their trauma exposures and with the help of the therapist, picked the trauma that was bothering them the most currently. If no particular trauma stood out at present, they picked the one that bothered them the most when it happened. These traumas were then used to create trauma narratives within the interventions, vital components of both the CBITS and TF-CBT protocols.

Trauma narratives were collected and categorized from 67 children participating in the research study who attended CBITS or TF-CBT treatment. Surprisingly, the majority of children did not create trauma narratives related to Hurricane Katrina. Thirty-one percent of the children in the research study created trauma narratives focused upon the grief associated with the death or incarceration of a loved one. Of interest is the fact that most of these deaths occurred before the storm or were unrelated to the storm itself. The second most common theme of the trauma narratives (25%) was direct exposure to the storm, or the immediate effects of their destroyed homes and communities. Next, 11% of children created trauma narratives related to their exposure to community violence, which was and continues to be an ongoing challenge in post-Katrina New Orleans. The remainder of trauma narratives focused upon accidents (9%), secondary trauma associated with the storm (7%), threat of death of a loved one (7%), domestic violence (4%), divorce (4%), and sexual abuse (2%). These findings, similar to those for children treated after September 11, 2001 (Hoagwood and the CATS Consortium in press), suggest that following disasters, many of the children who are likely to develop trauma symptoms are those who were already vulnerable due to having experienced previous traumas or deaths. This emphasizes the need for more community providers who are trained in evidence-based trauma treatments to serve these children, not only after disaster strikes, but in the pre-disaster period as well.

## Case Descriptions

Note: Both of the following cases are representative composite case descriptions in order to protect confidentiality of children and families who participated in PFDL.

Two case descriptions illustrate the way in which both prior traumatic exposure and violence exposure secondary to the hurricanes were important factors in treatment.

CBITS Case: Adam

Adam was an 11 year-old African American male who was living in New Orleans East when Hurricane Katrina made landfall. Adam experienced the loss of many close family members before and after the storm. These losses included the death of his grandmother in 2003, great grandfather in 2004, great grandfather in 2005, and pet hamsters in April and May of 2006. His mother and father separated soon after the storm, and upon returning from Georgia, Adam reported having only short phone conversations with his father. Although Adam's home and neighborhood were destroyed, his school was located in a neighborhood of New Orleans that was less affected by the storm. As a result, he and his mother evacuated to Georgia for 6 months, and later returned to his pre-Katrina school for the 2006–2007 academic year. Adam's mother lost her steady job as a result of the storm, and was unemployed at the time that Adam began the CBITS group.

Adam could be described as being "book smart" with a keen desire to achieve in his school and be accepted into the Catholic high school of his choice. Adam's goals for the CBITS group, documented at the first group session included: feeling less nervous, feeling more happy, calming himself down when he felt upset, doing more things that he used to do, making better decisions, and to improve his math grade. Adam's baseline PTSD score was 17, which was significantly above the study's cut-off score of 12. His mother agreed to enter him in CBITS at school, stating that she was most concerned with his self-esteem,

social skills, low-frustration tolerance and his avoidance of public bathrooms. Adam had perfect attendance across the 10 weeks of CBITS groups.

Adam's trauma narrative, developed during two individual "breakout" sessions, was as follows:

> "You know I went to Georgia right? Yeah, well at my new school there were a bunch of guys who were giving me trouble over being from New Orleans, I was the only one at my school so I guess I stuck out or something. These guys were on the football team, most of them, they all hang out together. So one day I have to use the bathroom you see? And I'm doing what I need to do when I hear someone walk in the bathroom behind me. It was between classes so I was hurrying to get done what I needed to get done. Then I hear this dude call out to the hallway, I don't remember exactly what he said, just a bunch of names. I jumped and nearly wet on my pants. So I finished what I was doing and turned, just then I saw three dudes standing behind me. One of them had my book sack, and then one of the others pushed me back into the wall. It really hurt 'cause he pushed me back into the toilet on the wall. He started yelling at me, I don't remember what - but it wasn't good...four eyes...stuff like that, and these were black dudes...the other guy dumped the books out of my sack. Then the other dude grabbed me and threw me on the floor. It didn't hurt, but I got hit in the head with my book sack. Then one of them hit me in the face with something wet and nasty. Hit me in the face with a nasty wet paper towel with toilet water on it. Mashed it in my face, this is when my glasses came off so I couldn't see no more. They didn't break my glasses. They ran, and I got up and washed my face fast. Nasty smelly! I then got my books and papers in my book sack, found my glasses on the floor, and ran out - I was late for class and got sent to the office. I didn't want to tell the teacher what happened 'cause one of the dudes was in my class. Went to the office and I told the office lady what happened, and she went in and told the principal. I went in and told her all of this and she called my mom. My mom came and got me. I didn't go to school the next day, and my mom called the principal the next day to talk to her."

Toward the end of therapy, Adam was able to face his "demons" in the school bathroom and begin using them again, albeit never between classes when the bathroom was busy with other students. Adam during the last session of CBITS (graduation), stated that he had learned to problem solve his social situations without getting "out-of-control," he appeared to the CBITS therapists to possess more self-confidence and had created closer friendships with both the boys and girls in his group. His mid-year PTSD score was measured to be only 1, which remained stable through his post-treatment evaluation where his PTSD score was measured to also be a 1.

## TF-CBT Case: Mandy

Mandy was an 8-year-old Caucasian girl who lived with her mother in Metairie prior to Hurricane Katrina. Mandy's parents had a long history of domestic violence, leading to eventual divorce. Mandy's maternal grandfather had died the year before Hurricane Katrina and Mandy was devastated by this loss since she and mother had lived with maternal grandparents following the divorce and she had been very close to her grandfather. Mandy had visits with her father every other weekend. She was visiting with father when the hurricane hit and father refused to allow mother to take Mandy to evacuate. As a result, Mandy waded through flood waters with father to the Super Dome and was eventually evacuated to Houston. She was separated from mother for 2 weeks. Grandmother's home was destroyed and the family is still living in a FEMA trailer. She scored 22 on the PTSD scale and had full PTSD on the diagnostic interview. Her mother agreed to participate in her TF-CBT treatment, saying that she was concerned about Mandy's nightmares, fears of storms, clinginess to mother, and irritability.

Mandy identified Hurricane Katrina as her worst trauma. However Mandy's narrative, developed during individual sessions, suggests that her current PTSD symptoms may have represented a retriggering of past symptoms, and that they were related in part to the feared traumatic loss of mother and violence from father:

> My name is Mandy. I am 8 years old. I go to school at ___. Now I live in a trailer with my mother, my mother's boyfriend, my brother and my grandmother. I like to sing in the choir and play with my friends. I used to go to a different school and live in a different place.
>
> When I was little I lived with my mom and my dad. They used to always fight. My dad would call my mom bad names. Sometimes he would hit her. It would make me feel bad. It made me think they didn't love each other. One time my dad hit my mom so hard she fell down and hit her head on the floor. She was bleeding, her face was covered with blood. I was afraid. I cried. I was sick inside. I thought she would die and I wouldn't have a mom. My dad told me shut up and call 911. I called and said hurry please hurry my mom is bleeding please Jesus hurry. They come and brought her to the hospital in the ambulance. My dad said she tripped and fell down the

steps. I was scared. I thought my mom would die and I was afraid of something happening to my dad. Why did this happen? Grandma came and sat and prayed with us. My dad said everything would be okay. I prayed to Jesus for my mom to come back to me. The doctor came and said that she would be okay. I cried and cried and said, Thank you dear Jesus.

I thought after that things would be ok. But it just kept getting worse at my house. One day my mom said we are going to leave. I thought what will Dad do, where will we live, I felt scared and confused but also relieved. No more fighting. No more worrying about my mom getting hurt. So we moved to another place, where my grandma lived. Then I started to visit my dad on the weekends. I really missed him in a way so I wanted to visit but the visiting didn't always go good. One visit my mom called. She wanted to come get me. She said there was a big storm coming. It was August 2005. She said we had to leave New Orleans and she wanted to come get me and take me with her. My dad said it was his weekend with me and she couldn't get me. I felt scared. I was thinking that I wanted my mom and grandma. My body felt shaky. I heard on TV that everyone was supposed to leave. I asked my dad when we were leaving and he said we're not going anywhere. I was afraid to say anything but he could tell I wanted to because he called me a scared-y cat. He said everyone who left was a bad name that I can't say. My mom called again and he called her the B-word and hung up on her. I felt all alone. I prayed to myself that I could change his mind. After a long time water started coming into the floors. My dad got pretty mad. I thought he was mad at me. The water was up to my ankles and then to my legs. Finally my dad said we should go. We went to the Super Dome. We walked through the water. It smelled bad. I saw bodies and one time I fell down and the dirty water got all over me. I was afraid. I thought I would never see my mother again. My father yelled at me to come on and not be a baby.

The Super Dome was the scariest part of all. There was no food there and the toilets was all broke and everything smelled terrible. It was so hot I felt sick. My dad kept yelling and I was afraid of what he might do. At night I heard people scream and cry. There was one nice lady next to me who reminded me of my grandma. She told me everything would work out ok. I heard her singing a song one time that I knew from choir. I asked my dad if I could sing with her for a minute and he said it was ok. I listened to her sing and it made me feel safer.

Finally the buses came and took us to Texas. I didn't know where my mother was or how I would ever find her. It took two weeks for us to find my mom and grandma and brother. When I finally saw my mom I never wanted to let her go, never ever ever ever again.

Now I am back in New Orleans with my mom and grandma. I have learned a lot of things from going through the storm and my family's problems. This is what I would tell other kids. Domestic violence is hurting people in the home. It hurts everyone in your family. Don't do it. If you're living with domestic violence it's not your fault. You're only a kid and you can't change grown ups. Try to get to a safe place. Call 911 if you can. Have a safety plan for disasters, it's better to be safe than sorry. Go to therapy, it will help you if you are scared. If you have a mom who loves you, you are the luckiest kid in the world.

At the end of therapy, Mandy and her mother reported that her symptoms were much improved. Her nightmares had ceased, and she was better able to tolerate separations from mother and her visits to her father. Her therapist tried to arrange a joint meeting with father as part of therapy, but this did not occur. However, Mandy felt more confident that she would be able to put a safety plan into place (calling 911, going to a neighbor's house, etc.) if this was ever needed during her visits to his house. At post-treatment, her PTSD score was 2, and she and her mother each only reported one symptom on the diagnostic interview.

## Lessons Learned

Our study in this project, both in PFDL and in the NIMH research study, offer several lessons that may be useful for future work in children's mental health following disaster.

First, the challenge of obtaining funding for mental health intervention is large. Most federal funding mechanisms after disasters only provide for outreach and education, rather than treatment. For example, Crisis Counseling Programs (CCP) funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) do not permit "office-based therapy" or "psychiatric treatment" http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg01.asp. Federal and state financial assistance in providing trauma-informed treatment and services in the New Orleans area was limited due to the restrictions placed upon post-disaster mental health services by Sect. 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 100–707). The Crisis Counseling Training and Assistance Program, funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act required that crisis

counselors functioning in a post-disaster community (1) provide services to disaster survivors who are assumed to have a high level of functioning; (2) provide services that do not require continuity of care; (3) empower disaster victims to advocate for services needed; and (4) have short-term relationships with disaster victims. Our experiences in working with children show, however, that their mental health needs are complex, and require substantial investment in treatment.

In particular, the existing mental health infrastructure was disrupted, lowering the baseline level of care being offered. For instance, although nearly half the population was expected to return within a year of the hurricanes, six of New Orleans' nine hospitals remain closed and only 22 of 196 psychiatrists are still practicing in the area (Weisler et al. 2006). Similarly, the Louisiana Psychological Association reported that 36% of its members were displaced following the storm (Souter 2006), with many psychologists either leaving the area or losing their positions (Munsey 2006). In addition, it has been difficult to recruit mental health professionals to the New Orleans area, especially those who are child-focused, and willing to commit for long-term service to the community. This recruiting challenge has been eased significantly over the past year by the increased utilization of the National Health Service Corps, U.S. Department of Health and Human Services, which offers educational loan repayment for qualified and committed clinicians who offer the New Orleans community a long-term commitment.

PFDL was created and has been sustained through the generous donations and support of several public, private, and non-profits organizations over the past three-and-a-half years. During the first year following Hurricane Katrina, it was extremely challenging to gather financial support for PFDL, a new and "inexperienced" disaster response program. But it was PFDL's core features of evidence-based practices, researcher–clinician collaboration, electronic record keeping, and the utilization of the knowledge and expertise of the school-based counselors that initially garnered short-term financial support for the program. The long-term financial support of PFDL can be attributed to the multitude of successful clinical outcomes that have provided students with prompt and appropriate mental health interventions and services.

Obtaining funding to evaluate aspects of this study proved similarly challenging, though we were able to leverage existing grants and obtain supplements that made some field work possible. Still, the funding was very modest, allowing only a small field trial.

Second, as demonstrated by the case studies and the traumas chosen by students as the most bothersome, we can see that the trauma of the disaster is just one part of the problem. Disasters offer an important window of opportunity to address both disaster-related PTSD and PTSD related to other events; and disasters may most traumatize those children who are already vulnerable due to previous traumatic experiences. The fact that Hurricane Katrina was not the most common trauma described in children's narratives is consistent with findings from other disaster studies (Hoagwood and the CATS Consortium in press). This has important implications for planning in the post-disaster period. Short-term, disaster-focused interventions are not enough—rather, sustained, trauma-focused approaches within a public health framework are needed. However, current funding mechanisms for post-disaster mental health do not match this need.

Third, following disaster, schools offer a possible venue for identifying children in need of intervention. While few schools have screened students for PTSD symptoms following community disasters (Cohen et al. 2006), a very rapid school-based screening occurred in 19 middle and high schools within 6 weeks after the Oklahoma City bombing. In contrast, a representative sample was not screened until 6 months after the September 11th terrorist attacks and universal screening did not occur in New York City schools after this disaster despite significant resource allocation for mental health services (Pfefferbaum et al. 2006). An examination of schools' responses to the mental health needs of children displaced by Hurricanes Katrina and Rita demonstrated that few schools or school districts implemented routine screening, but rather relied on their usual referral process for mental health care, in addition to conducting outreach and educational activities for displaced students (Jaycox et al. 2007). School districts that did screen detected a high level of need, but among those that did not, some did not perceive any need in their students. In the study described here, we used two different ways to identify children—using referrals from schools in PFDL, and using a universal screening questionnaire in the research study. Both means of identification proved feasible, but turned up children with varying needs, including issues around educational delay, severe mental illness and comorbidities, as well as disaster-related stress reactions. Thus, a system that screens children must be ready to handle a wide array of problems.

## Summary

PFDL could be a prototype for providing stepped-care mental health screening and treatment for large numbers of significantly affected children after a community-wide disaster, although empirical data are still needed to back up its components. This stepped care approach makes inherent sense in post-disaster communities that are significantly lacking in the ability to provide adequate intermediate and

long-term mental health care because it creates timely access to appropriate levels of mental health care, with a relatively small amount of professional resources. It is a comprehensive approach to identifying, triaging, and providing needed care to children, regardless of the reasons for their mental health needs, and attentive to finding the appropriate level of care for each. Our study demonstrated clear need for service among students exposed to this disaster, and attention to the varying mental health needs, moving beyond the singular focus on disaster-related symptoms, will be important in future disasters. Our research project will shed some light on how interventions can work post disaster, but we already know a good deal about how to help children who face trauma, and must find new ways to roll out such programs in the weeks, months, and years to affected communities. This includes finding ways to fund such efforts so that sustained and effective programs can be implemented.

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# A School-Based Mental Health Service Model for Youth Exposed to Disasters:
## *Project Fleur-de-lis*

By Douglas W. Walker, Ph.D.

Hurricane Katrina, which ravaged the Gulf Coast on August 29, 2005, was amongst the most devastating natural disasters in our country's history. The traumatic experiences of youth and families who endured the storm, the flooding that resulted from the break of the levees, the evacuation, and the aftermath of Katrina were unprecedented. The aftermath of the storm also exposed long-standing problems that continue to afflict many of our nation's cities and states, especially their poorest communities: lack of jobs, proper housing, and quality education. In the days following Hurricane Katrina, it became clear that jobs, homes, and schools were three inter-related factors that would dictate the immediate recovery of New Orleans. These three factors make up the "trinity" that has driven the recovery of New Orleans over the past two and a half years.

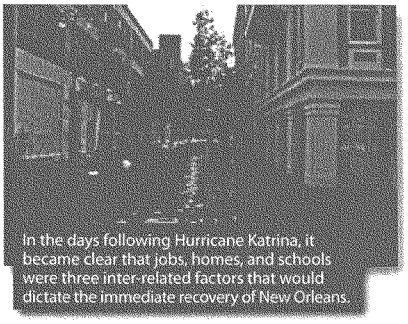
For those of us providing the long-term child and adolescent-oriented mental health care post-Katrina, it has been the New Orleans area schools which have provided the best opportunity to introduce not only examples of "best-practice," but new and innovative ways to link youth and families with mental health services. Project Fleur-de-lis was designed only days after Hurricane Katrina to address the intermediate and long-term mental health issues of students as they re-entered school and endured a post-Katrina landscape that evoked for many mixed feelings of grief, hope, and fear. The goal of this article is to describe the creation, design, impact, and "lessons learned" of an innovative school-based mental health system that has served the mental health needs of New Orleans-area youth since March of 2006.

### PROJECT FLEUR-DE-LIS

Project Fleur-de-lis is a collaborative program linking local social service agencies, schools, and nationally recognized researchers, program developers, and clinicians in a coordinated effort to provide state-of-the-art mental health services within 55 New Orleans-area schools. The goals of Project Fleur-de-lis are to 1) implement school intervention services to students exposed to trauma; 2) establish a mechanism for identification of and services to students with all mental health and psycho-educational needs beyond what can be addressed or identified in the school setting; 3) partner with national leaders to provide increased access to mental health care and effective trauma treatments for students in schools and the community; and 4) provide evidence that treatments for traumatized youth can be effectively delivered in a three-tiered stepped approach model of care utilizing school-based interventions, classroom-based interventions, and specialized community-based interventions in communities significantly impacted by natural or man-made disasters.

#### *Project History*

For every school reopening along the Gulf Coast following Hurricane Katrina, significant logistical and clinical factors impacted the type and structure of school-based mental health interventions. These factors included the time at which an intervention could be introduced into a recovering school, the vast number of youth that needed to be served, and the varying severity of post-trauma symptoms of youth identified as being in need of more intensive care outside the school setting. Project Fleur-de-lis was designed around the invaluable knowledge possessed by school teachers, counselors, and administrators of schools rebuilding after the hurricane. This knowledge, combined with evidence-based practices, innovative pathways of care, and integrated electronic records has created an intermediate and long-term school-based mental health response to Hurricane Katrina that has addressed not only trauma-related issues in youth, but the myriad of other psychological and educational problems that occur in the general population (e.g., anxiety, depression, learning disorders).



In the days following Hurricane Katrina, it became clear that jobs, homes, and schools were three inter-related factors that would dictate the immediate recovery of New Orleans.

For every school reopening along the Gulf Coast in the weeks and months after Hurricanes Katrina and Rita, a hierarchy of needs had to be satisfied before mental health services could be introduced to the students, faculty, and administration. Focus groups with principals and counselors from 42 area schools in the spring of 2006 revealed that many could not even consider allowing comprehensive mental health programming in their schools because they were still overwhelmed with overcrowded classrooms, lack of teachers, damaged physical plants, and meeting the needs of individualized education plans of new students whose educational records had been destroyed by the storms. Project Fleur-de-lis began its first school-based interventions in March of 2006 within a Catholic school in Orleans Parish and by the start of the 2006–2007 academic year, other schools had arrived at a time in their post-storm recovery that allowed the introduction of this school-based mental health program. By January 1, 2007, the Project was active in 45 schools and had referred via a school counselor driven triage process, 103 students for free psycho-educational testing, therapy, or psychiatric services in the community. Project Fleur-de-lis has grown to include 56 participating schools and the 24,000 students who are eligible for free services by way of their enrollment in these schools. Participating schools are made up of Catholic, public, public charter, and private schools that are located across seven civil Parishes in the Greater New Orleans area.

## PATHWAYS OF CARE

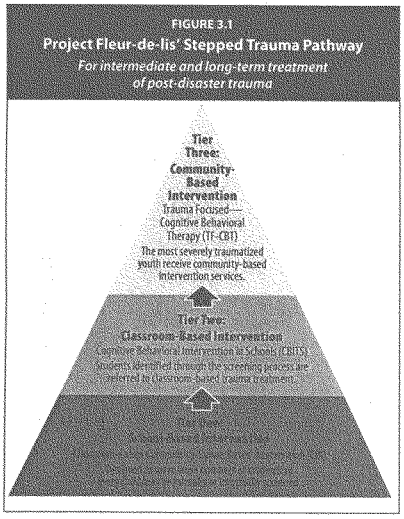
The Project Fleur-de-lis stepped model of care relies on two intervention pathways. The first pathway is comprised of the three core trauma-informed practices termed the Stepped Trauma Pathway. The second pathway is the classroom to community referral system, which is called Classroom-Community Consultation ($C^3$). Both pathways utilize a stepped approach to intervention where students receive a higher level of care if necessary, but the goal is to be able to address signs and symptoms early so a higher level of care/intervention is not necessary. Each pathway is described in more detail below.

## INNOVATIVE DESIGN: STEPPED TRAUMA PATHWAY

The goal of the Stepped Trauma Pathway (Figure 3.1) is to provide appropriate mental health interventions to all students that are suitable for each individual's level of need based on their trauma history and/or presenting symptoms. The Stepped Trauma Pathway is a combination of trauma informed treatments that are designed to provide care to varying numbers of children (classroom, group, individual) for varying degrees of need (mild, moderate, severe). Project Fleur-de-lis has worked collaboratively with the authors of these interventions to promote training and implementation of these programs in southeast Louisiana and the gulf-coast region.

***Tier One: Classroom-Camp-Community-Culture Based Intervention***

The problem of serving large numbers of youth in the schools was answered with the help of Save the Children which instituted a psycho-social program in the United States Gulf Coast to provide support to young people affected by Hurricane Katrina and its aftermath. Having been extensively field tested, Classroom-Camp-Community-Culture Based Intervention (CBI) (Macy, Macy, Gross, & Brighton, 2006) was attractive as a psycho-social intervention post-Katrina because of its use all over the world in addressing various types of traumatic exposures including ongoing armed conflict, refugee camps, and mass casualties as a result of natural disasters (tsunami, earthquakes, floods). This model of intervention is based on the premise that immediate, short-term interventions for trauma-exposed youth are beneficial in reducing the harmful effects of traumatizing experiences.




Within Project Fleur-de-lis, CBI was used to blanket an entire school so that every student had the opportunity to benefit from the stabilization program, and be formally (using standardized instruments) or informally screened throughout the CBI programming. Making up the first-tier of intervention within the Stepped Trauma Pathway, CBI provided the best opportunity to supply the most appropriate mental health intervention, at the most appropriate time post-disaster, to the most youth. As the sole sponsor of CBI in the Gulf Coast region, Save the Children trained 1,113 implementers and intervened with approximately 11,500 youth in the Gulf Coast, many of whom were enrolled in schools affiliated with Project Fleur-de-lis (Save the Children, 2007).

***Tier Two: Cognitive Behavioral Intervention in Schools***

The Stepped Trauma Pathway model was designed to then move students identified throughout CBI into more intensive intervention. This more intensive and "intimate" trauma focused intervention was provided by Cognitive Behavioral Intervention in Schools (CBITS) (Jaycox, 2004). Cognitive Behavioral Intervention in Schools is the most thoroughly tested trauma-focused school intervention program at present, having undergone two controlled trials (Kataoka et al., 2003; Stein et al., 2003). It includes group and individual sessions designed specifically for use in schools.

The application of Cognitive Behavioral Intervention in Schools to post-hurricane trauma was a natural choice given its proven efficacy with diverse populations and the relative ease of its dissemination and implementation. Also considered was its usefulness in addressing exposure to community violence, which for many youth in the New Orleans area was a daily occurrence prior to, and after, the storm. Because of the timing of the training for Cognitive Behavioral Intervention in Schools in the New Orleans area, formal referrals from tier one (CBI) to tier two (CBITS) were not possible, but future implementation of the Stepped Trauma Pathway post-evacuation in New Orleans will include this type of triage.

***Tier Three: Trauma Focused—Cognitive Behavioral Therapy***

Finally, the issue of serving the most severe traumas in youth was answered with the help of Trauma Focused–Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2006). Trauma Focused–Cognitive Behavioral Therapy, a SAMHSA model program, is a psychotherapeutic intervention designed to assist children, adolescents, and their caregivers overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school or community violence; or exposure to disasters or war. Trauma Focused–Cognitive Behavioral Therapy is designed as a 10-session treatment program that mixes individual student sessions with parent-only and parent-student sessions.

Trauma Focused–Cognitive Behavioral Therapy is a components-based intervention model that incorporates trauma sensitive treatments with cognitive behavioral, family, and humanistic principals and methods for children ages 3–18. During the 2006–2007 school year, several youth in Project Fleur-de-lis were identified as having direct exposure to the storm and/or the traumatic experience of being evacuated to the Super Dome or the Morial Convention Center. Beyond helping with traumas of youth who were directly exposed to the storm, over forty students have been referred for Trauma Focused–Cognitive Behavioral Therapy for other types of traumas (domestic violence, sexual abuse, accidents) making this intervention invaluable for our community-based clinicians. There also existed the opportunity to provide Trauma

Focused–Cognitive Behavioral Therapy to children who continued to have persisting trauma symptoms even after having received CBITS within their schools.

### CLASSROOM-COMMUNITY CONSULTATION ($C^3$)

The goal of the $C^3$ pathway of care is to provide an efficient and barrier-free triage system for students in need of intensive interventions and services that cannot be provided within their school setting. This collaborative process also allows for the provision of guidance to school counselors in their day-to-day interventions with students so as to catch school related problems early and often, and as a result avoid referrals for more intensive community-based interventions. $C^3$ also functions as a clearinghouse of information and resources for those schools and communities who have been stripped of their social service assets. This collaborative referral process has also benefited the school-based counselors by increasing their knowledge of trauma-related issues in youth, and strengthening relationships among participating members.

The strength of $C^3$ lies in its utilization of school mental health resources that were in place prior to Hurricane Katrina. Each week throughout the school year, counselors submit names of students they believe are in need of community-based services such as psychiatry, psychotherapy, and psycho-educational testing. The school-based counselor is required to gather information from parent, teacher, and child prior to presenting their case (which includes subjective data, and data derived from standardized screening instruments). This meeting is often made up of over 30 members who include the school-based counselors, Mercy Family Center psychologists, social workers and psychiatrists, and other invited community-based mental health professionals. In a collaborative process, members in attendance offer questions and feedback with the goal of determining if a student is in need of more intensive services. An electronic records system is used to collect and organize $C^3$ referrals and daily counselor encounters with students. If a student is determined to be in need of services, a referral form is created from the electronic records system that assists parents in understanding their child's current symptoms and how they will be linked with free psychological or psychiatric care.

### IMPACT

To date, Project Fleur-de-lis has provided intervention recommendations for 821 students who have been triaged during weekly $C^3$ meetings. These $C^3$ meetings have provided professional and emotional support to over 60 school-based counselors in the past two and a half years. This project's Stepped Trauma Pathway has provided over 5,000 students with trauma informed interventions appropriate to their level of need since its introduction into New Orleans area schools in the spring of 2006. Mercy Family Center, Project Fleur-de-lis' parent organization, has provided over $400,000 in free outpatient psychological or psychiatric care for those students who were referred through the $C^3$ pathway of care.

### LESSONS LEARNED

The first lesson learned was the unexpected demand for psycho-educational testing for students identified within Project Fleur-de-lis during the 2006–2007 school year. Of the 268 children staffed at the $C^3$ meetings, 116 (43%) were recommended for psycho-educational testing to rule out the existence of Attention Deficit Hyperactivity Disorder, learning disorders, or psychological issues (such as trauma) that were interfering with the student's ability to perform in school. The reason for the amount of these types of referrals might someday be explained by way of a complex algorithm, but some initial theories are as follows: First, Project Fleur-de-lis and Mercy Family Center were seeing the "typical" number of new incidences expected with the prevalence of Attention Deficit Hyperactivity Disorder (estimated at 3% to 7%) and learning disorders (2% to 10%), according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM;* American Psychiatric Association, 2000). Second, the students being recommended for psycho-educational testing had pre-existing conditions prior to the storm, but were not identified or recognized by their school as having significant deficits in learning and/or attention (15% of students referred for assessments had previously failed a grade but had not been tested to determine the cause of the learning problems). The third theory, which opens a potentially volatile discussion, is that many of the students referred for psycho-educational testing were being underserved by their former school and that they were significantly delayed academically when they entered into their new posttreatment school and curriculum.

The second lesson came by way of the unexpected use of our weekly $C^3$ meetings as a social support network where all participants could express their fear, doubt, and hope regarding the future of their schools and communities. It was overlooked by those of us employed within outpatient mental health treatment centers that the school counselors were often isolated in their schools, not having other mental health professionals in the next office to trade peer consultations or rely on for emotional support. By way of its own group process our weekly $C^3$ meetings have become "care for the caregiver" reconstituting each professional's fortitude and making it possible for them to go back to "the trenches" where they continue to exert their best effort in the face of overwhelming need in our community.

### CONCLUSION

Project Fleur-de-lis grew out of the destruction and despair in the months following Hurricane Katrina to become the largest school-based mental health program in the New Orleans area (Bendsen et al., 2007). In the years to come, we hope to continue expanding Project Fleur-de-lis in order to assist youth and families in the Greater New Orleans area in their long-term recovery from Hurricane Katrina. Additionally, lessons learned from the Project could someday assist New Orleans and other cities that experience similar disasters by informing public policy in disaster preparedness and immediate/long-term mental health responses for youth.

Douglas Walker

Douglas W. Walker, Ph.D., is the Clinical Director of Mercy Family Center and the architect and Clinical Director of Project Fleur-de-lis™. Dr. Walker received his Ph.D. from the University of North Texas. Since Hurricane Katrina he has acted as a liaison to local, regional, and national organizations focused upon the implementation of evidence-based practices in the Greater New Orleans area. Dr. Walker continues to provide direct service care at Mercy Family Center to youth and families in his hometown of Mandeville, Louisiana.



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National Association of School Psychologists

# What Is a School Psychologist?

BY THE NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

School psychologists help children and youth succeed academically, socially, behaviorally, and emotionally. They collaborate with educators, parents, and other professionals to create safe, healthy, and supportive learning environments that strengthen connections between home, school, and the community for all students.

School psychologists are highly trained in both psychology and education, completing a minimum of a specialist-level degree program (at least 60 graduate semester hours) that includes a year-long supervised internship. This training emphasizes preparation in mental health and educational interventions, child development, learning, behavior, motivation, curriculum and instruction, assessment, consultation, collaboration, school law, and systems. School psychologists must be certified and/or licensed by the state in which they work. They also may be nationally certified by the National School Psychology Certification Board (NSPCB). The National Association of School Psychologists sets ethical and training standards for practice and service delivery.

## WHAT DO SCHOOL PSYCHOLOGISTS DO?

School psychologists work to find the best solution for each child and situation. They use many different strategies to address individual student needs, and to improve classroom and school climates and support systems.

***School psychologists work with students to:***

- Provide counseling, instruction, and mentoring for those struggling with social, emotional, and behavioral problems
- Increase achievement by assessing barriers to learning and determining the best instructional strategies to improve learning
- Promote wellness and resilience by reinforcing communication and social skills, problem solving, anger management, self-regulation, self-determination, and optimism
- Enhance understanding and acceptance of diverse cultures and backgrounds

***School psychologists work with students and their families to:***

- Identify and address learning and behavior problems that interfere with school success
- Evaluate eligibility for special education services (within a multidisciplinary team)
- Support students' social, emotional, and behavioral health
- Teach parenting skills and enhance home–school collaboration
- Make referrals and help coordinate community support services

***School psychologists work with teachers to:***

- Identify and resolve academic barriers to learning
- Design and implement student progress monitoring systems
- Design and implement academic and behavioral interventions
- Support effective individualized instruction
- Create positive classroom environments
- Motivate all students to engage in learning

***School psychologists work with administrators to:***

- Collect and analyze data related to school improvement, student outcomes, and accountability requirements
- Implement school-wide prevention programs that help maintain positive school climates conducive to learning
- Promote school policies and practices that ensure the safety of all students by reducing school violence, bullying, and harassment
- Respond to crises by providing leadership, direct services, and coordination with needed community services
- Design, implement, and garner support for comprehensive school mental health programming

***School psychologists work with community providers to:***

- Coordinate the delivery of services to students and their families in and outside of school
- Help students transition to and from school and community learning environments, such as residential treatment or juvenile justice programs

***Where Do School Psychologists Work?***

The majority of school psychologists work in schools. However, they can practice in a variety of settings, including:

- Public and private schools
- Universities
- School-based health and mental health centers
- Community-based day-treatment or residential clinics and hospitals
- Juvenile justice centers
- Private practice

***How Do School Psychologists Make a Difference in Schools?***

All children and adolescents face problems from time to time. They may:

- Feel afraid to go to school
- Have difficulty organizing their time efficiently
- Lack effective study skills
- Fall behind in their school work

- Lack self-discipline
- Worry about family matters such as divorce and death
- Feel depressed or anxious
- Experiment with drugs and alcohol
- Think about suicide
- Worry about their sexuality
- Face difficult situations, such as applying to college, getting a job, or quitting school
- Question their aptitudes and abilities

School psychologists help children, parents, teachers, and members of the community understand and resolve these concerns. Following are examples of how school psychologists make a difference:

## HELPING STUDENTS WITH LEARNING PROBLEMS

Tommy's parents were concerned about his difficulty reading and writing. They feared that he would fall behind and lose confidence in himself. In school, the teacher noticed that Tommy often struggled to understand what he was reading and often needed the help of his classmates to do related written work. After observing Tommy, consulting with his teacher, and gathering specific information about his skills, the school psychologist collaborated with his parents and teachers to develop a plan to improve his reading and writing. The plan worked, and Tommy's reading, writing, and confidence as a learner improved.

## HELPING STUDENTS COPE WITH FAMILY AND LIFE STRESSORS

The teacher noticed that Carla, an able student, had stopped participating in class discussions and had difficulty paying attention. The school psychologist was asked to explore why Carla's behavior had changed so much. After discovering that Carla's parents were divorcing, the school psychologist provided counseling for Carla and gave her parents suggestions for this difficult time. Carla's behavior and emotional well-being improved, and she felt more secure about her relationship with her parents.

## HELPING STUDENTS WITH BEHAVIOR PROBLEMS LEARN NEW WAYS TO RESPOND

David was a high school student who often skipped class and got into fights with others. He acted out in class and had been suspended from school on various occasions. After establishing a relationship with David, the school psychologist taught him simple techniques to relax, recognize his needs, and to control his aggressive behavior. David's mother and his teacher worked together on a plan designed by the school psychologist to establish limits, recognize David's escalating tension, and improve communication. David's relationships with peers and adults improved and he began to make steady progress toward graduation.

## IMPROVING CLIMATES FOR LEARNING

Mr. Smith, the middle school principal, was concerned about the increasing number of discipline referrals and students with attendance problems in his school. After reviewing the school's data with the school psychologist, it was determined that the school had a bullying problem that contributed

both to conflicts occurring during unstructured times and students' staying home from school to avoid being picked on. The school psychologist worked with Mr. Smith, the staff, and parents to establish a school-wide positive behavior supports program that set clear behavioral expectations and rewards for good behavior and taught students how to respond to conflicts and bullying. The school successfully improved student attendance and decreased the number of office discipline referrals.

**To learn more about school psychologists and school psychology,** contact the National Association of School Psychologists: http://www.nasponline.org; 4340 East West Highway, Suite 402, Bethesda, MD 20814; (301) 657-0270

*The National Association of School Psychologists represents and supports school psychology through leadership to enhance the mental health and educational competence of all children.*

*Reprinted from* Helping Children at Home and School III. *(NASP, in press).* 


NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

# Identifying Seriously Traumatized Children: Tips for Parents and Educators

Events such as the Oklahoma City bombing, terrorist attacks in New York and Washington, DC, and even natural disasters such as tornadoes and floods place everyone at risk for some degree of trauma reaction. It is normal and expected that most children will experience some symptoms of acute distress—shock, crying, anger, confusion, fear, sadness, grief and pessimism. Depending on circumstances, particularly the additional trauma of loss of family members, most children will experience a gradual lessening of these symptoms over the days and weeks following the event and will be able to resume normal routines and activities with little change in performance. However, a large-scale crisis event places a significant number of children are at risk for severe stress reactions.

It is important to recognize that severe psychological distress is not simply a consequence of experiencing a threatening and/or frightening event; it is also a consequence of how a child experiences the event, coupled with his or her own unique vulnerabilities. If a child you are teaching or caring for has had experiences and risk factors such as those described below, you may need to consider a referral to a mental health professional such as a school psychologist or a private practitioner.

## The Child's Experience With Trauma

How traumatic is the event for a given child? The degree of psychological distress is associated with several factors:

1. ***Exposure.*** The closer a child is to the location of a threatening and/or frightening event, and the longer the exposure, the greater the likelihood of severe distress. Thus children living near, or whose parents work at or near, the site terrorist attacks, a school shooting, or a severe tornado are at greater risk than children living far away. However, for many children, the length of exposure is also extended by repeated images on television, regardless of their location.

2. ***Relationships.*** Having relationships with the victims of a disaster (i.e., those who were killed, injured, and/or threatened) is strongly associated with psychological distress. The stronger the child's relationships with the victims, the greater the likelihood of severe distress. Children who lost a caregiver are most at risk.

3. ***Initial reactions.*** How children first respond to trauma will greatly influence how effectively they deal with stress in the aftermath. Those who display more severe reactions (e.g., become hysterical or panic) are at greater risk for the type of distress that will require mental health assistance.

4. ***Perceived threat.*** The child's subjective understanding of the traumatic event can be more important than the event itself. Simply stated, severely distressed children will report perceiving

the event as extremely threatening and/or frightening. Among the factors influencing children's threat perceptions are the reactions of significant adult caregivers. Events that initially are not perceived as threatening and/or frightening may become so after observing the panic reactions of parents or teachers. In addition, it is important to keep in mind that children may not view a traumatic event as threatening because they are too developmentally immature to understand the potential danger. Conversely, unusually bright children may be more vulnerable to stress because they understand the magnitude of a disaster.

### Personal Factors Related to Severe Distress

Personal experiences and characteristics can place children at risk for severe stress reactions following traumatic events. These include the following

1. ***Family factors***. Children who are not living with a nuclear family member, have been exposed to family violence, have a family history of mental illness, and/or have caregivers who are severely distressed by the disaster are more likely themselves to be severely distressed.

2. ***Social factors***. Children who must face a disaster without supportive and nurturing friends or relatives suffer more than those who have at lease one source of such support.

3. ***Mental health***. The child who had mental health problems (such as depression or anxiety disorders) before experiencing a disaster will be more likely to be severely distressed by a traumatic event.

4. ***Developmental level***. Although young children, in some respects, may be protected from the emotional impact of traumatic events (because they don't recognize the threat), *once they perceive a situation as threatening,* younger children are more likely to experience severe stress reactions than are older children.

5. ***Previous disaster experience***. Children who have experienced previous threatening and/or frightening events are more likely to experience severe reactions to a subsequent disaster event severe psychological distress.

### Symptoms of Severe Stress Disorders

The most severely distressed children are at risk for developing conditions known as Acute Stress Disorder (ASD) or Posttraumatic Stress Disorder (PTSD). Only a trained mental health professional can diagnose ASD and/or PTSD, but there are symptoms that parents, teachers, and caregivers can look out for in high-risk children. Symptoms for ASD and PTSD are similar and include:

1. ***Re-experiencing of the trauma during play or dreams.*** For example, children may: repeatedly act out what happened when playing with toys; have many distressing dreams about the trauma; be distressed when exposed to events that resemble the trauma event or at the anniversary of the event; act or feel as if the event is happening again.

2. ***Avoidance of reminders of the trauma and general numbness to all emotional topics.*** For example, children may avoid all activities that remind them of the trauma; withdraw from other people; have difficulty feeling positive emotions.

3. ***Increased "arousal" symptoms.*** For example, children may have difficulty falling or staying asleep; be irritable or quick to anger; have difficulty concentrating; startle more easily.

ASD is distinguished from PTSD primarily in terms of *duration.* Symptoms of ASD occur within four weeks of the traumatic event, but then go away. If a youngster is diagnosed with ASD and the symptoms continue beyond a month, your child's mental health professional may consider changing the diagnosis to PTSD.

### Know the Signs and Get Help if Necessary

Parents and other significant adults can help reduce potentially severe psychological effects of a traumatic event by being observant of children who might be at greater risk and getting them help immediately. Knowledge of the factors that can contribute to severe psychological distress (e.g., closeness to the disaster site, familiarity with disaster victims, initial reactions, threat perceptions and personal vulnerabilities) can help adults distinguish those children who are likely to manage their distress more or less independently from those who are likely to have difficulties that may require mental health assistance.

The mental health service providers who are part of the school system—school psychologists, social workers and counselors—can help teachers, administrators and parents identify children in need of extra help and can also help identify appropriate referral resources in the community. Distinguishing "normal" from extreme reactions to trauma requires training and any concern about a child should be referred to a mental health professional.

For further information about the signs and symptoms of AST and PTSD in children and adolescents, please refer to the National Center for PTSD at the following website: *http://www.ncptsd.org/facts/specific/fs_children.html* or the National Association of School Psychologists *www.nasponline.org*

*Adapted from "Identifying Psychological Trauma Victims," by Stephen E. Brock. In* Best Practices in School Crisis Prevention and Intervention, *edited by S. E. Brock, P. J. Lazarus, and S. J. Jimerson (2001), National Association of School Psychologists. Modified from the article posted on the NASP website in September 2001.*


NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

# School Crisis and Disaster Preparedness and Response NASP Leadership: 1996–2009

Little more than a decade ago, crisis prevention and intervention were peripheral concerns for most American schools. Today, we know the issue must be a primary responsibility of every school district in the country. Our children and youth experience crises large and small that can significantly undermine their well-being and ability to learn. Crises can range from a major disaster or school shooting to traumatic family problems or the death of loved one or fellow student. Meeting the unique needs of children affected by a crisis is essential to minimizing immediate and long-term traumatic effects and to increasing the odds that they will continue to learn and grow despite the crisis. Schools are uniquely positioned to support this process, but they need resources and training to do so.

## Extensive Experience

The National Association of School Psychologists (NASP) has been a leader in school crisis response for more than a decade, first responding to requests to assist schools in the wake of the Oklahoma City bombing in 1996. Since then, NASP has provided direct support, training, and/or free public resources in response to:

- High profile school shootings from Pearl High School (MS) in 1997 to Virginia Tech (VA) in 2007
- Natural disasters including the California wildfires, tornados, midwest floods, Hurricanes Katrina and Rita, and international earthquakes and tsunamis
- Terrorism in the United States after September 11, 2001, and in Spain and England following bombings there
- Situational crises such as the loss of the Columbia Space Shuttle, the DC sniper, and military deployments to the wars in Afghanistan and Iraq
- Pandemic illnesses including SARS and H1N1 (Swine) Flu
- Suicide clusters across the United States
- Current economic crisis
- Major crisis event anniversaries

## School-Based Expertise

NASP's expertise integrates community-based crisis response approaches (e.g., that offered by the National Organization of Victims Assistance [NOVA]) with the specific skill set of school psychologists who are trained to address children's mental health and promote successful learning and development within the school context. We have learned that schools play a critical role in crisis prevention and response, meeting not just the needs of students but also those of staff, families, and often the local community. Schools are, in fact, integral to an overall community crisis response in terms of:

- Providing a safe haven
- Disseminating information
- Identifying individuals at risk
- Providing mental health services
- Linking individuals with community services
- Tracking displaced families
- Supporting long-term recovery
- Generally serving as a focus of normalcy and providing structure in the face of trauma

## Commitment to Enhanced School Crisis Capacity

NASP is committed to helping schools meet this challenge. In addition to providing direct support and resources, NASP is focused on advancing research and best practice, advocating for public policy that provides schools the

mandate and resources to build effective crisis response capabilities, partnering with government leaders and allied education organizations, and providing training to school personnel to build crisis management capacity at the local level. NASP emphasizes a comprehensive model that:

- Encompasses prevention, preparedness, intervention, and recovery
- Integrates physical and psychological safety
- Is targeted to children and youth
- Is appropriate to the learning environment
- Is culturally and linguistically
- responsive

## NASP School Crisis Services and Initiatives

**National Emergency Assistance Team—*Providing Direct Response***
**(http://www.nasponline.org/resources/crisis_safety/NEAT)**
Established in 1996, the National Emergency Assistance Team (NEAT) is comprised of nationally certified school psychologists who have had formal training in and direct crisis experience involving man-made and natural disasters. As mentioned above, NEAT members have responded to a wide array of crises in the past two decades. NEAT's role varies according to the needs of each situation and team members provide services ranging from consultation over the phone to providing direct interventions and support as part of local crisis team management when invited. NEAT's mission is to:

- Provide direct aid and assistance to schools and communities in emergency crisis situations (only when invited)
- Promote crisis management preparation and planning
- Expand the network of professionals able to lend support to their schools and communities during a major crisis event
- Advocate for safe, healthy schools through legislative and policy initiatives

**PREPaRE School Crisis Prevention and Intervention Training Curriculum—*Building Local Capacity***
**(http://www.nasponline.org/prepare)**
NASP's PREPaRE *School Crisis Prevention and Intervention Training Curriculum* (PREPaRE) is the first comprehensive crisis prevention and intervention curriculum developed for schools by school-based professionals who have had direct experience in preparing for and responding to school crises. PREPaRE grew out of the extensive experience of NASP leaders who realized the serious need for cohesive, comprehensive crisis training for school personnel. Building local crisis management capacity has been a primary goal of PREPaRE since its inception in 2006. PREPaRE is grounded in research that:

- Integrates the U.S. Department of Education's four crisis phases: prevention/mitigation, preparedness, response, and recovery
- Makes use of the National Incident Management System (NIMS) and its Incident Command Structure
- Develops and coordinates the skills of existing school personnel
- Delineates important aspects of crisis team and crisis plan development and community collaboration
- Emphasizes the mental health implications for children and youth when a crisis event occurs
- Provides extensive training in school-based mental health crisis intervention
- Addresses how to minimize traumatic impact through good prevention, intervention, response, and recovery efforts within the school context

**Online Crisis Resources—*Supporting Schools, Families, and Communities***
**(http://www.nasponline.org/resources/crisis_safety)**
NASP develops and makes available to the public a variety of resources to help parents and educators prepare for and support children and youth in the wake of a crisis event. Resources are disseminated directly through allied education organizations, the media, government websites, and the NASP website. In the immediate aftermath of September 11, 2001, the NASP website handled more than four million hits accessing specially developed crisis response materials. Since then, the NASP website has been seen as a critical resource for families and professionals responding to crises. Schools have permission to adapt most of the handouts to the needs of their school communities. Many handouts are translated and/or offered in audio versions.

Examples of topics include:

- Helping children cope
- Children's trauma reactions
- Death and grief
- Anxiety and depression
- Violence prevention
- Military deployment
- Talking to children about violence
- Promoting resilience
- Children with special needs
- Cultural competence
- Displaced families
- Memorials
- Talking with the media
- Suicide prevention/intervention
- Threat assessment
- Promoting tolerance

**Foundation Support—*Public Service for Schools in Need***
**(http://www.nasponline.org/about_nasp)**

NASP is committed to providing direct support when possible to schools and children in acute need after a crisis. This takes the form of pro bono or reduced-fee work by NASP leaders and staff and grant support from NASP's two foundations, the NASP Children's Fund and the NASP Education and Research Trust (ERT). Specific examples include:

- Providing PREPaRE training and resources throughout Mississippi and Louisiana for school personnel serving schools affected by Hurricanes Katrina and Rita
- Working with the NASP Children's Fund and KaBOOM! to fund ($75,000) and build a playground for the Live Oak Elementary School in the NOLA Recovery School District during the NASP 2008 Annual Convention
- Raising more than $8,000 from NASP members through the NASP Children's Fund to provide grants to schools affected by Katrina
- Supporting school psychologists impacted by disaster (waiving membership fees, replacing professional resources at cost, reducing professional development fees, facilitating job placement)
- Providing school supplies and comfort items (e.g., stuffed animals) to children affected by trauma (NASP Children's Fund)
- Establishing grant funds (limited) within the ERT to send NEAT members to help schools who request support after a major crisis but who don't have funding, and to underwrite PREPaRE training for underfunded, high-needs schools

**Professional Development and Publications—*Promoting Best Practices***
**(http://www.nasponline.org/publications/booksproducts)**

Expanding the knowledge base on school crisis response is a priority. In addition to *PREPaRE* training workshops, NASP offers many professional development opportunities at the NASP annual conventions and summer conferences. For example, the NASP 2008 Annual Convention in New Orleans offered more than 35 sessions on crisis related issues, including keynote speaker Dr. David Schonfeld, Director of the National Center for School Crisis and Bereavement, Cincinnati Children's Hospital Medical Center.

NASP also publishes and copublishes a variety of resources on school crisis response that are used in graduate training and professional practice. Examples include:

- *Best Practices in School Crisis Prevention and Intervention* (800-page comprehensive reference for school crisis team members and a graduate school textbook)
- *School Crisis Prevention and Intervention: The PREPaRE Model* (325-page detailed overview of the PREPaRE model and its foundational research)
- *School Psychology Review, School Psychology Forum*, and *Communiqué* (peer-reviewed journal and newspaper articles contributing to the literature on the latest research and best practice)
- *Helping Children at Home and School II: Handouts for Families and Educators* (includes a section dedicated to Crisis & School Safety)
- *Early Warning, Timely Response: A Guide to Safe Schools* (released in partnership with the U.S. Department of Education, U.S. Department of Justice, National Institutes of Mental Health, and leading education and mental health organizations)

- *Safeguarding Our Youth: An Action Guide to Implementing Early Warning, Timely Response* (released in partnership with the U.S. Department of Education, U.S. Department of Justice, and leading education and mental health organizations)

**Professional Collaboration and Advocacy—*Enhancing Our National Crisis Response Capacity***
Effective school crisis management is always a team effort. NASP collaborates with local, state, and national education organizations and government entities to raise awareness and improve the nation's school crisis response capacity. Examples include:

- Providing resources to organizations for dissemination to their memberships in the event of a crisis
- Reviewing and/or contributing to federal government public domain documents
- Partnering with local school districts (e.g., Fairfax County Public Schools, VA) to have crisis resources for parents translated into multiple languages
- Conducting training for and consulting with allied groups such as the National Association of Elementary School Principals, National Association of Secondary School Principals, American School Counseling Association, the School Social Workers of America, National School Boards Association, and the National Association of School Nurses
- Working with the American School Counseling Association (ASCA) and the American Red Cross to allow eligibility of state-licensed or state-certified school psychologists and school counselors as Disaster Mental Health (DMH) professionals in the aftermath of natural and man-made disasters
- Collaborating with National Association of School Nurses and the National PTA to develop a fact sheet for parents and teachers on H1N1 Swine Flu (translated into Spanish and included with the resources on flu.gov)
- Coordinating with the Office of Safe and Drug Free Schools to send NEAT members to respond to major crisis events
- Advocating for legislation and public policies that support school and community capacities to meet the unique needs of children and youth in the aftermath of crises and to promote safe schools
- Conducting media outreach and submitting/publishing op-eds related to major school crises

**International Outreach—*Strengthening School Crisis Response Capacity Worldwide***
NASP maintains important relationships with crisis response and school safety experts around the world. NASP both provides expertise and seeks it. Our partnerships focus on sharing knowledge, providing support and resources in the event of a major crisis, and creating an international network of professionals dedicated to improving school crisis prevention and response for children and youth. Examples include:

- Providing translated resources and consultation after the terrorist bombings in Madrid and London
- Consulting with school psychologists in China after the earthquake in Sichuan in 2008
- Provide technical support in the aftermath of the school shootings in Germany in spring 2009
- Sending NEAT members to respond to the earthquakes in Turkey and to Shri Lanka to provide direct support after the Indian Ocean Tsunami
- Collaborating with experts from the International Stress Prevention Centre in Kirvat Shmona, Israel to train European school psychologists, sponsored by the European Union
- Conducting PREPaRE training in Canada, Greece, and England (upcoming). Greece is currently considering adapting PREPaRE for use in their county on a broad basis
- Conducting general school crisis training in the United Kingdom, the Netherlands, France, Germany, Hungary, Slovakia, Greece, Romania, Switzerland, Italy, Malta, Poland, Sweden, Denmark, Norway, Palestine, Lebanon, Finland, and Australia
- Collaborating with international organizations such as the International School Psychology Association (ISPA) and the International Crisis Response Network (ICRN


NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

# Helping Children After a Natural Disaster: Information for Parents and Teachers

*By Philip J. Lazarus, NCSP, Florida International University*
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Natural disasters can be especially traumatic for children and youth. Experiencing a dangerous or violent flood, storm, or earthquake is frightening even for adults, and the devastation to the familiar environment (i.e., home and community) can be long lasting and distressing. Often an entire community is impacted, further undermining a child's sense of security and normalcy. These factors present a variety of unique issues and coping challenges, including issues associated with specific types of natural disasters, the need to relocate when home and/or community have been destroyed, the role of the family in lessening or exacerbating the trauma, emotional reactions, and coping techniques.

Children look to the significant adults in their lives for guidance on how to manage their reactions after the immediate threat is over. Parents, teachers, and other caregivers can help children and youth cope in the aftermath of a natural disaster by remaining calm and reassuring children that they will be all right. Immediate response efforts should emphasize teaching effective coping strategies, fostering supportive relationships, and helping children understand their reactions.

Schools can help play an important role is in this process by providing a stable and familiar environment. Through the support of caring adults school personnel can help children return to normal activities and routines (to the extent possible), and provide an opportunity to transform a frightening event into a learning experience.

## Issues Associated With Specific Disasters

**Hurricanes.** Usually hurricanes are predicted days to weeks in advance, giving communities time to prepare. These predictions give families time to gather supplies and prepare. At the same time, however, these activities may generate fear and anxiety. Although communities can be made aware of potential danger, there is always uncertainty about the exact location of where the hurricane will impact. When a hurricane strikes, victims experience intense thunder, rain, lightning, and wind. Consequently, startle reactions to sounds may be acute in the months that follow. Among a few children subsequent storms may trigger panic reactions. Immediate reactions to hurricanes can include emotional and physical exhaustion. In some instances children may experience survivor guilt (e.g., that they were not harmed, while others were injured or killed).

**Earthquakes.** Aftershocks differentiate earthquakes from other natural disasters. Since there is no clearly defined endpoint, the disruptions caused by continued tremors may increase psychological

distress. Unlike other natural disasters (e.g., hurricanes and certain types of floods), earthquakes occur with virtually no warning. This fact limits the ability of disaster victims to make the psychological adjustments that can facilitate coping. This relative lack of predictability also significantly lessens feelings of control. While one can climb to higher ground during a flood, or install storm shutters before a hurricane, there is usually no advance warning or immediate preparation with earthquakes. Survivors may have to cope with reminders of the destruction (e.g., sounds of explosions, and the rumbling of aftershocks; smells of toxic fumes and smoke; and tastes of soot, rubber, and smoke).

**Tornadoes.** Like earthquakes, tornadoes can bring mass destruction in a matter of minutes, and individuals typically have little time to prepare. Confusion and frustration often follow. Similar to a hurricane, people experience sensations during tornadoes that may generate coping challenges. It can be difficult to cope with the sights and smells of destruction. Given the capricious nature of tornadoes, survivor guilt has been observed to be an especially common coping challenge. For instance, some children may express guilt that they still have a house to live in while their friend next door does not.

**Floods.** These events are one of the most common natural disasters. Flash floods are the most dangerous as they occur without warning; move at intense speeds; and can tear out trees, destroy roads and bridges, and wreck buildings. In cases of dam failure the water can be especially destructive. Sensations that may generate coping challenges include desolation of the landscape, the smell of sludge and sodden property, coldness and wetness, and vast amounts of mud. Most floods do not recede overnight, and many residents have to wait days or weeks before they can begin the cleanup.

### Recovery Can Take Time

Although the natural disasters may only last a short period, survivors can be involved with the disaster aftermath for months or even years. Collaboration between the school crisis response team and an assortment of community, state, and federal organizations and agencies is necessary to respond to the many needs of children, families, and communities following a natural disaster. Families are often required to deal with multiple people and agencies (e.g., insurance adjustors, contractors, electricians, roofers, the Red Cross, the Federal Emergency Management Agency (FEMA), and the Salvation Army). Healing in the aftermath of a natural disaster takes time; however, advanced preparation and immediate response will facilitate subsequent coping and healing.

### Possible Reactions of Children and Youth to Natural Disasters

The severity of children's reactions will depend on their specific risk factors. These include exposure to the actual event, personal injury or loss of a loved one, level of parental support, dislocation from their home or community, the level of physical destruction, and pre-existing risks, such as a previous traumatic experience or mental illness. Adults should contact a professional if children exhibit significant changes in behavior or any of the following symptoms over an extended period of time.

- **Preschoolers**—thumb sucking, bedwetting, clinging to parents, sleep disturbances, loss of appetite, fear of the dark, regression in behavior, and withdrawal from friends and routines.
- **Elementary School Children**—irritability, aggressiveness, clinginess, nightmares, school avoidance, poor concentration, and withdrawal from activities and friends.
- **Adolescents**—sleeping and eating disturbances, agitation, increase in conflicts, physical complaints, delinquent behavior, and poor concentration.

A minority of children may be at risk of post-traumatic stress disorder (PTSD). Symptoms can include those listed above as well as re-experiencing the disaster during play and/or dreams; anticipating or feeling that the disaster is happening again; avoiding reminders of the disaster; general numbness to emotional topics; and increased arousal symptoms such as inability to concentrate and startle reactions. Although rare, some adolescents may also be at increased risk of suicide if they suffer from serious mental health problems like PTSD or depression. Again, adults should seek professional mental health help for children exhibiting these symptoms.

**Immediately Following a Natural Disaster: Information for Parents and Teachers**

**Remain calm and reassuring.** Children take their cues from you, especially young children. Acknowledge the loss or destruction, but emphasize the community's efforts to cleanup and rebuild. To the extent it is possible to do so, assure them that family and friends will take care of them and that life will return to normal.

**Acknowledge and normalize their feelings.** Allow children to discuss their feelings and concerns, and address any questions they may have regarding the event. Listen and empathize. An empathetic listener is very important. Let them know that their reactions are normal and expected.

**Encourage children to talk about disaster-related events.** Children need an opportunity to discuss their experiences in a safe, accepting environment. Provide activities that enable children to discuss their experiences. This may include a range of methods (both verbal and nonverbal) and incorporate varying projects (e.g., drawing, stories, music, drama, audio and video recording). Seek the help of the school psychologist, counselor, or social worker if you need help with ideas or managing the conversation.

**Promote positive coping and problem-solving skills.** Activities should teach children how to apply problem-solving skills to disaster-related stressors. Encourage children to develop realistic and positive methods of coping that increase their ability to manage their anxiety and to identify which strategies fit with each situation.

**Emphasize children's resiliency.** Focus on their competencies. Help children identify what they have done in the past that helped them cope when they were frightened or upset. Bring their attention to other communities that have experienced natural disasters and recovered (e.g., Miami, FL and Charleston, SC).

**Strengthen children's friendship and peer support.** Children with strong emotional support from others are better able to cope with adversity. Children's relationships with peers can provide suggestions for how to cope and can help decrease isolation. In many disaster situations, friendships may be disrupted because of family relocations. In some cases, parents may be less available to provide support to their children because of their own distress and feelings of being overwhelmed.

Activities such as asking children to work cooperatively in small groups can help children strengthen supportive relationships with their peers.

**Take care of your own needs.** Take time for yourself and try to deal with your own reactions to the situation as fully as possible. You will be better able to help your children if you are coping well. If you are anxious or upset, your children are more likely to feel the same way. Talk to other adults such as family, friends, faith leaders, or counselors. It is important not to dwell on your fears or anxiety by yourself. Sharing feelings with others often makes people feel more connected and secure. Take care of your physical health. Make time, however small, to do things you enjoy. **Avoid using drugs or alcohol to feel better.**

**Immediately Following a Natural Disaster: Specific Information for Schools**

**Identify children and youth who are high risk and plan interventions.** Risk factors are outlined in the above section on children's reactions. Interventions may include classroom discussions, individual counseling, small group counseling, or family therapy. From classroom discussions, and by maintaining close contact with teachers and parents, the school crisis response team can help determine which students need counseling services. A mechanism also needs to be in place for self-referral and parent-referral of students.

**Provide time for students to discuss the disaster.** Depending on the situation, teachers may be able to guide this discussion in class, or students can meet with the school psychologist or other mental health professional for a group crisis intervention. Classroom discussions help children to make some sense of the disaster. They also encourage students to develop effective means of coping, discover that their classmates share similar questions, and develop peer support networks. **Teachers should not be expected to conduct such discussions if children are severely impacted or if they themselves are distressed.**

**Allow time for staff to discuss their feelings and share their experiences.** Members of your crisis team should also have the opportunity to receive support from a trained mental health professional. Providing crisis intervention is emotionally draining and caregivers will need an opportunity to process their crisis response. This could include teachers and other school staff if they have been serving as crisis caregivers for students.

**Secure additional mental health support.** Although many caregivers are often willing to provide support during the immediate aftermath of a natural disaster, long-term services may be lacking. School mental health professionals can help provide and coordinate mental health services, but it is important to connect with community resources as well in order to provide such long-term assistance. Ideally these relationships would be established in advance.

**Helping Children Adjust to Relocation After a Natural Disaster**

The frequent need to relocate after a disaster creates unique coping challenges. It may contribute to the social, environmental, and psychological stress experienced by children and their families. Children will be most impacted by the reactions of their parents and other family members, the duration of the relocation, their natural coping style and emotional reactivity, and their ability to

stay connected with friends and other familiar people and activities. To the extent possible parents and other caregivers should:

- Provide opportunities for children to see friends.
- Bring personal items that the child values when staying in temporary housing.
- Establish some daily routines so that the child is able to have a sense of what to expect (including returning to school as soon as possible).
- Provide opportunities for children to share their ideas and listen carefully to their concerns or fears.
- Be sensitive to the disruption that relocation may cause and be responsive to the child's needs.
- Consider the developmental level and unique experiences of each child; it is important to remember that as children vary, so will their responses to the disruption of relocation,

In addition, school personnel should:

- Determine the status of every child in the school. Contact each child who is absent and keep a record. Identify the needs of children whose home was destroyed or damaged.
- Find out the phone numbers and addresses of every student that had to relocate. Encourage classmates to write notes or make phone calls.
- Develop an advisory committee of students to report back to school staff about what resources and changes in routines will help students cope.
- Listen to and observe students' behavior. It takes time for children to understand and adjust to disasters. It is perfectly normal for them to discuss the event over and over again. Provide opportunities for children to discuss how they are coping. Use creative arts (e.g., drama, art, music, photography) to help them express their emotions.
- Help connect families to community resources. Bring agencies into the school that can deal with needs related to housing, finances, and insurance. Ensure that children get any necessary medical and emotional assistance.
- Increase staffing for before and after school care. If possible, extend the service for additional hours and even on weekends.
- Incorporate information about the disaster into related subject areas, as appropriate. Science, math, history, and language arts are especially relevant.

*Adapted from Lazarus, P. J., & Jimerson, S. R., Brock, S. E. (2002). Natural Disasters. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), Best Practices in School Crisis Prevention and Intervention (pp. 435-450), Bethesda, MD: National Association of School Psychologists and other crisis information posted on the NASP website at www.nasponline.org.*

P R E PaR E

Prevent Reaffirm Evaluate Provide and Respond Examine

# Program Overview
## November 2009

The *PREPaRE School Crisis Prevention and Intervention Training Curriculum* (PREPaRE) is designed to help schools meet the needs of students, staff, and families following school associated crisis events. *PREPaRE* is a comprehensive crisis prevention and intervention curriculum developed by school-based professionals who have had direct experience in preparing for and responding to school crises. A primary goal of *PREPaRE* is to build crisis management capacity at the local level, part of the National Association of School Psychologists' decades-long leadership in the field of school crisis response. Crises that affect schools range from natural disasters, terrorism and pandemic disease to school violence, the death of students or staff members and economic distress. How schools respond can shape the immediate and long-term affects of a crisis on a school community. Training and preparedness are critical to effective response and recovery.

### Comprehensive and Research Based

*PREPaRE* is grounded in research and theory that integrates the U.S. Department of Education's four crisis phases: prevention/mitigation, preparedness, response, and recovery; and makes use of the National Incident Management System (NIMS) and its Incident Command Structure. Specifically, *PREPaRE* combines the important aspects of crisis team and crisis plan development and community collaboration with extensive training on the mental health implications for children and youth when a crisis event occurs. It also addresses how to minimize traumatic impact through good prevention, intervention, response, and recovery efforts. While most children and youth can be expected to recover from trauma exposure, the impact of these events can vary greatly depending on individual experience and risk and protective factors. Experts agree that proper interventions are critical to promoting healthy coping. In addition, the school crisis response addresses serious consequences, such as Posttraumatic Stress Disorder, which is related to increased risk for low academic achievement, depression, aggressive or delinquent behaviors, and substance abuse Additionally, experts note that school-based intervention may be the best way to identify and meet the needs of children and their families after a crisis, and that given proper training and resources educators and school-based mental health professionals are well-situated to provide such interventions.

### Designed to Meet the Unique Needs of Schools

*PREPaRE* is an evidence-based crisis response curriculum specifically designed for schools by school-based professionals. The curriculum meets the unique needs and functions of school crisis teams, including reflecting school structures and laws, laying out the specific Incident Command Structure and steps for cohesive team development, providing common training and language, and integrating school personnel and community provider roles. *PREPaRE* fits within an in-service staff development model, is affordable, and enables schools to comply with legal requirements regarding crisis preparedness.

> *"We have found it to be an excellent approach to thinking about and planning for crisis prevention, response, and, especially, recovery. It has given us a common language and a shared set of basic principles for talking among ourselves and to other district staff. We feel confident that the strategies in the PREPaRE model represent state-of-the-art best practices. This material has become a key component of our district's approach to Emergency Response and Crisis Management."*
>
> —Martha J. Rosen, PhD, Manager of Psychological Services, Minneapolis Public Schools

### Enhances School Safety, Wellness Promotion, and Learning

*PREPaRE* is a comprehensive model that encompasses safety and crisis management from prevention to long-term recovery within the learning environment, with emphasis on the school-based mental health response to crises. The model aligns with a multi-tier delivery system and builds on existing personnel resources. *PREPaRE's* prevention and preparedness elements supports school safety, improved school climate, student behavior and academic functioning, student resilience, and staff response capabilities. *PREPaRE's* response and recovery elements provides training in mental health and crisis interventions, which strengthen the school community by reducing negative trauma reactions, facilitating recovery, and minimizing disruption to learning. Research shows that school mental health programs, prevention services, and social-emotional supports improve educational outcomes by decreasing absences and discipline referrals and improving test scores.

### *PREPaRE* Workshops

There are two core *PREPaRE* workshops, *WS#1-Crisis Prevention & Preparedness: The Comprehensive School Crisis Team* and *WS#2-Crisis Intervention & Recovery: The Roles of School-Based Mental Health Professionals*. These can be taken together or independently of each other. School districts can either sponsor workshops for entire teams and/or all relevant staff on site or send team members to local, state, or national level trainings. Workshop participants receive extensive handouts and planning and implementation resources. To facilitate ongoing local professional development, each workshop has an accompanying Training of Trainers (ToT) workshop. The ToTs allow local educators to become *PREPaRE* trainers and offer workshops to their school- and community-based professionals on an ongoing basis. For a detailed description of *PREPaRE* workshops, visit www.nasponline.org/prepare.

> *"Workshop 1 gave us the structure to provide a district-wide training. Every school has completed the crisis plan, which has provided the district office a measure to ensure that schools are addressing school safety and practicing drills. Similarly, all school mental health professionals including school psychologists, school counselors and school social workers have completed Workshop 2, which has enabled them to define the roles of mental health service providers in times of crisis. PREPaRE has provided the continuity amongst providers that we have striven to reach for years."*
>
> –Dennis Rastatter, Director of Student Outreach, Thompson School District, Loveland, Colorado

### Developing Local Capacity (2006-2009)

Table 1: The following Table summarizes the number of individuals who have received *PREPaRE* training.

| WORKSHOPS | # OF INDIVIDUALS TRAINED |
|---|---|
| WS#1-Crisis Prevention & Preparedness | 2198 |
| WS#1-Crisis Prevention & Preparedness (ToT) Training-of-Trainers | 233 |
| WS#2-Crisis Intervention & Recovery | 2385 |
| WS#2-Crisis Intervention & Recovery (ToT) Training-of-Trainers | 252 |

Table 2: The following Table summarizes the number of school districts and state, national, and international organizations that have received *PREPaRE* training.

| LOCAL, STATE, NATIONAL, & INTERNATIONAL DISSEMINATION | |
|---|---|
| Number of School Districts in the United States and Canada within which *PREPaRE* Workshops have been conducted *(Does not include districts that send staff to training off-site.)* | 54 |
| Number of States within which *PREPaRE* Workshops have been conducted *(Includes trainings conducted at the district, university and state levels)* | 36 |
| Number of State and National Organizations that have held *PREPaRE* trainings *(NASP is working with state and national education organizations to raise awareness of the importance of crisis training and PREPaRE. This includes the National Association of Elementary School Principals, National Association of Secondary School Principals, American School Counseling Association, and the School Social Workers of America, and conducting PREPaRE training for the National Association of School Nurses.)* | 21 |
| Number of Countries within which *PREPaRE* Workshops have been conducted *(U.S., Canada, England, and Greece; the University of Athens is considering adapting the PREPaRE model for use in their country.)* | 4 |

### Approved and Recommended by School Personnel

Every *PREPaRE* workshop includes mandatory pre- and post-tests and evaluations. From a random sample of approximately 1,000 workshop evaluations, *PREPaRE* participants indicate a high degree of workshop satisfaction, the majority rating workshop elements a 9 or a 10, with 10 being the highest possible rating. Additionally, participants report being significantly less anxious about crisis response and more confident about being a crisis team member, as well as demonstrating increased knowledge based on pre- and post-tests. Finally, initial anecdotal feedback from school personnel who have put their training to work indicates that *PREPaRE* training improves the response capabilities and outcomes for students. NASP is seeking grant opportunities to conduct additional research on the *PREPaRE* model.

> *"Shortly after our PREPaRE training, our district experienced three crises that proved our training prepared us to handle the situation. We were able to offer guidance and direction to administration, the counselors who had not been PREPaRE trained, teachers, and staff. We had the needed materials for record keeping and handouts for parents and knew the procedures to follow. The affected schools were grateful for outside support from counselors who were not as emotionally connected so that we could be the scaffolding support for those adults who were in crisis themselves."*
>
> –Ginny Armstrong, LCSW, Ed S Coun., Idaho Falls School District #91, Idaho

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Mingo, T., & Deeds, S. (2009). Crisis management. Three steps to "PREPaREdness:" One district's response to crisis intervention. *Communiqué: Newspaper of the National Association of School Psychologists, 38*(1), 6.

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ΕΛΕΥΘΕΡΟΤΥΠΙΑ [Eleytherotypia or Free Press] (Athens, Greece). 4-12-08, Δυοαμερικανοιειδικοιαναλυουντι πρεπεινακανουνοτυπευθυνοιγια προληψη: Οτανξεσπάσειηκρίσηστοσχολείοείναιαργά [Two American experts analyze what should make persons in charge for prevention: After a school crisis is too late]

ΕΛΕΥΘΕΡΟΤΥΠΙΑ [Eleytherotypia or Free Press] (Athens, Greece), 4-13-08, Δυοαμερικανοιειδικοιαναλυουντι πρεπεινακανουνοτυπευθυνοιγια προληψη: Οτανξεσπάσειηκρίσηστοσχολείοείναιαργά [Two American experts analyze what should make persons in charge for prevention: After a school crisis is too late].

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Reeves, M. A., Brock, S. E., & Cowan, K. C. (2008). Managing school crises: More than just response. Effective crisis management begins long before a critical incident occurs. *Principal Leadership: Middle Level Edition, 8*(9), 10-14.

Reeves, M. A. & Nickerson, A. B. (in press). Crisis teams to support school safety. In A. S. Canter, L. Z. Paige, & S. Shaw (Eds.), *Helping children at home and school III: Handouts for families and educators.* Bethesda, MD: National Association of School Psychologists.

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# Program Evaluation Summary
**November 2009**

To evaluate workshop effectiveness and to facilitate PREPaRE curriculum development, collection of participant satisfaction and pre- and post-workshop data is a standard element of all workshop offerings. This document summarizes the program evaluation data collected since the curriculum was pilot tested in April 2006 and before May of 2008 (Brock, Nickerson, Reeves, Woitaszewski, & Savage, in preparation). These data provide initial insight into participant workshop satisfaction and provide guidance regarding the extent to which the PREPaRE curriculum influences participant school crisis prevention and intervention attitudes and knowledge.

## Workshop Satisfaction

Table 1 offers descriptive statistics for the three questions asked of participants at the conclusion of their training. These data suggest that participants' satisfaction with their workshop experience is very high, they feel significantly better prepared to respond to school crises, and they would highly recommend the workshop to others.

**Table 1. Participant Workshop Satisfaction. Participant Ratings for the *Crisis Prevention and Intervention Workshop* (Workshop #1) and the *Crisis Intervention and Recovery Workshop* (Workshop #2)**

| *Question* | *Workshop #1* | | | *Workshop #2* | | |
|---|---|---|---|---|---|---|
| | N | Mean | SD | N | Mean | SD |
| 1. Using a 10-point scale, please rate your overall workshop experience (1 = I did not like this session at all; 10 = I liked this session a lot!). | 1,141 | 8.6 | 1.56 | 984 | 8.9 | 1.44 |
| 2. Using a 10-point scale, please indicate the degree to which you think you are better prepared to respond to school crises (1 = not at all; 10 = a lot!). | 1,136 | 8.19 | 1.62 | 988 | 8.6 | 1.47 |
| 3. Using a 10-point scale, please indicate the likelihood that you would recommend this workshop to others (1 = absolutely no; 10 = absolutely yes). | 1,138 | 8.91 | 1.55 | 988 | 9.1 | 1.48 |

## Workshop Effect on Participants' Attitudes Toward School Crisis Work

Table 2 offers descriptive statistics for the pre- and post-workshop questions asked of participants to assess their attitudes toward crisis prevention and preparedness. Using a 5-point scale, with higher scores indicating more positive attitudes, Workshop #1 participant responses indicated significant increases in perceived knowledge about crisis prevention and preparedness ($t$ = -34.57, $df$ = 1,177, $p$ <.001) and confidence in their ability to collaborate with others to develop a comprehensive school crisis response management ($t$ = -23.02, $df$ = 1,174, $p$ <.001). Further, results indicated increased enthusiasm about collaborating with others to develop a comprehensive school crisis response management plan ($t$ = -14.95, $df$ = 1,173, $p$ <.001), as well as increased perceived importance of school crisis prevention and preparedness knowledge and skills in schools ($t$ = -4.28, $df$ = 1,176, $p$ <.001).

Table 3 offers descriptive statistics for the pre- and post-workshop questions asked of participants to assess their attitudes toward crisis intervention and recovery. Again using a 5-point scale, participant responses indicated significant decreases in anxiety about providing crisis intervention ($t$ = -15.57, $df$ = 1,007, $p$ < .001) and fearfulness that they might make a mistake during crisis intervention ($t$ = -12.50, $df$ = 1,007, $p$ < .001). Further, results indicated increased confidence in knowing what to do when required to respond as a part of a school crisis team ($t$ = -20.29, $df$ = 1,007, $p$ <.001).

**Table 2. Workshop #1 Participants' Attitudes Toward Prevention and Preparedness on a 1–5 Scale, With Higher Scores Indicating More Positive Attitudes**

| *Question* | *Pretest* | | | *Posttest* | | |
|---|---|---|---|---|---|---|
| | **N** | **Mean** | **SD** | **N** | **Mean** | **SD** |
| 1. How knowledgeable are you about school crisis prevention and preparedness? | 1,178 | 2.75 | .81 | 1,178 | 3.56 | .70 |
| 2. How confident are you in your ability to collaborate with others to develop a comprehensive school crisis response management plan? | 1,178 | 3.22 | .96 | 1,178 | 3.80 | .75 |
| 3. How enthusiastic are you to collaborate with others to develop a comprehensive school crisis response management plan? | 1,174 | 3.71 | .91 | 1,174 | 4.03 | .80 |
| 4. How important do you feel school crisis prevention and preparedness knowledge and skills are in today's schools? | 1,177 | 4.62 | .63 | 1,177 | 4.69 | .55 |

**Table 3. Workshop #2 Participants' Attitudes Toward Crisis Intervention on a 1–5 Scale, With Higher Scores Indicating More Positive Attitudes (N = 1,008)**

| *Question* | *Pretest* | | *Posttest* | |
|---|---|---|---|---|
| | **Mean** | **SD** | **Mean** | **SD** |
| 1. How anxious would you feel if you were required to conduct a school crisis intervention? | 3.35 | 0.93 | 3.84 | 0.79 |
| 2. How confident are you in your ability to know what to do if you were required to respond as part of a school crisis response team? | 2.89 | 0.92 | 3.52 | 0.89 |
| 3. How fearful are you that you might make a mistake during a school crisis intervention? | 3.54 | 0.88 | 3.92 | 0.76 |

## Workshop Effect on Participant School Crisis Work Knowledge

The data collected evaluated the degree to which participants' demonstrated increased crisis prevention, preparedness, intervention, and recovery knowledge following their workshop experience. Results for Workshop #1, *Crisis Prevention and Preparedness*, revealed significant increases in participants' crisis prevention and preparedness knowledge test scores following workshop participation. The mean total pretest score was 5.25 out of 10 ($SD = 1.80$), and the mean posttest score was 8.79 out of 10 ($SD = 1.46$; $t = -58.49$, $df = 1211$, $p < .001$).

Results for Workshop #2, *Crisis Intervention and Recovery*, also revealed significant increases in participants' crisis intervention knowledge test scores following workshop participation. While the mean total pretest score was 1.35 out of 5 ($SD = 0.78$), the mean posttest score was 3.80 out of 5 ($SD = 0.92$; $t = -71.27$, $df = 1007$, $p < .001$).

## Summary of Findings

Overall, the preliminary quantitative research evaluating the PREPaRE workshops indicates that the PREPaRE curriculum is achieving its stated goals and as such is an effective school-based crisis prevention and intervention professional development tool. Workshop participants demonstrate increased knowledge about crisis prevention and preparedness, improved attitudes and confidence, and increased enthusiasm about the importance of developing collaborative comprehensive school crisis response plans.

## Reference

Brock, S. E., Nickerson, A. B., Reeves, M. R., Woitaszewski, S., & Savage, T. (in preparation). Development, evaluation, and future directions of the PREPaRE School Crisis Prevention and Intervention Training Curriculum. *Journal of School Violence.*

 

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School Crisis Prevention and Intervention Training Curriculum

## PREPaRE TRAININGS November 2006–November 2009

### Developing Local Capacity

A primary goal of NASP's *PREPaRE School Crisis Prevention and Intervention Training Curriculum* (PREPaRE) is to build school crisis management capacity at the local level by establishing a common crisis prevention and intervention framework. PREPaRE is the first comprehensive crisis prevention and intervention curriculum developed by and for school-based professionals who have had direct experience in preparing for and responding to school crises. PREPaRE consists of two core workshops and two corresponding training of trainer (ToT) workshops, which can be taken together or independently of each other. School districts can either sponsor workshops for entire teams and/or all relevant staff or site or send team members to local, state, or national level trainings. Below is an overview of PREPaRE trainings that have been conducted nationally and internationally since the curriculum's inception in 2006. Please note this list changes frequently as trainings are conducted. This summary also accompanies the PREPaRE Overview and PREPaRE Program Evaluation Summary documents.

**Number of individuals who have received PREPaRE training**

| Workshops | # of Individuals Trained |
|---|---|
| WS#1 – Crisis Prevention & Preparedness | 2,198 |
| WS#1 – Crisis Prevention & Preparedness Training of Trainers (ToT) | 233 |
| WS#2 – Crisis Intervention & Recovery | 2,385 |
| WS#2 – Crisis Intervention & Recovery Training of Trainers (ToT) | 252 |

**Number of school districts and other organizations that have received PREPaRE training**

| | |
|---|---|
| Number of school districts in the United States and Canada within which PREPaRE workshops have been conducted *(See full list of districts below. Does not include districts that send staff to training off site.)* | 54 |
| Number of states within which PREPaRE workshops have been conducted *(Includes trainings conducted at the district, university, and state levels)* | 36 |
| Number of state and national organizations that have held PREPaRE trainings | 21 |
| Number of countries within which PREPaRE workshops have been conducted *(United States, Canada, England, and Greece; the University of Athens is considering adapting the PREPaRE model for use in their country.)* | 4 |

**Local U.S. school districts that have sponsored PREPaRE trainings**

| | |
|---|---|
| **ALASKA**<br>• Juneau School District | **ARIZONA**<br>• Avondale Elementary School District #44<br>• Flagstaff Unified School District<br>• Glendale Elementary School District #40 |
| **CALIFORNIA**<br>• Clovis Unified School District<br>• Campbell Union High School District<br>• Huntington Beach Union High School District<br>• Orange County Department of Education<br>• Palm Springs School District<br>• San Bernadino City Unified School District<br>• San Joaquin County Office of Education | **COLORADO**<br>• Adams 12 Five Star School District<br>• Cherry Creek School District<br>• Harrison School District<br>• Mesa County Valley School District #51<br>• Thompson R2-J School District |

| | |
|---|---|
| **CONNECTICUT**<br>• Newtown Public Schools | **FLORIDA**<br>• Duval County Public Schools<br>• Miami Dade Public Schools<br>• Orange County Schools<br>• School District of Manatee County |
| **GEORGIA**<br>• Clayton County Public Schools<br>• Fulton County Schools<br>• Glynn County Schools | **ILLINOIS**<br>• Chicago Public Schools<br>• East St. Louis Area School District<br>• Waukegan Public Schools |
| **LOUISIANA**<br>• Ouachita Parish Schools | **MASSACHUTES**<br>• Mashpee Public Schools |
| **MARYLAND**<br>• Garden City Public Schools | **MINNESOTA**<br>• Minneapolis Public Schools |
| **NORTH CAROLINA**<br>• Cabarrus County Schools<br>• Charlotte-Mecklenburg School District<br>• Gaston County Schools<br>• Pitt County Schools | **NORTH DAKOTA**<br>• West Fargo Public Schools |
| **NEW JERSEY**<br>• Camden County Educational Services<br>• Cherry Hill Public Schools | **NEVADA**<br>• Clark County School District<br>• White Pine County School District |
| **NEW YORK**<br>• Newburgh Enlarged School District | **OREGON**<br>• Douglas ESD |
| **PENNSYLVANIA**<br>• Bucks County Intermediate Unit<br>• Lincoln Intermediate Unit #12<br>• Northwest Tri County Intermediate Unit | **SOUTH CAROLINA**<br>• Georgetown County Schools<br>• Richland School District #2 |
| **TEXAS**<br>• Houston Independent School District<br>• Region 17 ESC<br>• Region 4 ESC | **VIRGINIA**<br>• Loudon County School District<br>• Norfolk Public Schools |
| **WISCONSIN**<br>• CESA 3 Special Education | **WYOMING**<br>• Sweetwater School District #1 |

List does not include many other districts that have sent select personnel to trainings at the state and national levels.

| **National and state organizations that have conducted/sponsored PREPaRE workshops** | |
|---|---|
| • Association of School Psychologists of Pennsylvania<br>• California Association of School Psychologists<br>• Colorado Society of School Psychologists<br>• Delaware Association of School Psychologists<br>• Florida Association of School Psychologists<br>• Georgia Association of School Psychologists<br>• Idaho School Psychology Association<br>• Illinois School Psychology Association<br>• Indiana Association of School Psychologists<br>• Michigan Association of School Psychologists<br>• Missouri Association of School Psychologists<br>• Montana Association of School Psychologists | • National Association of School Nurses<br>• National Association of School Psychologists<br>• New York Association of School Psychologists<br>• North Carolina Association of School Psychologists<br>• North Dakota Association of School Psychologists<br>• Ohio School Psychologists Association<br>• South Carolina Association of School Psychologists<br>• Washington State Association of School Psychologists<br>• West Virginia School Psychologists Association |

| **State Department Sponsored Trainings** |
|---|
| • Indiana Department of Education<br>• Colorado Department of Education<br>• State of Delaware Office of Prevention |

| **University Sponsored Trainings** |
|---|
| • Northern Arizona University<br>• Chapman University, CA<br>• University of California – Santa Barbara<br>• George Washington University, DC<br>• Loyola University, IL<br>• National Louis University, IL<br>• Southern Illinois University – Edwardsville<br>• The Chicago School, IL<br>• Emporia State University, KS<br>• Appalachian State University, NC<br>• St. John's University, NY<br>• University of Athens, Greece<br>• University of Wisconsin – LaCrosse |

**PREPaRE International Presentations**

Brock, S. E., Feinberg, T. A., & Reeves, M. A. (2007, February). *Crisis intervention and recovery: The roles of school-based mental health professionals.* Workshop presented at the International Critical Incident Stress Foundation's 9th World Congress on Stress, Trauma, & Coping, Baltimore, MD.

Brock, S. E. (2008, April). *Responding to school and community crises: Defining crisis events and understanding psychological needs.* Paper presented at the International Symposium: Crisis Prevention and Intervention in the Community, Athens, Greece.

Brock, S. E., & Jimerson, S. R. (2008, April). *Crisis prevention and intervention in the school community.* University of Athens, Greece.

Brock, S. E., & Reeves, M. A. (2009, March). *Crisis prevention, preparedness, response & recovery: The roles of school administrators.* Paper presented at the Ministry of Education, Athens, Greece.

Brock, S. E., & Reeves. M. A. (2009, March). *Crisis intervention and recovery: The roles of school-based mental health professionals.* University of Athens, Greece.

Feinberg, T. A., & Lieberman, R. A (2009, July). *Crisis prevention and intervention: Overview of the PREPaRE model.* Workshop presented at School Crisis Prevention and Intervention Conference, St. Gallen, Switzerland.

Feinberg, T. A., Reeves, M. A., & Zenere, F. (2008). *Crisis intervention and recovery: The roles of the school-based mental health professional.* Workshop presented for School District #2, Moncton, New Brunswick, Canada.

**PREPaRE NASP Sponsored and National Conference Presentations**

Brock, S. E., Lieberman, R. A., & Feinberg, T. A, (2006, March). *Crisis intervention and recovery: The roles of school-based mental health professionals.* Workshop presented at the annual meeting of the National Association of School Psychologists, Anaheim, CA.

Brock, S. E., & Reeves, M. A. (2006, July). *First responder: The role of the school psychologist in a crisis situation.* Workshop presented at the National Association of School Psychologists & American Healthcare Institute's Third Annual Critical Issues in School Psychology Summer Conference, Chicago, IL.

Brock, S. E., Lieberman, R. A., Reeves, M. A., Nickerson, A. B., Jimerson, S. R., & Feinberg, T. A. (2007, January). *Training of Trainers – Crisis intervention and recovery: The roles of school-based mental health professionals.* Workshop presented at the National Association of School Psychologists PREPaRE training, Las Vegas, NV.

Brock, S. E., Nickerson, A. B., Lieberman, R. A., & Reeves, M. A. (2007, March). *Crisis intervention and recovery: The roles of school-based mental health professionals.* Workshop presented at the annual meeting of the National Association of School Psychologists, New York.

Brock, S. E., Reeves, M. A., & Lieberman, R. A. (2007, March). *Training of Trainers – Crisis intervention and recovery: The roles of school-based mental health professionals.* Workshop presented at the annual meeting of the National Association of School Psychologists, New York.

Brock, S. E. (2008, July). *A brief overview of the PREPaRE crisis intervention and recovery workshop, with discussion of how the current literature informs the PREPaRE curriculum.* Workshop presented at the National Association of School Psychologists Delegate Assembly Meeting, San Jose, CA.

Brock, S. E., Reeves, M. A., & Nickerson, A. B. (2009, February). *Crisis intervention and recovery: The roles of school-based mental health professionals.* Workshop presented at the annual meeting of the National Association of School Psychologists, Boston.

Feinberg, T. A., & Brock, S. E. (2005, April). *Crisis prevention and intervention workgroup status report.* Special session presented at the annual meeting of the National Association of School Psychologists, Atlanta, GA.

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**From *Education Week*, Published: October 5, 2005**
**COMMENTARY**

## Weathering the Storm

### After the Gulf Coast Hurricanes, Children's Mental Health Must Be a Top Priority

***By William Pfohl & Howard Adelman***

Schools have emerged as a clear ray of hope amid the devastation and chaos left by Hurricanes Katrina and Rita. Images of children engaged in the "normal" life of school provide welcome relief after so many scenes of unimaginable destruction and human suffering. While accusations continue to fly over who failed to respond to the Katrina disaster appropriately, schools all over the country managed to open their doors in a matter of days to thousands of displaced children, seemingly without misstep.

It is difficult to overestimate the role that schools will play in the recovery of children and their families affected by these disasters. Neither should we *underestimate* the magnitude of the task or the resources required to undertake it. The success of these early days reflects the responsive, problem-solving nature of the school environment, but the hard work is yet to come. The academic and logistical issues for Gulf Coast schools that reopen and for schools accepting displaced students are tremendous, with lack of records, resources, and adequate staffing and space chief among them. They will be further complicated by the significant and long-term challenge of supporting the mental-health needs of students.

While the U.S. Department of Education has said it will deal with requests for waivers of federal rules on a case-by-case basis, it seems clear to us that certain provisions of the No Child Left Behind Act should be relaxed. *Intensive academic learning will need to take a back seat to recovery for some students for some time.* How soon children begin to regain their emotional equilibrium will vary, depending on their degree of trauma exposure, pre-existing risks, the integrity of their family support systems, and, in large measure, the adequacy of the mental-health support they receive. As we saw after Sept. 11, 2001, schools that provided immediate and sustained mental-health support were able to contribute significantly to students' well-being as well as academic achievement.

Like children after 9/11, survivors of Hurricanes Katrina and Rita are likely to experience feelings of fear, anger, grief, anxiety, loss, and hopelessness. School personnel will be supporting students who may have trouble eating, sleeping, concentrating, or interacting with others, and who may exhibit symptoms such as crying, regression, misbehaving, withdrawal, or aggression. These symptoms can last for months or longer, and many children may be at risk of developing post-traumatic stress disorder. Some will be at risk for suicide.

The good news is that schools' unique capacity to facilitate the connection between mental health, learning, and development presents a built-in opportunity to respond to these needs. The learning environment provides a natural context for growth and healing. It is familiar and accessible to students and designed to promote collaboration with families and community services. Moreover, virtually every community has a school, and most children spend a good portion of their active waking hours there, giving staff members the opportunity to observe students' mental-health needs and either provide them help directly or refer them to the appropriate service providers.

The latter will be especially important in schools where the severity and scope of mental-health needs are beyond the capacity of current school mental-health professionals to address without

help. Services need to encompass not just students, but also their families. Data from previous crises suggest that 25 percent or more of affected individuals may be in need of mental-health services. Sheer numbers alone could overwhelm schools' ability to provide such help, making it imperative to coordinate with community service providers. This is particularly true given the fact that many school personnel in the affected areas will be dealing with their own trauma and loss, and will need support themselves.

Schools' rapid response and warm welcome to students in recent weeks represent the first essential steps in starting children on the road to recovery. Supporting this journey over the coming months will require additional finances, personnel, training, flexibility, and patience. For some time, schools will need to continue to: be realistic about the challenges they face, while emphasizing that recovery is possible; keep the needs of the students, collectively and individually, at the center of all efforts; engage (or establish) their crisis teams; equip staff members with information about children's trauma reactions and strategies for helping them; bring in necessary additional support for staff and students; embrace families and communicate with them consistently and openly; balance academics with social and emotional learning and social support; focus on students' strengths and the opportunity presented by the crisis to help them become more resilient and competent problem-solvers; and note lessons learned in this experience, to better prepare for future crises.

School personnel take on the weight of our children's world in a variety of ways every day. Those helping Katrina and Rita survivors are undertaking a Herculean task, and they deserve our support and gratitude. More important, they need our understanding that the return to "education as normal" will be a process, not a pronouncement. With this understanding must come the commitment to provide the resources necessary to make genuine recovery and learning possible.

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**As first appeared in *Education Week*, October 5, 2005. Posted with permission from the authors.**

# 5. Disaster Case Management- National Commission on Children and Disasters. *Interim Report. 14 Oct. 2009. Quoted directly from page 31-32.*

Recommendation 5.1: Establish a holistic federal disaster case management program with an emphasis on achieving tangible positive outcomes for all children and families within a Presidentially-declared disaster area.

Following Hurricanes Katrina and Rita, the federal government provided at least $209 million for disaster case management[103] 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.[104]

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.[105, 106] For example, as the first federally funded case management program, Katrina Aid Today drew to a close in March 2008 and some case management providers shut down their operations. Cases were closed, not because the client's needs had been met, 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 not implemented.[107]

The Commission recognizes that FEMA is evaluating four pilot disaster case management programs authorized following Hurricanes Gustav and Ike in 2008. However, the Commission recommends that FEMA move aggressively to determine a preferred program by the end of 2009. The Commission will collaborate with FEMA as appropriate to develop expert consensus around a disaster case management program, with specific parameters and elements as indicated below.

The Commission supports the recommendation of the U.S. Government Accountability Office (GAO) for the development of a federal disaster case management program[108] 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

103 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 an 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.
104 "Greater Coordination and Evaluation of Programs," ed. GAO, 7 (see n. 27).
105 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. P.L. 109-295, title VI, §689f, codified at 42 U.S.C. §5189d (2006). The Post-Katrina Act was passed in October 2006.
106 "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.
107 Ibid.
108 Ibid., 36.

children. Disaster case management should be led by a single federal agency that will coordinate, among all relevant agencies and organizations, disaster case management and ensure there is:

- Adequate understanding of the health, nutrition, education and human services needs of children and families;
- Involvement of voluntary agencies that provide disaster case management; and
- 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 case management program, in advance, 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 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.

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 prepare a roster of disaster case managers from professional organizations that can provide surge capacity following a disaster.

Following Hurricanes Katrina and Rita, 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.[109] These difficulties, in conjunction with current privacy policies, have created barriers to the provision of disaster case management services.[110] 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.[111] As a result of FEMA's interpretation of information sharing and privacy requirements under the Privacy Act,[112] 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.[113] The Commission recommends a review and modification of current privacy policies and laws as 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.

109 Ibid., 15-20.
110 Ibid., 19-20.
111 Ibid., 19-20
112 P.L. 93-579; 5 U.S.C. § 552a (1974).
113 "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.

Questions for the Record
*Children and Disasters: A Progress Report on Addressing Needs*
December 10, 2009
From Senator Mary Landrieu to W. Craig Fugate

1. On August 3, 2009, FEMA announced the creation of the "Children's Working Group". The working group is tasked with identifying and facilitating the integration of children into all FEMA planning efforts, and improving the Agency's capacity to work collaboratively with its partners and other non-governmental stakeholders. I am pleased that FEMA took proactive steps to create this working group and respond to concerns expressed by the Commission on Children and Disasters prior to the release of its interim report.
    - Please describe the Working Group's method of operation and the work it has carried out in the last 4 months?
    - Has FEMA decided to change any of its policies or programs based on recommendations from the Children's Working Group?

**Response:** The Children's Working Group (CWG) is chaired by a senior leadership member, staffed with a full time coordinator, and reports to the Administrator. The Group is comprised of members from virtually every sector of FEMA and is responsible for ensuring that the unique needs of children are addressed and integrated into all disaster planning and operational efforts initiated at the Federal level.

The Chair and Lead Coordinator facilitate overall efforts of the Group, including collaborating closely with the National Commission on Children and Disasters (the Commission), other federal partners, and non-governmental stakeholders. The Chair and/or Lead Coordinator meet regularly with individual Group members and respective subject matter experts, while the internal working team meets on a bi-weekly basis.

CWG achievements over the past four months:

- FEMA worked closely with the Commission to incorporate children's needs into the development of the 2010 Homeland Security Planning Guidance, which now identifies how grant dollars and resources may be used to support preparedness and planning activities for children.
- The Working Group collaborated with the American Red Cross, the Commission, and other pediatric experts to develop a Shelter Supply List identifying the basic items necessary to sustain infants and children in a mass care shelter and emergency congregate care environment. Additionally, FEMA'S Logistics Management Directorate is in the process of identifying the best means for rapidly acquiring and distributing these supplies to an impacted area.
- FEMA and the Department of Health and Human Services - Administration for Children and Families (ACF) finalized an Inter Agency Agreement allowing for the immediate deployment of a holistic disaster case management program with an emphasis on achieving tangible positive outcomes for all children and families within a presidentially-declared disaster area.

- Members of the CWG and Commission participate regularly on the National Disaster Housing Task Force (NDHTF) and sub-groups of the NDHTF to better identify gaps in the delivery of disaster housing assistance as it relates to families with children.

As indicated above, FEMA and its partners have made specific changes as a result of the CWG. It is the responsibility of the CWG to elevate the needs of children across the Agency and to work with each applicable FEMA directorate/office in doing so. Immediately upon the CWG's establishment, the Chair, Lead Coordinator, and members of the Group identified five initial and primary areas of focus as they relate to the Commission's recommendations. The key focus areas include: (1.) Disaster Management and Recovery, (2.) Disaster Case Management, (3.) Child Care, (4.) Sheltering Standards, Service and Supplies, and (5.) Housing. Substantial enhancements have been implemented in these areas which will allow FEMA to better respond to the needs of children as they relate to disaster preparedness, response, and recovery efforts. Much of this progress is due to FEMA's/CWG's commitment of working together as a team and their ability to collaborate with federal partners, external stakeholders, and other subject matter experts.

2. You mentioned that FEMA has worked with the Red Cross and the Commission to develop shelter standards for children and a supply kit for infants and toddlers.
    - Can you describe the sheltering and supply standards that are in place, and tell us whether FEMA utilized these standards in its recent response to disasters in American Samoa, Georgia, or other areas of the United States?

**Response:** FEMA staff, participating with the National Commission on Children and Disasters (the Commission), Evacuation, Transportation, and Housing (ETH) Subcommittee, supported the development of two specific shelter support documents last year:

1. FEMA staff convened a small panel of subject matter experts (SMEs), in support of the ETH Subcommittee's efforts, to develop the Commission's document titled "Supplies for Infants and Toddlers in Mass Care Shelters and Emergency Congregate Care Facilities." This list of supplies serves as the basis for FEMA Logistics to develop the capacity to rapidly deploy the listed supplies if requested by an affected State during a presidentially declared disaster; this effort is nearing completion. Once finalized, an accompanying Standard Operating Procedure (SOP) will be developed and both will be shared with FEMA Regional Offices and State counterparts. The timeline for completing the SOP is February 2010 and distribution will occur soon thereafter. It should be noted that these supplies would likely incur a State Cost Share and may affect the frequency with which they are requested. To our knowledge, to date no affected State has specifically requested support with the referenced supplies.

2. The ETH Subcommittee drafted and submitted an annex to the National Voluntary Organizations Active in Disaster (National VOAD) Standards and Indicators document that addressed the specific needs of children in disasters. The National VOAD Standards and Indicators document has yet to be published for its members' use, but it is FEMA's understanding that the American Red Cross planned to pilot the Annex in 2009 and report

back to the ETH Subcommittee. FEMA recommends that the Committee contact the American Red Cross to determine if the annex was piloted and related results.

FEMA does not operate disaster shelters directly; therefore, the agency has limited direct impact on the adoption of the National VOAD or other "Standards" on future disasters. The adoption, implementation, and enforcement of shelter Standards rests with State, Tribal, Territorial, and local jurisdictions.

FEMA does, however, support the delivery of shelter services by providing States with reimbursement for eligible sheltering expenses under Section 403 of the Stafford Act in response to a presidentially declared emergency or major disaster declaration. Eligible sheltering expenses may include facility related expenses, purchase of shelter supplies and medical equipment, reimbursement for shelter management, and security. In the event of a catastrophic event and at the request of an impacted State, FEMA also has the contracting ability to support the implementation and execution of turnkey shelter operations that include the establishment, operations, and demobilization of congregate shelters.

Additional FEMA efforts underway to improve overall shelter support capabilities include the following:

- FEMA is reviewing available State-developed shelter standards, such as those in California, and other agency efforts to improve the capability to determine and support the needs of shelter residents and ensure the State perspective is integral to any development of shelter standards.
- FEMA is working to develop planning guidance for State, local, and Tribal governments that will outline information needed to plan and provide functional needs support services within general population shelters, as a step down from specialized medical care shelters.
- FEMA participates in an interagency workgroup to develop uniform shelter assessment tools and planning guidance that can be used to enhance State and local planning and operational support capabilities. The workgroup includes SMEs from State, Federal, and non-governmental organizations (NGOs).

# Questions for the Record

*Children and Disasters: A Progress Report on Addressing Needs*
December 10, 2009
From Senator Mary Landrieu to Nicole Lurie

1. **The National Commission on Children and Disasters released its Interim Report on October 14, 2009, which includes recommendations targeted towards federal agencies and state and local government.**
   - **What are your initial reactions to the Commission's recommendations?**
   - **What steps have you taken to implement the recommendations that are directed at your agency?**

The US Department of Health and Human Services has a long history of commitment to serving the needs of children and we appreciate the work of the National Commission on Children and Disasters. The Department has conducted a comprehensive review of the Interim Report recommendations and has already begun to implement them. The Commission made interim recommendations specifically related to several ACF programs: Child Care, Disaster Case Management, and Child Welfare. Highlights of these recommendations and steps ACF has taken are provided in Appendix 2 of the testimony and summarized below:

- Child Care: We support both of the Commission's recommendations with respect to child care: 1) to require States to develop comprehensive disaster plans for child care to ensure coordination with key stakeholders, including public health and child care resource and referral agencies; and 2) to improve capacity to provide child care services in the immediate aftermath of and recovery from a disaster. The HHS Child Care Bureau (CCB) has provided technical assistance on emergency planning; asked States to report on disaster preparedness efforts in their State Plans for the Child Care and Development Fund (CCDF) program; and developed the Child Care Resources for Disasters and Emergencies website, which includes information and resources about emergency preparedness for the child care community, including disaster response and recovery efforts and lessons learned.

- Disaster Case Management: We agree with the Commission's recommendation to establish a holistic federal disaster case management program with an emphasis on achieving tangible positive outcomes for all children and families within a Presidentially-declared disaster area. On December 1, 2009, ACF and FEMA signed an Interagency Agreement to allow for implementation of the ACF Disaster Case Management Program, when necessary, after a future major disaster has been declared by the President.

- Child Welfare: Although State welfare agencies are required to have disaster plans, the Commission recommends that guidance, technical assistance, and model plans be provided to assist State and local child welfare agencies in meeting currently applicable disaster planning requirements and further require collaboration with State and local emergency management, courts and other key stakeholders. Toward the goals of this recommendation, ACF's Children's Bureau (CB) proactively addresses disaster preparedness, response and recovery

by providing onsite technical assistance and by developing a variety of materials, disseminated through the National Resource Centers' newsletters, websites, webcasts, and listserves. The Children's Bureau has worked with ACF Regional Offices and the State child welfare agencies and courts to build disaster preparedness, response, and recovery plans.

In addition to the above steps taken by ACF, the Office of the Assistant Secretary for Preparedness and Response (ASPR) has included specific attention to the needs of children in its programs and policies. In 2005 through 2007, ASPR's Biomedical Advanced Research and Development Authority awarded $17.6 million for the manufacture and delivery of over 4.8 million doses of pediatric liquid potassium iodide developed specifically for children, who are the most susceptible to the dangerous effects of radioactive iodine. In addition, training on pediatric response is offered each year at the HHS Integrated Training Summit and grantees of the Hospital Preparedness Program have used funds toward partnership projects focused on ensuring medical surge and appropriate care for pediatric populations.

As part of its efforts to address the needs of children and the specific concerns raised in the Interim Report, ASPR has met with Commission members and staff on multiple occasions to ensure coordination and communication. ASPR integrates the needs of children in its disaster planning and operations activities through attention to children's medical needs in its incident-specific playbooks, inclusion of pediatric-specific equipment in medical caches, and pediatric expertise on its Disaster Medical Assistance Teams. In addition, a pediatrician was recently hired to serve as a Deputy Chief Medical Officer in ASPR's National Disaster Medical System (NDMS), thereby fulfilling a specific recommendation of the Commission. This person will build upon efforts that have already been initiated to review and expand ASPR's pediatric response capabilities.

Shortly after the release of the Interim Report, ASPR hosted a two-day workshop focused on pediatric medical response and medical countermeasures during which participants, including two Commissioners, offered vital feedback about enhancing ASPR's capabilities. ASPR has also sought the input of non-governmental expertise on better integrating children's needs in exercises and drills. ASPR's Biomedical Advanced Research and Development Authority has actively increased its attention to pediatric issues in medical countermeasures by including pediatric subject matter experts on all of its Public Health Emergency Medical Countermeasures Enterprise Requirements Working Groups and Integrated Program Teams. ASPR will continue to engage the Commission as it moves forward with the development of its final recommendations to offer the highest level of care to our Nation's children following emergencies and disasters. The recommendations contained in the Interim Report reflect important concerns and ASPR will continue to work to address the issues identified in the report.

2. **Save the Children issued a report in July that indicated a startling lack of preparedness among child care centers. In particular, the report found that most facilities lacked plans for evacuation, reunification, temporary operating standards, or children with special needs.**

- **Do you believe that HHS should modify program rules under the Child Care and Development Block Grant Program (CCDBG) to require facility operators that receive an award to meet emergency preparedness standards in these areas?**

Child Care and Development Block Grant Program (CCDBG) funding is awarded to State, Tribe, and Territorial grantees and does not go directly to child care facilities. Instead, grantees use funds to provide assistance to low-income families primarily in the form of vouchers, which allow parents to choose among center and home-based child care providers. Grantees also may enter into contracts with child care facilities to reserve slots for families receiving benefits.

HHS supports improved emergency planning and preparedness for child care providers. However, it is not currently within the CCDBG program's statutory authority to require *all* child care providers to meet emergency preparedness standards. We plan to consider this issue in CCDBG reauthorization. The CCDBG program requires that child care providers serving children who receive subsidies (a subset of the larger provider community) meet certain specified requirements including: 1) prevention and control of infectious diseases; 2) building and physical premises safety; and 3) minimum health and safety training. Currently, States have the responsibility for licensing and regulating child care providers (and deciding which standards they must meet).

3. **In the aftermath of Hurricanes Katrina and Rita, HHS authorized a series of waivers under the Child Care Development Block Grant program for income, work requirements, and documentation to enable more displaced families to access the program and place their children in day care.**

   - **Were those waivers helpful in allowing families to access child care for their children, and what other challenges did HHS observe among displaced parents who were attempting to address this need?**

After Hurricanes Katrina and Rita, P.L. 109-148 provided the HHS Secretary with temporary authority to waive certain provisions of the CCDBG Act for States affected by the Gulf hurricane disasters.

Three States (Louisiana, Mississippi, and Texas) applied for and received waiver approvals. The waivers granted to these States were related to two specific provisions of the CCDBG Act: 1) the State Match and Maintenance-of-Effort (MOE) requirement required to draw down the full amount of the CCDBG block grant, and 2) the requirement to spend at least 4 percent of block grant funds on child care quality improvement. The waiver from the Match and MOE requirements gave the States more flexibility to decide how to use their State dollars to respond to the disaster (because the State was not required to allocate those funds into child care). The waiver from the 4 percent quality improvement requirement allowed the States more flexibility to spend the funds on direct services to families.

States did not apply for waivers related to income or work requirements for families. States already have flexibility to waive income and work requirements for families that the State deems to be "in need of protective services" in the CCDBG program. After Hurricane Katrina, HHS

provided guidance to States in an Information Memorandum (IM) (ACYF-IM-CC-05-03) to provide grantees with options of how to use the flexibility permitted by the block grant to serve families impacted by the disaster. One option included in this IM was to broaden the State's definition of "protective services" to permit emergency eligibility for children affected by a Federal or State declared emergency, thereby exempting families from income and work requirements.

Overall, the primary challenge for families with accessing child care after Hurricanes Katrina and Rita was a lack of availability of additional funding to support the surge of families in need of support after the disaster because CCDBG is a capped block grant. Another challenge for families was finding available child care since many centers and family child care homes were damaged or destroyed. There was a lack of funding and support to provide rebuilding assistance to help child care providers become operational again. Rebuilding of the child care infrastructure should be a priority in communities, similar to the emphasis on reopening schools and getting children back to school in order to protect children and stabilize and support a quicker recovery in the community.

4. **In fiscal year 2008, the House Labor, HHS and Education Subcommittee on Appropriations put forward a proposal to fund and equip a dedicated health and medical response teams under the Commission Corps. These teams would enable the Corps to better respond to public health emergencies allowing them to be deployed for extended periods of time in response to a catastrophic event.**

   - **Has the Department considered the creation of dedicated response teams made up of federal employees to your knowledge?**

   The Department's Office of the Assistant Secretary for Preparedness and Response currently has among its assets the National Disaster Medical System (NDMS), which consists of dedicated response teams made up of civilian intermittent federal employees. These individuals are Special Government Employees (SGE) who have indefinite federal appointments, have federal credentials, and can be activated and deployed at a moment's notice.

   - **How would you envision NDMS and HAMR Teams working jointly to provide medical and mental health services to a disaster impacted area?**

   NDMS already collaborates with the PHS Commissioned Corps during medical responses. NDMS is designed to provide acute medical care, while the Health and Medical Response (HAMR) teams were conceived to be a longer term response asset supporting the public health mission. HAMR teams would be coordinated by the Office of the Surgeon General.

**Questions for the Record**
***Children and Disasters: A Progress Report on Addressing Needs***
**December 10, 2009**
**From Senator Mary Landrieu to William Modzeleski**

***The National Commission on Children and Disasters released its Interim Report on October 14, 2009, which includes recommendations targeted towards federal agencies and state and local government. What are your initial reactions to the Commission's recommendations? What steps have you taken to implement the recommendations that are directed at your Department?***

Generally, we believe that the Interim Report performs an important service by highlighting a number of important issues related to the unique problems experienced by children caught in disasters. We appreciate the work of the members of the Commission and believe that the findings and recommendations contained in the Interim Report help expand and refine our understanding of emergency management challenges, particularly for our most vulnerable citizens.

In particular, two of the recommendations contained in the Interim Report are related to elementary and secondary education. *Recommendation 7.1* calls for the establishment of a school disaster preparedness program through which the U.S. Department of Education would provide dedicated and sustained funding to all State educational agencies (SEAs) to support disaster response planning, training, exercises, and evaluation at the State and local levels.

Currently, the Department administers the Readiness and Emergency Management for Schools (REMS) grant competition. This competition provides grants directly to local educational agencies (LEAs) to create, strengthen, or improve emergency management plans at the district and school-building levels. Funds from the program can be used to train school personnel in emergency management procedures; to coordinate with local community partners, including local government, law enforcement, public safety or emergency management, and public health and mental health agencies, and to improve local capacity to sustain emergency management efforts. We have made more than 700 grants to school districts in 47 of the 50 States, as well as to the District of Columbia and Puerto Rico. Based on enrollment data in these districts and the requirement that REMS grantees develop emergency management plans for each of their schools, we estimate that these grants have benefitted more than 39,000 schools serving about 23 million students.

While the REMS program is not designed to provide sustained support to each SEA as outlined in the Interim Report, the program provides a focus that is consistent with the recommendation, emphasizing planning, training, exercises and evaluation in the four phases of emergency management activities (prevention/mitigation, preparedness, response, and recovery). We believe that the REMS program provides much of what is envisioned in the broader program recommended by the Commission.

In addition to developing building-level emergency management plans that take an all-hazards approach, REMS grantees have also developed responses to a range of emergency management challenges that are shared with other grantees and form the basis for some of the technical assistance we provide to LEAs around emergency management issues.

*Recommendation 7.2* calls for efforts to enhance the ability of school personnel to support children who are traumatized, grieving, or otherwise recovering from a disaster. In implementing the REMS grant competition, we find that applicants and grantees frequently struggle with planning for "recovery" activities – the fourth phase of emergency management framework. As part of our efforts to provide training and technical assistance to REMS grantees we have developed some "advanced training" courses, including a course focused on bereavement. While the recommendation appears to envision a broader focus, incorporating recovery from trauma not related to loss of life, we believe this already-developed curriculum and training activity is a good beginning in responding to the recommendation. We are exploring mechanisms that will permit us to make this course available to a broader range of school personnel.

***Congress established the Emergency Impact Aid program in October 2005 to provide tuition reimbursements for K-12 students displaced by Hurricanes Katrina and Rita. The Department of Education administered this program until it sunset at the end of the 2005-06 school year and served over 180,000 students in 49 states and the District of Columbia. How well did the tuition reimbursement program function for K-12 students and schools that were affected by the 2005 hurricanes?***

The Emergency Impact Aid for Displaced Students Program, which provided support to local educational agencies (LEAs), nonpublic schools, and Bureau of Indian Education (BIE) schools for the cost of educating students displaced by Hurricanes Katrina and Rita during school year 2005-2006, worked quite well in distributing funds quickly to States and public and private schools. It was a very intense process with short deadlines for the submission of applications and the distribution of funds.

The law was signed by President Bush on December 30, 2005. The Department was required to publish an application notice within 14 days after the legislation was signed; LEAs were required to submit applications to their SEAs within 14 days of the publication of the notice; SEAs were required to submit applications to the Department, based on the data in the LEA applications, within seven days of the LEA application deadline. Additional submissions were required for each quarter, and the Department issued payment installments for each quarter, starting March 2, 2006. In total, the Department distributed $878 million to 49 states (only Hawaii did not apply) and Washington, D.C., on behalf of over 140,000 students.

Only the disbursements to private school parents were based on tuition; all other payments were reimbursements based on a per-student cap in the legislation. The funds were used to reimburse LEAs for expenses already incurred for education services to displaced students and could be applied to a broad range of costs, from payroll to transportation.

***The legislation also authorized higher education loan adjustments and waivers for special education and IDEA program requirements. Please explain whether you believe these provisions were helpful to displaced students and impacted schools.***

Under the rules that normally apply to the Federal student aid programs, institutions would have been required to return funds to lenders and to the Department if an institution closed for a term or more, which was the case of Katrina. In general, we believe that this is the correct policy but it would have been harmful to the institutions that were impacted by the hurricane as they would have been required

to return nearly $30 million in student loan and other aid funds. We believe that, overall, the waivers worked well and provided institutions needed funds that they would have otherwise had to return. Given that we allowed institutions to retain student loan funds, it was only appropriate to do so if students were not obligated to repay loans that were disbursed for the academic period that was curtailed due to the disaster, and we believe that this approach worked well. Because of the limitations in terms of time (did the school re-open in a reasonable period of time after the storms) and place (how far out of the immediate disaster area), some institutions and students felt that they did not get a benefit that they should have. Given the fact that this was an exception to the general policies governing the Federal student aid programs, some specific limits were appropriate.

Regarding special education waivers, the Hurricane Education Recovery Act did not authorize any waivers of programmatic requirements under the Individuals with Disabilities Education Act (IDEA). Under 20 USC 1412(a)(18)(C), the Secretary has authority to waive the State maintenance-of-effort requirement under the IDEA, but the Department did not receive any requests to grant such waivers.

***The Commission has recommended the development of a training program to help teachers and school employees recognize symptoms of trauma and identify students in crisis. The National Association of School Psychologists offers training to school employees in this area, and there has also been some discussion between the Department and the Commission about developing online courses geared toward school staff for this purpose. Does the Department support this recommendation, and are there existing programs that could be expanded to provide this type of training?***

We believe that it is very important for teachers and school employees to recognize the symptoms of trauma and identify students in crisis, whether those problems are related to a disaster or not. The Elementary and Secondary School Counseling Program, the Safe Schools/Healthy Students initiative, and the Grants to Integrate Schools and Mental Health Systems all support a variety of activities designed to help address the mental health needs of students, including training and professional development strategies for teachers and other school personnel. Additionally the REMS program requires that grantees plan for all four phases of emergency management, including the recovery phase, and REMS projects frequently include professional development for teachers and other school personnel to help them acquire the skills necessary to help students recover from a crisis situation and return as quickly as possible to a more normal routine.

We have also developed training programs to support REMS grantees, including the advanced training on bereavement issues discussed previously, and look forward to expanding training options for grantees and also to developing and implementing strategies to make these resources more readily available to schools and school districts in general.

Questions for the Record
*Children and Disasters: A Progress Report on Addressing Needs*
December 10, 2009
From Senator Mary Landrieu to Paul Pastorek

1. Hurricanes Katrina and Rita displaced an estimated 370,000 students throughout the Gulf Coast. Congress authorized the Emergency Impact Aid program to provide tuition reimbursements to host schools that took these students in. Schools in Louisiana and Texas took in the largest amount, with Louisiana accounting for 45,317 of them.
    - Was program funding sufficient to cover the cost associated with educating displaced children in both public and private schools?
        - **Answer:** Yes, enough funding was awarded to Louisiana to ensure that all displaced students identified were funded. The per pupil allocation amounts were close to the estimated cost of education per student in our state. The public schools utilized the federal dollars to mitigate the costs incurred with taking in all these children on such short notice. They used the federal dollars in conjunction with the extra State funds provided. The private schools were reimbursed tuition to ensure that the costs associated with private school education were covered.
    - Given the amount of displaced students that Louisiana took in, how would the State have accommodated all of them if private schools were unable to receive tuition reimbursements through the program? To your knowledge, were there any difficulties in disbursing the funds to private schools?
        - **Answer:** If the State public schools would have had to accept 100% of the private school students, a great burden would have been placed on the public school systems. The ability to have private school students from the hurricane affected areas enroll in other private schools gave relief to the situation.
        - The Louisiana Department of Education developed a special reimbursement system for the private schools for the displaced student funds. Once developed, the system worked well and there were no difficulties in disbursing funds to private schools
2. A National Institute of Mental Health study found that pre-storm trauma combined with exposure to Hurricane Katrina and its consequences left over 40,000 children at risk of lower school achievement, physical health problems, depression, and other mental health conditions. The Government Accountability Office, Save the Children, and RAND have all highlighted the potential of school-based counseling programs to address the surge in mental health needs that result in the aftermath of a disaster.
    - Do you agree that school-based counselors are well-suited to meet this need, and what should be done to better equip them for this mission?
    - **Answer:** We do not agree that school-based counselors are well-suited to address the surge in mental health needs that result in the aftermath of a disaster. According to the American School Counselor Association, working with one student at a time in a therapeutic, clinical mode is an inappropriate activity for school counselors. School counselors are equipped to assess and refer for appropriate treatment. For interventions, it would be more appropriate for School Social Workers and Psychologists to perform these services depending on the severity of the need.

- School Counselors, teachers and other school personnel should receive training on the identification of trauma in students and the proper protocols for referral.
- The Louisiana Department of Education received a Project SERV (School Emergency Response to Violence) grant from the US Department of Education in the amount of $2.75 Million in September 2005 (right after Katrina). As a result of the grant many activities occurred to address the mental health needs of students and staff:
  - Training modules were developed by a team of professionals from the Departments of Education, Social Services, Health and Hospitals, Office of Addictive Disorders, Office for Citizens with Developmental Disabilities, Office of Mental Health, Office of Public Health; the Governor's Office, LSU Health Sciences Center's Department of Psychiatry, and the United State Public Health Service
  - 5 training modules and accompanying activities were developed:
    - ✓ Module 1: Training Techniques and Facilitation Skills
    - ✓ Module 2: Reactions to Disaster: Schools Helping Children and Caregivers with Recovery and Reintegration
    - ✓ Module 3: Creating Safe Environments
    - ✓ Module 4: Creating Classroom Communities
    - ✓ Module 5: Healthy Responses to Life Changing Events
  - The Project SERV initiative was aligned and coordinated with the Office of Mental Health's (OMH) LA Spirit Counseling project that was funded through a SAMHSA/FEMA grant for "psychological first aid" and crisis counseling.
  - This coordination provided the schools and school personnel with a support system.
  - LA Spirit personnel participated in the Project SERV training and accompanied the Project SERV teams to the trainings.
  - Project SERV teams consisted of personnel from OMH's Crisis Intervention Teams (LA Spirit) to help establish relationships between the schools and the Crisis Intervention Teams that were assigned to those schools. The Project SERV teams trained district and/or school level teams on the modules and the school personnel that participated in the training re-delivered the training to their own faculty.
  - Project SERV modules were presented at a series of conferences within the state:
    - ✓ State Homeless Liaisons Conference
    - ✓ LA School Nurses Association Conference
    - ✓ National Association of Social Workers Conference
    - ✓ LaCHIP/Covering Kids Conference
    - ✓ LA Association of Safe and Drug Free Schools and Communities Conference
    - ✓ LA LEADS Conference

- Based on our experience with the many and varied mental health issues that result in the aftermath of a disaster, it takes all school personnel to be trained on identification and proper referral of students. Below are Issues that School Personnel faced in the days, weeks and months following the storms:

  Issues of Concern, as Expressed by School Personnel

  - Students exhibiting disruptive behaviors
  - Students withdrawn and confused
  - Students unable to concentrate
  - Depression in students, staff and parents
  - Students participating in more risky behaviors
  - Parents exhibiting symptoms of stress and depression
  - Staff burnout
  - Low staff morale
  - Inadequate classroom space

Questions for the Record
*Children and Disasters: A Progress Report on Addressing Needs*
December 10, 2009
From Senator Mary Landrieu to Matt Salo

1. In the months following Hurricanes Katrina and Rita, a number of evacuees experienced difficulty accessing their Medicaid and SCHIP benefits. They arrived in host states without insurance cards or financial information, and their medication and treatment regimens were often interrupted. As a result, the Children's Health Insurance Program (CHIP) Reauthorization Act passed by Congress earlier this year included a requirement for the Secretary of Health and Human Services (HHS) to consult with State Medicaid and CHIP Directors to develop a model process for coordination, enrollment, retention and coverage under Medicaid and CHIP for children who frequently change their State of residency.
    - How have State Medicaid and CHIP Directors worked with the Department to address these issues, and what plans or agreements are in place to ensure that future disaster evacuees and their children have continuous access to health care services under Medicaid and SCHIP?
    - Do the states need further assistance in this effort from the federal government?

**Response:** In conversations with state officials it became clear that there was not a systematic, widespread conversation that took place between HHS and all of the states. While the gulf states that were the most heavily impacted by Katrina DID report excellent working relationships with the Center for Medicare and Medicaid Services (CMS) at HHS, other states that served primarily as hosts for evacuated children, reported that there has been little or no ongoing conversations on the issue after the fact.

States in the affected region (the Gulf States) also reported that there have been ongoing conversations within their regions which has been facilitated and improved by CMS participation. These states have reported that the discussions are geared towards addressing issues of access to information, not just during emergencies, but all the time. They also pointed out that, independent of Katrina-related activities, the New England regional states were also working well together in a similar fashion.

On a positive note, Texas reported that CMS's development of a template for Disaster Relief section 1115 demonstration projects enabled the quick approval of a plan to deal with Hurricane Ike and eliminated the need for negotiations and allowed for much quicker implementation.

The states that reported a lack of ongoing dialogue with CMS indicated that they would certainly find additional technical assistance useful and welcomed the opportunity to work with CMS to improve areas where the federal response was lacking, ineffective, or counterproductive. For example, some states reported that while CMS pressured host states to do everything in their power to ensure that newly evacuated residents of the Gulf coast were covered by Medicaid or CHIP as quickly as possible, CMS also made efforts afterwards to take away or withhold federal funding due to missing eligibility documentation that was essentially trivial. These states pointed out that CMS guidance changed from time to time, and while this is generally understandable, the guidance frequently left the states to suffer from multiple retroactive policy changes that

narrowed the federal assistance available. These states urged that any necessary guidance changes from CMS apply only prospectively, given that states are complying in a very good-faith effort to ensure maximum seamless coverage. Some states further suggested that Congress regulate how CMS handles their post-reviews of these kinds of disasters to ensure that such events do not happen again.

Many states indicated that the ongoing development of interoperable Health Information Technology and Health Information Exchange systems promises to help avoid many of the coordination/confusion problems encountered by beneficiaries and states in the immediate aftermath of Hurricane Katrina. While there is a federal process in place and federal dollars are committed, more immediate investment geared towards allowing providers to purchase the appropriate hardware and software.