ROUNDTABLE WORKSHOP 25
CHILDREN AND YOUTH IN DISASTERS:
CLOSING GAPS AMONG RESEARCH, PRACTICE, AND POLICY
CO-HOSTED BY THE NATIONAL ACADEMIES
AND
THE NATIONAL COMMISSION ON CHILDREN AND DISASTERS
JUNE 25, 2009

Participants

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Ernest Allen, J.D.*
Michael Anderson, M.D., FAAP*
Konstantine Buhler
Merry Carlson, MPP* (via teleconference)
Dennis Epley
Brian Flynn, Ed.D.
Randall Gnatt J.D.
Robin Gurwitch, Ph.D.
Jack Harrald, Ph.D.
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The event was open to the public and held at the Kaiser Family Foundation, Inc., The Barbara Jordan Conference Center, 1330 G Street NW, Washington, DC 20005. Approximately 150 members of the public attended in person and via teleconference.

Opening Remarks

Jack Harrald, Chair of the National Academy of Sciences Disasters Roundtable, welcomed all in attendance. He said the National Academy of Sciences is pleased to collaborate with the National Commission on Children and Disasters on this workshop, a collaboration that will not end with this event. He noted that disasters are extreme events that disproportionately impact the vulnerable, particularly children. Citing Federal Emergency Management Agency (FEMA) Administrator Craig Fugate's assertion that children "are not small adults," he noted that this roundtable is a start toward better recognizing and addressing their unique needs. Americans must better understand how extreme events affect children and connect science and research with policies, regulations and laws. Dr. Harrald then introduced Mark Shriver, Chairperson of the National Commission on Children and Disasters and Vice President and Managing Director of U.S. Programs for Save the Children.

Mr. Shriver thanked Dr. Harrald and the National Academies for inviting the Commission to co-host the roundtable. He said the Commission is honored to engage with the National Academies, an organization in operation for over 100 years.

Mr. Shriver noted that the last 10 years have been a frightening time for children. Save the Children has called it the "disaster decade." With hurricanes, school shootings, floods and other disasters occurring regularly, it is no longer a question of if or where they will occur, but rather how prepared are communities to respond when they do. Hurricane Katrina displaced 196,000 K-12 students; it took six months to reunify the last child with her family. Today, Louisiana children continue to struggle with health, mental health and educational challenges. Mr. Shriver said children comprise 25% of the American population, but they are forced to fit into adult-sized disaster response systems.

Mr. Shriver said the National Commission on Children and Disasters is an independent, bipartisan Federal body authorized by statute consisting of 10 members who were appointed by former President Bush and the Democratic and Republican Congressional leaders. Expertise from a variety of professions and disciplines is represented, including pediatrics, emergency management, state government and the nonprofit sector. The Commission is tasked with conducting a comprehensive assessment of children's needs when preparing for, responding to, and recovering from all hazards. The Commission has an ambitious set of areas to review, he said, including health, mental health, child care, child welfare, education, transportation, evacuation housing, juvenile justice and emergency management. To manage this workload, the Commission formed four subcommittees comprised of Commissioners and subject matter experts from the field. In October 2009, the Commission will submit an Interim Report to the President and Congress detailing its initial findings, conclusions and recommendations; in October 2010, the Commission will submit its Final Report.

Mr. Shriver outlined the Commission's immediate areas of focus: institutions with daily responsibility for kids, such as schools, juvenile justice facilities, group homes and child care centers, each of which should be required to have a comprehensive disaster plan. Essential elements of those plans include not only evacuation, but relocation, reunification and continuance of services. Plans should be developed with local and state planning experts and integrated with local and state emergency plans.

Preparedness is a shared responsibility, a principle to which FEMA Administrator Fugate adheres. The Commission is working with FEMA, the American Red Cross, and local emergency managers to develop detailed shelter guidelines for children that are being piloted in the field this year. After the pilot concludes, the guidelines will be revised as needed based on feedback from the field, and the Commission will continue working with FEMA to formalize them into national standards.

Mr. Shriver said the Commission feels that long-term recovery must focus on human recovery. The Federal government, he said, must develop a national long-term recovery framework. Additionally, a single, consistent definition of disaster case management is

needed to ensure children's needs are effectively met across the Federal and state government spectrums.

The best way to inspire confidence in the way America prepares for, responds to and recovers from disasters is to ensure children are a priority. Mr. Shriver concluded by thanking those present for the contributions they will make to the Commission's work.

Dr. Harrald introduced Konstantine Buhler, Founder, Always Ready Kids. Mr. Buhler said he founded Always Ready Kids five years ago to raise awareness and empower youth in the area of disaster preparedness efforts, as well as to provide relief to disaster victims. Since then, Always Ready Kids has helped 14,000 people prepare for disasters and has aided projects on four continents. Always Ready Kids works with schools, nonprofits and government agencies, as well as communities and individuals to achieve its goals.

Mr. Buhler said disasters are on the rise and on the minds of young people. Today's young generation has grown up with constant news of bombings, floods, fires and school shootings on the Internet and the television news outlets. Accounts of society 40 years ago where schoolchildren were unaware of terrorist attacks or school shootings is unfathomable to today's youth: kids today are aware of occurring disasters and want to be prepared and equipped to respond. Mr. Buhler encouraged those present to make youth part of the solution, not a problem, in disaster response.

Mr. Buhler offered five observations about today's young generation and disasters:

1. Youth feel a responsibility in disaster preparedness.
2. There may be a disconnect between youth and their parents when it comes to disasters.
3. Youth will prepare their parents if equipped to do so.
4. Youth are an ideal demographic for disaster preparedness and management.
5. Youth can be a catalyst toward a cultural shift that embraces disaster management.

Mr. Buhler said youth feel a responsibility for their families, friends and communities and want to help protect them because they know one day they will inherit those communities. The Teen Community Emergency Response Team (CERT) program is an example of a successful way to incorporate youth into community disaster preparedness and response.

A disconnect between youth and their parents regarding disaster preparedness is emerging: parents believe they are prepared while youth know they are not. Today's young people want to bring disaster preparedness into the household; they will prepare the household if given the tools. Youth can learn to be aware of their surroundings and can help their parents become so as well.

In disaster preparedness discussions and planning, teenagers, pre-teens and adolescents are often overlooked despite their physical capabilities. Not only can they assist with

physical response, they are also psychologically savvy and can quickly adjust to changing circumstances. Young people are knowledgeable about technology and can use all available mechanisms to help spread information quickly to many.

With youth, a cultural shift that makes disaster preparedness and response a regular concern in communities can be affected. Communities want to incorporate youth and recognize the importance of involving them, a fact readily evident in the various emergency preparedness and response curricula being developed and/or put to practical use. Youth know disasters will strike, and thus feel preparedness and response should be included in their educational experience. Mr. Buhler urged the preparation of youth and the incorporation of preparedness into the youth mentality.

Panel I

Dr. Harrald introduced Monica Schoch-Spana, of the University of Pittsburgh Medical Center, to moderate the first panel. Dr. Schoch-Spana introduced the discussion objectives for Panel I:

- What actions are needed to improve provision of mental health services for children and youth during and after disasters?
- Articulate the problem statement related to mental health services for children in disasters.
- Discuss concrete actions towards problem-solving.

Dr. Schoch-Spana said post-disaster response should cultivate a culture of survivorship rather than victimization. She then introduced Gerard Jacobs, of the Disaster Mental Health Institute at the University of South Dakota, to share the practitioner perspective. Dr. Jacobs said that in 1991, the American Red Cross announced that disaster mental health services would become a routine part of the organization's disaster response. From that time, a shortage of adequate professional staff persisted. To compensate, the American Red Cross honed in on school-focused consultations, parental education materials, child-focused programs in mass casualty operations and disaster child care.

The issue of preparedness is critical, he said. The National Biodefense Science Board was provided with a set of mental health recommendations last year that Dr. Jacobs hopes will soon be acted upon. The recommendations advocated community-based psychological first aid training for educators, child care providers and parents so they can respond immediately to symptoms in children. The recommendations also included a component for teaching children how to administer psychological first aid, which helps children better understand what is happening around them and how to cope.

Community psychological first aid is a very basic grassroots psychological support for family, friends, neighbors and oneself that can be administered by members of the community itself. It is based on the unique needs of each community, not a one-size-fits-all approach. The human psyche does not work the same in each individual, and cultural backgrounds can affect how one responds to traumatic situations: research suggests that alienation from the mainstream exists in many ethnic communities, but if psychological first aid is administered by members of that community, the response is more effective.

In many countries, psychological first aid training begins in kindergarten and is most successful when used as a preparedness technique. Dr. Jacobs recommends the development of a disaster mental health cadre focused on the needs of children that includes the involvement of ethnic minority providers, school nurses and counselors, and psychologists; he also recommends planning for mental health as part of the overall disaster planning process in each community.

Dr. Schoch-Spana introduced Robert Pynoos, of the National Center for Child Traumatic Stress at the University of California, Los Angeles, to discuss the research perspective. Dr. Pynoos said if one surveys disaster research across the world, nearly 40% of disaster survivors are mental casualties. The greater the magnitude of the disaster, he said, the greater the severity of the mental health reaction. But Americans do not generally consider disasters from that perspective and little money is committed to mental health response and recovery.

Post-disaster ecology (i.e. reunification, rebuilding schools, etc.) is very important, said Dr. Pynoos; increased unemployment has been consistently shown to lead to increased instances of domestic abuse, juvenile delinquency, and other community challenges. He encouraged those present to think of post-disaster ecology as mental health intervention with developmental and cultural parameters. The mental health field knows how to tailor mental health responses to specific stages of human development (i.e. expectant mothers, children at various ages), and studies clearly show the steps to be taken when intervening with adolescents, pre-school children, and other ages. Researchers know how to gather data that enables real-time screening for mental health response. Certain types of reactions can immediately identify those who need mental health triage and/or additional attention. Also, children who are sensitive in their daily lives can be assumed to continue that sensitivity during and after disasters and can be handled differently than the general population to help reduce and manage their fears. Dr. Pynoos said interventions can be stratified so that triage can be grouped accordingly.

Furthermore, he said that outreach to specific high risk groups (for example, foster children) can be conducted to aid in the recovery process. Families can be taught how to handle disaster anniversaries, often a challenging time for disaster survivors. He also encouraged remembering to treat the mental health needs of the adults as part of the child's treatment.

A division between disaster/crisis work and mental health response is often evident. However, there are modern training platforms available through national networks that can teach regions to work and partner together to maximize the broader community's ability to deploy all available resources and expertise. Dr. Pynoos recommended that child-serving systems become more trauma-informed; combine that approach with community-based psychological first aid and a powerful resource emerges to help ensure the nation is better prepared for disasters.

Dr. Schoch-Spana introduced RADM Brian Flynn (USPHS, Ret.), formerly a U.S. Assistant Surgeon General, to discuss the policy perspective. Policy is seldom driven by evidence or best practices, he said. Often it is driven by dramatic events, political interests, agendas, and earmarks. Thus policies can lack comprehensive organization and be unevenly applied.

RADM Flynn said there are three important areas of policy:

1. *Parity*. Behavioral and mental health considerations do not receive the same attention following disasters as matters of physical health. Where funds are committed demonstrates clearly where focus is placed.
2. *Integration*. Great work has been done in various "stovepipes" (i.e. individual organizations and sectors) but horizontal integration across those efforts is lacking. Often this integration is personality-dependent: the leadership must be interested and engaged. RADM Flynn recommended that the U.S. Department of Health and Human Services establish a policy requiring that all Federal departments and agencies develop and administer a comprehensive, integrated five-year program, with integrated budgeting, to mitigate, prepare for, respond to and recover from adverse psychosocial consequences of disasters.
3. *Prevention*. RADM Flynn said the best services are those that never have to be delivered. Policies should promote preventative measures and priorities and should be formalized in regulations and laws. Examples of policy questions include:
    - What level of evidence should drive policy?
    - Is service policy informed by research on interventions and delivery models?
    - Will policies be developed to respond to behavioral health needs in national and transnational emergencies?

RADM Flynn said today's public mental health system is very different than it was when the Substance Abuse and Mental Health Services Administration (SAMHSA) was created, and thus should be updated accordingly.

Dr. Schoch-Spana introduced Robin Gurwitch, of the National Center for School Crisis and Bereavement. Dr. Gurwitch said that sometimes a policy advances because of those championing it, so advantage should be taken of assets like Mark Shriver, the National Commission on Children and Disasters and the Obama Administration to gain traction.

A child's resilience is built as s/he becomes involved. The preparedness of families and communities for disasters is a strong tool in disaster response: preparedness builds resilience, which in turn increases the level of preparedness of the community, a cycle that can help small children, adults, and those in between. A variety of other resilience-building tools are available; for example, relaxation skills can be taught to small children so they can learn to remain calm when they get upset.

When public health and outreach is discussed, a stigma on mental health remains evident. Extensive efforts have been made to reduce the negative impressions left by the term

"mental health" but the stigma persists. Dr. Gurwitch asked how we can help families, children, schools, and everyone respond so that a community fares better following a disaster. She suggested adding trauma-informed government to the list of trauma-informed entities suggested earlier in the panel.

Dr. Gurwitch concurred that modern science can enable the strengthening of structures and communities, children and families, but she asked how that message should be distributed. Recommendations are nice, she said, but if the community does not listen to the message, few alternatives remain. Those selected to be "messengers" must be trusted by the community to which they are speaking in order to be effective delivery mechanisms.

All disaster response and relief services should also incorporate issues of bereavement. Grief is a lengthy process, and grief related to disasters and crisis is compounded. Dr. Gurwitch said good information about effective approaches is available, and questioned how that information may be used to avoid recreating the wheel. For example, she said, if we know which children are anxious in general, then we know what can be done to help those anxious children following a disaster.

Hurricane Katrina remains front-of-mind for many, but planning for other events such as pandemic influenza must be considered more globally. Dr. Gurwitch encouraged advocating changes that will truly affect the way America's disaster response machinery incorporates mental health considerations.

Panel II

Juan Ortiz, Emergency Management Coordinator for the City of Fort Worth, Texas, introduced the discussion objectives for Panel II:

- How can schools help children, youth and families prepare for and recover from disasters?
- Describe the role that schools can and should play in supporting children in the setting of a disaster and during the recovery period.
- Describe what steps schools can and should take to better prepare for disasters.
- Discuss policy needs and directions to facilitate better preparation for schools nationwide to respond to disasters and support recovery efforts for children, families and school staff.

Mr. Ortiz introduced Kathleen Henning, Region 3 President for the International Association of Emergency Managers, to discuss the practitioner perspective. Ms. Henning said she was touched by the morning's discussion about the psychological well-being of children, but turned to physical safety and well-being for this panel. A collaborative plan must be in place for the community that was developed with the involvement of emergency managers. If various community plans (i.e. schools, child care facilities, community centers, law enforcement, etc.) do not integrate with each other, conflicts in the response can quickly arise.

Ms. Henning said that to ensure children, family and school issues are fully integrated into local community disaster plans, all community stakeholders must be involved. Citizen Corps Councils represent government entities, the private sector, citizen activists and leaders, youth groups and other community stakeholders, all of whom can and should inform the development of a comprehensive community plan. Local emergency management planning councils are also useful, and have even influenced other relevant aspects of the community. For example, as a result of local planning council discussions, some local zoning councils have begun considering more carefully and strategically the proposed location of child care and school facilities (for example, avoiding locating them in floodplains). Finally, at the state level, governor emergency management advisory committees can incorporate large association information into statewide planning, such as using state Head Start associations to disseminate information to all Head Start centers throughout the state.

Ms. Henning said that to improve the care of children during disasters, particularly for unannounced or unanticipated events, community collaboration and the avoidance of silos is critical. During the sniper attacks in Washington, DC, a previously created Emergency Operations Center (EOC) shelter task force assembled vital community players, such as the local school board, the Department of Aging, the Office on Disability, community centers and other community and municipality stakeholders. These various groups collectively discussed sheltering concerns and better coordination with schools. Often forgotten is the fact that school boards operate independently of local governments, which can create a situation where the board has an effective plan that was communicated to students and parents but never connected or shared with local emergency management. Such disconnects can also hinder schools from becoming aware of an event occurring within their own community in real time.

To ensure the needs of children are addressed in long-term recovery solutions for the community, Ms. Henning suggested that EOCs meet after emergencies occur to review and dissect the community's response to the disaster; children's advocates must be represented on those committees. Ms. Henning also said it is critical to ensure that disaster preparedness is an integral part of school curricula. The American Red Cross has preparedness curricula and programs such as Masters of Disaster, Teen CERT and others teach children of varying ages how to handle disasters. Ms Henning suggested that existing grant programs be utilized to create public/private partnerships that distribute programs and curricula.

She noted that many communities have eliminated emergency planners due to tightening budget constraints, reassigning emergency planning responsibilities to remaining personnel such as fire chiefs, chiefs of police, etc. However, emergency planners have a broader, more far-reaching perspective than those with a more sharply defined focus and should thus not be eliminated from community personnel rosters.

Ms. Henning concluded by noting that additional regulations and rules are not the answer to these challenges. Synergies must be identified that will help overcome the barriers that keep communities from successful emergency preparedness planning.

Mr. Ortiz introduced Dennis Epley, a school board member for the Waverly-Shell Rock (Iowa) Community School District, to discuss the policy perspective. Mr. Epley said that in May 2008, a Category 5 tornado tore through a community near Waverly-Shell Rock. Nearly a mile wide, the storm leveled a brick high school and other buildings. Severe flooding also occurred throughout the state that year, resulting in considerable destruction.

Mr. Epley said that a school district housing 250 students was completely destroyed by the tornado; books and materials were found as far away as Wisconsin. In Waverly, floodwaters crested two feet higher than the record, heavily damaging three school buildings. Cedar Rapids suffered serious damage to two elementary schools and a district administration building. The tornado caused five fatalities, but no deaths or injuries were linked to any of the schools. Fortunately, the schools were not occupied because the school year had ended. Had the disasters occurred during the school year, Mr. Epley said he was unsure what the response would have been. The importance of having a comprehensive disaster plan for schools was underscored during a subsequent visit to New Orleans, Louisiana, where an elementary school principal told Mr. Epley that some children had not been in class for as long as 18 months while schools were rebuilt.

Mr. Epley asked what role schools should play in helping their communities recover. He noted that schools are often used as community emergency shelters after disasters occur, and following the Iowa disasters of 2008, some undamaged school buildings were used as FEMA service centers. Mr. Epley said that schools are the heart and center of communities, particularly smaller communities. In Waverly-Shell Rock, the focal point of the community's recovery effort became the relocation of the school to a nearby warehouse: the whole community came together to help physically relocate the school so that the school year could begin on time. The start of the 2008 school year was a return to normalcy for many children who throughout the summer had dealt with destroyed homes and other repercussions of the disasters. For them, school meant friends, a clean place to be, familiarity.

Mr. Epley observed that mitigation efforts appear to fall into two categories: making physical changes to prevent or minimize damage to buildings and systems, and developing written plans for disaster response and recovery. Plans must be general enough to cover many different disasters yet specific enough to identify who, what, where, how and when certain actions must be taken. A key component of community plans is communication, he said. When a disaster strikes, the community will be starving for information: what roads are open? where is gas/medical assistance/food available? Communities' disaster plans must be interagency efforts that involve input from all stakeholders. They should not be prepared and shelved until needed, but updated and reviewed annually, as well as after utilization. Mr. Epley said that schools should also have safe rooms and should be constructed with unique local needs in mind (i.e. basements in tornado-prone areas).

Following the 2008 Iowa disasters, Mr. Epley lobbied the state legislature, not for more money but to streamline the overall response process following disasters. He said he is aware of Federal guidance and physical assistance relative to rebuilding efforts, but has been unable to identify any Federal assistance that is available to help schools develop their plans.

Mr. Ortiz introduced David Schonfeld, Director of the National Center for School Crisis and Bereavement, to synthesize the panel's comments and deliver the research perspective. Dr. Schonfeld said that Marleen Wong, of the University of Southern California, was unexpectedly unable to attend the roundtable but had sent her comments to Dr. Schonfeld to incorporate into his own. Ms. Henning's and Mr. Epley's remarks raise the question of why mental health concerns are relevant in school settings. The research, Dr. Schonfeld said, demonstrates there are some things that can be anticipated in the absence of active mental health interventions: children will have greater difficulty with cognitive functioning than they might in the absence of a disaster; they might experience difficulty sleeping and concentrating; anxiety, depression and other mental health-related reactions will directly impact their ability to achieve academically; significant increases in absenteeism can be expected; and increased symptoms of social regression can present, which can result in increased instances of suspension and expulsion from school.

Schools are unique sites to help children after disasters. Dr. Wong wanted to convey that there is a need for initial and periodic assessment and reassessment of the mental health recovery status of students and staff to inform interventions that may still be needed. She noted that intervention needs can morph over time and recommended funding studies that can inform the type of services needed as well as effective service delivery mechanisms. Also absent from disaster response approaches are cultural and contextual considerations, which should be primary considerations. Another benefit to increased mental health awareness in schools is that children attend school over time, where their needs evolve over time. The evolution of those needs, as well as of other life events can cause cumulative stress for children. Schools are there for the long run, creating continuity and familiarity for children. School staff are familiar with children, they know what it is to be a child, how to interact with children, and possess personal familiarity with the children that attend their school. A range of mental and behavioral health services can be provided in schools over time.

Psychological first aid and supportive services can be provided in school settings as well. Schools are communities and certain services and milestones occur within the context of the community: disasters eventually become part of the community's history and methods for how best to teach that history to children must be determined, including how children can learn to be part of the community as it moves on in the aftermath.

Dr. Schonfeld admonished that while the needs of children are minutely considered, the needs of school staff are also critical. Teachers and staff are often impacted more than their students, reducing their ability to support their students. The emotional and mental health needs of teachers, staff, principals and superintendents are routinely overlooked in

disaster preparedness and response planning, where they are considered responders with little contemplation of supports they might themselves need.

Panel III

Darlene Sparks Washington reviewed the discussion objectives for Panel III:

- What actions are needed to increase the resilience of children in disasters?
- Identify the critical stakeholders for increasing child and youth resilience in disasters.
- Outline concrete steps that integrate research, practice and policy approaches to promote resiliency in children and families in disaster preparedness planning.

Ms. Washington said that as the panel prepared for this discussion, divergent views of what resilience is emerged: for some it is a concept, while for others it is a framework or a state of being. However, the various views converge on the fact that resilience is not simply a return to a pre-event state. Rather, it is about helping individuals and families create their "new normal."

Ms. Washington introduced Lori Peek, of the Colorado State University, to discuss the research perspective. Dr. Peek offered a pair of working definitions to set the context for her remarks:

1. Vulnerability: the potential for loss.
2. Resilience: a set of capacities that enable positive adaptation during or following exposure to disaster.

She noted that resilience has moved from being an outcome to, more recently, encompassing a set of capacities that facilitate a process that unfolds over time as a result of development. Dr. Peek then outlined three key points about vulnerability and resilience:

1. Neither represents static characteristics.
2. Both vary across time, physical location and social context, and should be examined across those various levels.
3. They are interactive but not opposites.

When talking about children, a tremendous developmental range (infancy to 18 years of age) is involved; vulnerability for an infant is very different from vulnerability for a 16-year old. Further, when discussing resilience, individual resilience and community resilience are both salient, as they directly impact each other's resilient capacities.

What makes a child resilient? Dr. Peek said literature shows that strong intellectual skills, critical thinking, learning and adaptability, and strong bonds with others in their community contribute immensely to building a child's resilience. In fact, resiliency is rooted in a child's relationships with others, outgrowths of other social contextual factors. Not that all resilient children have strong relationships, but the most resilient children tend to have strong networks of people who encourage them to be thoughtful in challenging environments. The most resilient children are also often surrounded by stable housing, available health care, stable parental employment and access to resources.

Additionally, Dr. Peek said a child's demographics play a large role: how does race, class, gender, and the community surrounding a child shape the child's resilience? At the macro level, how do policies, media and other considerations affect children's resiliency?

Dr. Peek presented three key points for promoting resilience:

1. Children are not innately resilient.
2. Resilience must be developed before disasters occur.
3. Vulnerability is multifaceted so strategies for promoting resilience should be too.

Dr. Peek said that as humans evolved, a set of fundamental capacities that help us through everyday life and difficult times developed. Children are not innately resilient: the characteristics discussed earlier encourage the development of resilience as a result of actions taken. Importantly, resilience must be developed before a disaster. After an event, every person and institution the child relies on is stretched past their limits handling the event and it is unlikely they will be able to offer many supports to the child at that time.

Decades of research exists on resilience that must inform policy and practice. Additionally, evaluation of programs and policies already in place is critical to determine whether they achieve their goals and are beneficial. If money, time and effort is to be put into such programs, they should be proven to work.

Ms. Washington introduced Sally Phillips, of the Agency for Healthcare Research and Quality, to discuss the policy perspective. Dr. Phillips said there is a general tendency to think in terms of large disasters and scenarios when considering resilience and disasters, but children have enormous capacity to act responsibly if given the tools. For example, how many times do newspapers publish stories of toddlers dialing 9-1-1 when a parent is incapacitated? Children should not be underestimated at any age; rather, they must be equipped with tools they understand and can use to react.

Dr. Phillips said many programs are well-known but remain untested. Most successful programs share important elements: they have a child-friendly message; they have age-appropriate materials; there is an incentive to participate; and they are represented by a friendly mascot or trustworthy figure. She once took casual surveys of children in Boston, Atlanta and Denver about readiness programs they might have heard of. Some of the programs they responded with included Stop-Drop-Roll, Smokey the Bear and Duck and Cover.

Another well-established program, D.A.R.E. (Drug Abuse Resistance Education) has been comprehensively evaluated. D.A.R.E. is a police officer-led program that incorporates an effective logo, bumper stickers and age-appropriate teachings. Another program, the Masters of Disaster, has not been evaluated for actual effectiveness and has yet to catch on. Dr. Phillips also noted that the Boy Scouts of America offer a merit badge for emergency preparedness.

Dr. Phillips recommended that a national child emergency empowerment campaign be mounted. Such a campaign could be led by a member of Congress or the Senate.

Hollywood could possibly be a partner in the effort (Disney, for example). Strategic industry partners might become involved (i.e. Sony and its Wii gaming system). Whatever the campaign ultimately becomes, it should be evaluated from the start.

Ms. Washington introduced MaryEllen Salamone, a Board member of Families of September 11, to discuss the practitioner perspective. Ms. Salamone said she founded another organization, Children of September 11, because little information was available or effectively disseminated to impacted families following the terrorist attack. Ms. Salamone often speaks with people on a peer level, allowing her to develop a frank perspective regarding the availability of services and their effectiveness. When Ms. Salamone's husband died in the World Trade Center collapse, her children were aged two, four and six. Following the attack, she tried to get information about resources and supports available for her and, more importantly, her children. She made numerous phone calls but found every avenue a dead end. She was frequently told that children do not grieve until they are eight years old.

Ms. Salamone said there are many great programs available that foster resiliency. Much of the information about those programs, however, is not effectively distributed. It is difficult for a child to recover from a disaster when what society expects from the child is completely different from what the child actually experiences. The general population does not understand that recovery from trauma is diminished when proper attention is not paid to a child's needs. Ms. Salamone said this leads to a disconnect: the common belief that children will "get over this in no time." To refute this claim, she noted that:

- Expressions of grief in the context of normal child development continue throughout childhood.
- Society wrongly believes that children "get over" trauma and loss in one year.
- The practice of dispatching crisis counselors for only the first days following a trauma/disaster is commonplace but wholly inadequate.

That children will get over trauma quickly is untrue. Trauma impacts a child's development, and service providers must be reeducated so they understand what children really go through. School provision of mental health counselors for a day or two after a disaster does not adequately allow for the progression of trauma and grief processing.

Ms. Salamone then discussed another disconnect regarding memorialization. She said that allowing disaster survivors the opportunity to remember the event is important to the mourning process and promotes healing. Allowing children to participate in the memorialization of a traumatic event is important and encouraged by mental health professionals. Yet many schools do not allow any memorialization of the September 11th attacks. Additionally, memorialzations when allowed are usually planned by adults for adults, with the assumption that they know what children want to do during memorials and how they want to participate. Children must be asked what they want and empowered so they know that the adults and community around them all share the bad feelings of the event.

Ms. Salamone introduced another disconnect: the discrepancy between children who need mental health assistance and children who actually receive it. The *American Journal of Psychiatry* estimates that 75-80% of youth in need of mental health services do not receive assistance (Katoka, 2002, American Journal of Psychiatry, 159(9), p. 1548)[1]. Children with unmet mental health needs demonstrate reduced resilience. Because children spend so much of their time at school, schools must be able to identify children who may need mental health services.

Ms. Salamone's fourth disconnect is that disaster plans usually only address physical needs. Most states now require disaster response plans in all schools. These plans outline steps to secure the physical safety and evacuation of students and staff, but there is often little if any instruction about how to promote safety so that it increases a child's feelings of security rather than fear. School disaster plans help children feel secure, but disaster plans and exercises must be introduced and communicated using methods that are appropriate to children so they are empowered rather than frightened.

The next disconnect Ms. Salamone discussed was that of volunteerism empowering youth. She recommended that children be encouraged to take action. Schools and communities often develop child "volunteer" programs where, in reality, adults do most of the work. As a result, children do not feel they are doing much that is meaningful to the effort. Also, the culture of youth must be kept in mind to ensure that they want to participate in new programs that are developed. For example, following the Virginia Tech shootings, the university made counselors available to the student community on a specific day: no one met with the counselors, but millions of hits on Facebook demonstrated that the youth were responding to and discussing the event using the language and tools relevant to their own culture.

Ms. Salamone concluded by asserting that adults must ask questions to understand what children and youth need, then provide that for them in their own culture. Misconceptions about how children respond to trauma must be reversed through policy and culture change.

Ms. Washington introduced David Abramson, of the National Center for Disaster Preparedness. He said that many communities have the capacity to encourage and build resilience in children but lack the capability to act upon that capacity. There are multiple factors that help children develop resilience, including social and civic institutions within a community and social marketing that extends to a broader "mega-resilience." He noted that a resilient community has shared norms, strong community institutions, and a sense of shared responsibility for each other.

Dr. Harrald concluded by recapping the panel discussions and outlining themes that he observed:

- Include all stakeholders, especially children and youth, in planning and implementation.
- Integrate mental health and safety aspects at the community level.

[1] Speaker citation.

- Plan ahead for multiple unexpected events.
- Identify physical and human resources.
- Provide interagency coordination before disasters. Review and practice that coordination.
- Create environments of ongoing growth and learning.
- Identify champions to spearhead programs at every level.
- Strong community resiliency coalesces around a unifying entity.

Dr. Harrald thanked the day's panelists, participants and guests, concluding the event.

Participant Affiliations:
David Abramson: National Center for Disaster Preparedness
Ernie Allen: National Center for Missing and Exploited Children
Michael Anderson: University Hospitals, Case Western Reserve University
Konstantine Buhler: Always Ready Kids
Merry Carlson: Division of Homeland Security and Emergency Management, State of Alaska
Dennis Epley: Waverly-Shell Rock Community School District, Iowa
Brian Flynn: Independent Consultant
Robin Gurwitch: National Center on School Crisis and Bereavement
Jack Harrald: The National Academies
Jacqueline Haye: National Commission on Children and Disasters
Kathleen Henning: International Association of Emergency Managers
Gerard Jacobs: University of South Dakota
Victoria Johnson: National Commission on Children and Disasters
Roberta Lavin: Administration for Children and Families, U.S. Department of Health and Human Services/United States Public Health Service
Sheila Leslie: Nevada General Assembly; 2nd Judicial District Court
Bruce Lockwood: Bristol-Burlington Health District, Connecticut
Graydon "Gregg" Lord: Homeland Security Policy Institute, George Washington University
Vinicia Mascarenhas: National Commission on Children and Disasters
Juan Ortiz: City of Fort Worth, Texas
Lori Peek: Colorado State University
Sally Phillips: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
Robert Pynoos: University of California, Los Angeles
Irwin Redlener: National Center for Disaster Preparedness, Columbia University; The Children's Health Fund
Christopher Revere: National Commission on Children and Disasters
MaryEllen Salamone: Families of September 11
Monica Schoch-Spana: University of Pittsburgh Medical Center
David Schonfeld: National Center for School Crisis and Bereavement, Cincinnati Children's Medical Hospital Center
Mark K. Shriver: Save the Children
Lawrence Tan: Emergency Medical Services Division, New Castle County Department of Public Safety
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