In the aftermath of Hurricane Katrina, thousands of children in foster care were displaced from their home areas to other counties and states by the emergency evacuation. These children had difficulty accessing health care, education, and social services and faced situations that compromised their personal safety. One month after the hurricane, local authorities reportedly could not account for 158 children who had been in foster care. To prevent the unnecessary suffering of foster children in the future, we must learn from the lessons of Hurricane Katrina. Through an analysis of the experiences of social service, legal, education, and medical care professionals involved with children after Hurricane Katrina,
common themes and lessons emerge. Reports of stakeholders involved with foster children displaced by the Hurricane Katrina disaster indicate the need to strengthen information sharing and emergency coordination among localities and states for the purpose of protecting the access of foster children to health care, education, and social services following a disaster event.

To address these needs, the development of an information-sharing manual for foster children that includes agencies’ resource information and emergency safety tips will provide needed disaster-preparedness guidance for foster care system stakeholders. These stakeholders include social service providers, guardians ad litem, foster parents, juvenile justice system workers, school administrators, pediatric health care providers, Court Appointed Special Advocates (CASAs), and local disaster relief agency representatives. Compilation of an information shar-

4. In Keeping With Casey’s Mission, Hurricane Relief Focuses on Children and Families Left Behind, CASEY CONNECTS (The Annie E. Casey Found., Baltimore, MD), Fall 2005, at 2. “One of the challenges facing Alabama was an influx of displaced foster families from Louisiana and Mississippi.” Id.

5. See Lessons Learned for Protecting Children, supra note 2, at 4. “Many foster families who were living out of state faced problems finding providers to accept their Medicaid card for mental health services and medication.” Id.

6. Id. at 5.

   Louisiana officials said that 29 schools were destroyed, and about half of the state’s schools were damaged . . . . Displaced students’ records were often not immediately available to their new districts. As a result, districts often enrolled students based on information provided by parents about grade level, disability status, and other factors. Louisiana and Texas collaborated to eventually make displaced Louisiana students’ record available to authorized Texas personnel.

   Id.

7. Id. at 3.

   Prior to the hurricanes, approximately 1,885 families were under investigation for abuse and neglect, and 364 were receiving family services in the affected areas . . . . About 640 of the state’s social workers were also initially displaced from the heavily affected communities, making it even more difficult to find displaced foster children.

   Id.

8. Peter Watson, Stakeholder Involvement in Child Welfare, CHILD WELFARE MATTERS (Nat’l Child Welfare Res. Ctr. for Org. Improvement, Portland, ME), Fall 2005, at 1–2, available at http://muskie.usm.maine.edu/helpkids/rcpdfs/cwmatters2.pdf. A list of stakeholders for children in foster care as defined by other child welfare agencies may include county agencies; children, youth, and families served; public and private service providers and/or provider organizations; child welfare agency staff; court and law enforcement staff; public agencies and providers of mental health care, health care, juvenile jus-
ing and emergency coordination manual with related training that brings together stakeholders around issues of foster children’s needs is ideal for delivering consistent messages and for providing a forum for collaboration. Manuals of this sort could be designed to clarify state and federal laws for the purpose of expediting the resumption of services to foster children displaced due to disaster situations.9 Similar projects that have facilitated information sharing among foster care system stakeholders within localities during nonemergencies can be looked to for their potential use as model programs10 and expanded to include information on emergency preparedness. Development of a comprehensive manual of this kind holds significant promise in helping to establish a uniform understanding of relevant federal and state laws on information sharing.

Many child welfare systems do not have emergency plans for disaster events.11 This leaves children in foster care more vulnerable to the type of upheaval witnessed in Hurricane Katrina–affected communities.12 Children in foster care deserve greater consideration in emergency planning because of their special needs13 and

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12. See Lessons Learned for Protecting Children, supra note 2, at 4. “In some cases, foster parents were unable to cope with the effects of the storm and returned children to the child welfare agency.” Id.

13. Susan dosReis et al., Mental Health Services for Youths in Foster Care and Disabled Youths, 91 Am. J. Pub. Health 1094, 1094 (2001). “[C]hildren in foster care have more chronic medical problems, and a substantial proportion exhibit . . . psychological disorders. Research indicates that between 40% and 60% of youths in foster care have at least 1 psychiatric disorder, and approximately 33% have 3 or more diagnosed psychiatric problems.” Id.
needs that arise in the course of the disaster.\textsuperscript{14} The proper tools are necessary to guide the planning efforts of stakeholders in achieving an appropriate level of readiness.\textsuperscript{15} Navigation of the existing laws relevant to foster children in emergency situations is the cornerstone to building stronger partnerships between stakeholders in localities and across state lines.\textsuperscript{16} A manual that makes laws and procedures for information sharing readily accessible, and that includes information on local and nationwide resources, such as the American Red Cross, CASA,\textsuperscript{17} the Federal Emergency Management Agency (FEMA), and the National Center for Missing and Exploited Children (NCMEC),\textsuperscript{18} will better equip stakeholders to plan for and respond to the needs of foster children in disaster situations.

A comprehensive information-sharing and emergency preparedness manual for children in foster care will be useful in \textit{all} types of disaster events impacting communities across the country. Natural disasters, terrorist attacks, and large-scale

\textsuperscript{14} Comm. on Pediatric Emergency Med., Am. Acad. of Pediatrics, \textit{The Pediatrician’s Role in Disaster Preparedness}, 99 Pediatrics 130, 130 (1997). “Children who have experienced a disaster may suffer a sense of loss (e.g., home, family, friends, pets, and possessions), sustain physical injury, and develop stress-induced problems.” \textit{Id.}

\textsuperscript{15} Children’s Bureau, U.S. Dep’t of Health and Hum. Servs., \textit{Coping With Disasters: A Guide for Child Welfare Agencies} 9 (1995), [hereinafter Guide for Child Welfare Agencies]. “For the vulnerable children and families in the child welfare system, a disaster and the increased stress it brings can seriously undermine efforts aimed at family preservation and/or permanency planning. A developed and tested child welfare disaster plan increases the likelihood that the needs of children and their families can be met during this stressful time.” \textit{Id.}

\textsuperscript{16} \textit{See Lessons Learned for Protecting Children, supra} note 2, at 2. Children could benefit from data-sharing agreements among organizations. Agreements to share data on displaced children and families could help speed efforts to locate them . . . . Standing agreements for data sharing among organizations tracking missing persons and the American Red Cross and the Federal Emergency Management Agency (FEMA) can help locate missing persons more quickly.

\textit{Id.}

\textsuperscript{17} SUSAN ORR, CHILDREN’S BUREAU, HURRICANE RELIEF CALL 2 (2005), http://www.hunter.cuny.edu/socwork/nrcfcpp. “National CASA is working with Louisiana to send volunteers to shelters throughout the country to locate children and foster families. The state is trying to make arrangements to get foster parents and children back in Louisiana.” \textit{Id.}

\textsuperscript{18} \textit{See Lessons Learned for Protecting Children, supra} note 2, at 2, 4. “Officials from National Center for Missing and Exploited Children (NCMEC) told us that both the American Red Cross and FEMA had information on the location of children in their databases, but it was difficult to obtain this information because of privacy concerns.” \textit{Id.} at 2. Therefore, “standing agreements among state child welfare officials and the American Red Cross and FEMA on data sharing and coordination could expedite recovery efforts.” \textit{Id.} at 4.
public health emergencies likely will require more interagency collaboration than typically happens on an ongoing basis. Planning to quickly open channels of information exchange among stakeholders may reduce unnecessary disruptions to children in foster care. Training conducted on the manual will strengthen collaboration and reinforce lessons while providing a forum for discussion of relevant foster children needs in an emergency.

The needs of children in foster care during Hurricane Katrina were neglected on many levels due to the lack of information sharing. These needs will be discussed in this chapter and are divided into the following categories: education, mental and physical health, social services, and personal safety. Discussion of each category will address ongoing problems experienced by children in foster care, how these problems were magnified during the disaster, and what has been suggested in various disaster after-action reports. This will be followed by a discussion of model projects that promote the sharing of children’s information among stakeholders and interagency collaboration. Finally, strategies will be suggested for the expansion of information-sharing initiatives that involve stakeholders in addressing the needs of children in foster care in disaster situations.

I. Education of Children in Foster Care

Before Hurricane Katrina, many children in foster care were easily able to enroll in school without paperwork delays under the McKinney-Vento Homeless Assistance Rights Act. Like the homeless individuals that are the focus of the McKinney-Vento Act, children in foster care frequently deal with changes in living arrangements, and the unavailability of paperwork, such as past academic reports and immunization records typically required of new students prior to school enrollment, posed problems. The McKinney-Vento Act covers “children who are awaiting foster care placement” and allows such children to enroll in school without

19. See Lessons Learned for Protecting Children, supra note 2, at 3. When Hurricane Katrina struck, Louisiana “was in the process of creating a statewide child welfare information system but did not have extensive case information in a central database.” Id. Many case files were destroyed or displaced in the storm, sometimes forcing case workers to reconstruct them from memory. Id. “[S]ome court proceedings related to adoptions and reunifications had to be delayed. Id.

20. Sarah Hudson-Plush, Improving Educational Outcomes for Children in Foster Care: Reading the McKinney-Vento Act’s “Awaiting Foster Care Placement” Provision to Include Children in Interim Foster Care Placements, 13 Cardozo J.L. & Gender 83, 83, 87 (2006). “Neither the statute nor the corresponding regulations define what it means to be ‘awaiting foster care placement.’” Id. at 83. Consequently, states are “forced—in the absence of any binding federal interpretation—to develop their own interpretation of what it means to be ‘awaiting foster care placement.’” Id. at 87.

delay, even when no records are immediately available.\textsuperscript{22} The enrollment provisions of McKinney-Vento are especially important for children in foster care displaced during disasters because they are not accompanied by their biological parents or their social workers and may have greater difficulty accessing copies of their academic and medical records.\textsuperscript{23} They may also experience multiple changes in enrollment because of foster placement changes, leading to serious consequences in their educational development and progress.\textsuperscript{24}

The educational records of children in foster care are also important for recognition by the school system of student needs for special educational services. Although parents are best positioned to make changes in school decisions for children, those in foster care may go without the benefit of their biological parents advocating for their education. Knowing who can be involved in authorizing or advocating for school placement or education decisions is important for success.\textsuperscript{25} For foster children who may have learning disabilities or require special accommodations by the school, documentation will help schools develop an individual-

\textsuperscript{22} U.S. Dep’t of Educ., School as Safety Net: Connecting Displaced Children With Educational and Support Services 12–13 (2006) available at http://www.serve.org/nche/downloads/dis_hb/school_safety_net.pdf [hereinafter School as Safety Net]. The McKinney-Vento Homeless Assistance Act gives unaccompanied youth the right to immediately enroll in school, including HeadStart programs. \textit{Id.}; See Laura Barnhardt, Homeless Group Sues Schools, BALTIMORE SUN, Apr. 27, 2006, at 4B. In Maryland, the Public Justice Center filed a class action lawsuit against Baltimore County Public Schools for violations of the McKinney-Vento Act by the routine failure to provide adequate transportation to homeless students and to identify students in need of services, and by leaving numbers of homeless students without federally mandate protections. \textit{Id.}

\textsuperscript{23} See Hudson-Plush, supra note 19, at 84. The goal of the original version of the McKinney-Vento Act passed by Congress in 1987, entitled the Stewart B. McKinney Homeless Assistance Act, was “ensuring the enrollment, attendance and success of homeless children and youth in school.” \textit{Id.}

\textsuperscript{24} See School as Safety Net, supra note 21, at 10. “Changing schools with each move would damage students’ emotional security and academic success. Generally, it takes students 4 to 6 months to recover from a change in school. And so, it is in the student’s best interest to stay at the school of origin.” \textit{Id.}; Hon. Joan Cooney et al., Attending to the Educational and Developmental Needs of Children Involved in the Child Welfare System: A Shared Responsibility, PLI/Crim. 63, 67 (2006) (citing statistics from multiple studies) (“Removal from the family, multiple moves in foster care and the attendant disruptions in school placements can result in school failure.”).

\textsuperscript{25} See Cooney, supra note 23, at 67. “If a child is placed in foster care, or changes foster care, the law guardian can ensure that the child continues to receive any necessary services and that when possible, the child remains in his/her educational placement.” \textit{Id.} at 67. Agency attorney (attorney with child welfare or a non-profit agency): “They can also work with the caseworkers to ensure they have all necessary documentation regarding the services a child is mandated to receive, and that they confirm that the child is receiving these services.” \textit{Id.}
ized education plan (IEP) to meet their needs. These plans, required by law for students whose evaluations reveal special needs, help enable a student to receive adequate academic assistance.

After Hurricanes Katrina and Rita, there were approximately 200,000 students in pre-kindergarten through twelfth grade in Louisiana public schools who were displaced. For many children in foster care, enrollment in school in the aftermath of the disaster served as a gateway to social services and health care services. Enrollment in school also helped restore the normalcy of a daily routine and offered children a connection to counseling services. In some cases, clothing

26. *Id.* at 71. ("The key document for children who receive special education services is the Individualized Education Plan (IEP). An IEP is a legally binding document that details both the services a child is mandated to receive and the setting in which the child should receive the services." (referring to the Individuals with Disabilities Education Act (IDEA), 20 U.S.C.A. § 1400 (2006), which protects the right of children with disabilities to receive free appropriate public education (FAPE), including any accommodations for special learning needs. Students who may apply are children with autism, developmental delays, emotional disturbance, mental retardation, specific learning disability, speech or language impairment, or other health impairment)); *Just Children*, *Legal Aid Justice Ctr.*, *Helping You Help Your Child: A Focus on Education* 48 (6th ed.). "The IEP specifies: what services your child will receive, where your child will receive services ('placement'), when the services will begin, how long the services will last, [and] how and when your child’s progress will be measured." *Id.*

27. *Individuals with Disabilities Education Act (IDEA), 20 U.S.C.A. § 1400 (2005).*


School services complement the services of relief agencies by providing a team of caring, nurturing professionals, who attend to a spectrum of needs: Every school district has a local homeless education liaison . . . who is a ‘first responder’ in the case of a disaster . . . Schools employ nurses, counselors, and other medical and mental health professionals who specialize in caring for children and youth. Special education staff members ensure that children with special needs receive appropriate services. Displaced children are automatically eligible for free meals. Schools can provide displaced children with clothing, shoes, school uniforms, books, backpacks, and school supplies. *Id.* They also provide support for parents. *Id.*

and school supplies were made available by the school systems where displaced children enrolled.\footnote{See Pane, supra note 27, at 61–2. In a survey of school principals conducted after the hurricanes, many reported donations of school supplies, clothing, equipment, and furniture from parents, community members, and outside organizations. \textit{Id.}} When foster families evacuated, children in foster care faced greater challenges re-enrolling in new schools and connecting to services because many did not have access to personal and other educational records.\footnote{See \textit{Lessons Learned for Protecting Children}, supra note 2, at 3.} Although some of the issues with sharing school records after Hurricane Katrina were seen as logistical and/or technological,\footnote{See \textit{Lessons Learned for Protecting Children}, supra note 2, at 5. “Mississippi student records, including academic records, were automated and made available to students’ new [school] districts.” \textit{Id.}} many more instances could be attributed to confusion over who could access foster children’s information and what information could be shared. Enrollment delays left many children out of school for long periods of time following the hurricane.\footnote{David Abramson, Nat’l Ctr. for Disaster Preparedness & Operation Assist, \textit{On the Edge: Children and Families Displaced by Hurricanes Katrina and Rita Face a Looming Medical and Mental Health Crisis} 3 (2006) [hereinafter \textit{On the Edge}]. “Over one-fifth of the school-age children who were displaced [from Hurricane Katrina] were either not in school, or had missed 10 or more days of school in the past month.” \textit{Id.; See also David Abramson et al., Nat’l Ctr. for Disaster Preparedness & the Child’s Health Fund, The Recovery Divide: Poverty and the Widening Gap Among Mississippi Children and Families Affected by Hurricane Katrina 3 (2007), available at http://www.ncdp.mailman.columbia.edu/files/The%20Recovery%20Divide_Full%20Report.pdf. “Among elementary school children six to eleven years old, 29% had missed ten or more days of school in a given month during the last quarter of the spring semester, and 41% of teenagers missed at least ten days of school in a given month during the same period.” \textit{Id.}}

From lessons learned by the enrollment of children in school after Hurricane Katrina, the Department of Education has suggested that the work of relief agencies be done in concert with local school systems to provide the best method for re-enrolling displaced children in schools.\footnote{See \textit{School as Safety Net}, supra note 21, at 10. Relief agencies can support enrollment by “helping schools and parents obtain school and medical records; assisting with any necessary immunizations; providing schools with documentation of any immunizations you provide; and providing schools with information when immunizations are unnecessary.” \textit{Id.}} They further recommend that school systems collaborate with relief agencies, particularly on-site at evacuation shelters, in order to obtain information about a child when evacuees are filling out other intake paperwork.\footnote{See id. at 20. “Allow the school district to conduct enrollment onsite at your agency, or have your staff members complete school enrollment documents as part of your standard intake process and forward them to the local liaison.” \textit{Id.}} Such emergency collaboration initiatives, together with

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31. See Pane, supra note 27, at 61–2. In a survey of school principals conducted after the hurricanes, many reported donations of school supplies, clothing, equipment, and furniture from parents, community members, and outside organizations. \textit{Id.}

32. See \textit{Lessons Learned for Protecting Children}, supra note 2, at 3.

33. See \textit{Lessons Learned for Protecting Children}, supra note 2, at 5. “Mississippi student records, including academic records, were automated and made available to students’ new [school] districts.” \textit{Id.}

34. David Abramson, Nat’l Ctr. for Disaster Preparedness & Operation Assist, \textit{On the Edge: Children and Families Displaced by Hurricanes Katrina and Rita Face a Looming Medical and Mental Health Crisis} 3 (2006) [hereinafter \textit{On the Edge}]. “Over one-fifth of the school-age children who were displaced [from Hurricane Katrina] were either not in school, or had missed 10 or more days of school in the past month.” \textit{Id.; See also David Abramson et al., Nat’l Ctr. for Disaster Preparedness & the Child’s Health Fund, The Recovery Divide: Poverty and the Widening Gap Among Mississippi Children and Families Affected by Hurricane Katrina 3 (2007), available at http://www.ncdp.mailman.columbia.edu/files/The%20Recovery%20Divide_Full%20Report.pdf. “Among elementary school children six to eleven years old, 29% had missed ten or more days of school in a given month during the last quarter of the spring semester, and 41% of teenagers missed at least ten days of school in a given month during the same period.” \textit{Id.}

35. See \textit{School as Safety Net}, supra note 21, at 10. Relief agencies can support enrollment by “helping schools and parents obtain school and medical records; assisting with any necessary immunizations; providing schools with documentation of any immunizations you provide; and providing schools with information when immunizations are unnecessary.” \textit{Id.}

36. See id. at 20. “Allow the school district to conduct enrollment onsite at your agency, or have your staff members complete school enrollment documents as part of your standard intake process and forward them to the local liaison.” \textit{Id.}
an awareness of information-sharing possibilities and limitations, will serve to streamline the post-disaster enrollment of foster children.

II. Mental and Physical Health of Children in Foster Care

Children in foster care generally face greater obstacles than other children in accessing health care for assessment and treatment of both their physical and mental health. In many cases, even if a health care provider is able to request and receive approval from social workers for access to the foster child’s files, it is unlikely that these files contain full patient care histories. This is due in large part to problems with medical record sharing for children in foster care. Inaccessibility of foster children’s past medical records creates problems for maintaining treatment regimens and continuity of care because foster children may see multiple providers as their foster placements change.

Accessing health care and receiving treatment became particularly difficult for displaced children in foster care following Hurricane Katrina. Many families did not carry copies of their own or their children’s healthcare information.

37. Laurel K. Leslie et al., Foster Care and Medicaid Managed Care, 82 Child Welfare 367, 371 (2003). Given the frequency of physical, developmental, and mental health problems in this vulnerable population, comprehensive, coordinated care is essential. For most children covered by Medicaid, this coordinating function typically falls to the parent. The child in foster care, however, lacks a single, clearly defined person to act in his or her behalf.

38. Id. at 369. Information regarding prior medical care may be unavailable when children enter foster care due to caregiver unavailability or caseworker oversight. Consent and confidentiality issues may limit the acquisition of medical records. If medical information is obtained during intake, it may not be clearly transmitted to subsequent caseworkers or foster parents. Health care providers find themselves trying to identify and treat conditions without access to the child’s medical history, including information such as immunizations, allergies, and prior medical problems. As a result, appropriate treatments may be delayed.

39. Dep’t of Health Monroe County, NY, Georgetown University Child Dev. Ctr., Foster Care Pediatrics: Meeting the Health Care Needs of Children in the Foster Care System 6 (2000). “Barriers identified to providing health care services for this population [children in foster care] include lack of access to previous medical records, issues of consent (negotiating who has the authority to sign for what), and problems when children transition (communicating with providers so that children don’t experience a disruption in services).” Id.

40. See Irwin Redlener et al., Responding to an Emerging Humanitarian Crisis in Louisiana and Mississippi: Urgent Need for a Health Care “Marshall
Especially for children in foster care, information on past enrollment and health history was more difficult to obtain. For those children in foster care who did have their Medicaid insurance card information available but were displaced to new states, many still faced difficulties locating a provider who would accept Medicaid cards. For those children who were prescribed a new medication or were in need of refills for treatment of their chronic health conditions, many were unable to receive medications because they lacked proof of Medicaid enrollment to show to pharmacies.

Caring for health needs was especially difficult for child-evacuees who presented at new clinics or hospitals out of the area and out of state. For those foster children

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41. See Leslie, supra note 37, at 371. Consent issues for medical treatment of children in foster care may be particularly difficult due to consent and confidentiality regulations, the child in foster care may lack a single ‘surrogate parent’ or care coordinator who can act in his or her behalf for all health care issues. For example, although foster parent consent is sufficient for most medical treatments, birthparent consent may be necessary to receive certain treatments, such as psychotropic medicines. Consent may be obtained through the court system, but, this process can be slow and delay necessary services. In addition, both Medicaid and child welfare zealously safeguard information regarding clients and may have different policies regarding the release of information, complicating data sharing between agencies and providers.

42. See Lessons Learned for Protecting Children, supra note 2, at 4. “Many foster families who were living out of state faced problems finding providers to accept their Medicaid card for mental health services and medication.” Id.

43. David E. Thomas et al., Baton Rouge Pediatricians’ Experiences Meeting the Health Needs of Evacuated Children, 117 Pediatrics S396, S399 (2006). Pediatricians involved in the response to Hurricane Katrina found local pharmacies were unable to fill prescriptions as patients lacked Medicaid or other insurance identification. Id.; Barbara Rath et al., Adverse Health Outcomes After Hurricane Katrina Among Children and Adolescents with Chronic Conditions, 18 J. Health Care for the Poor & Underserved 405, 407–08 (2007). In a cohort study of 531 individuals aged 0 to 24 years, 33.9 percent of the cohort with pre-existing chronic health conditions ran out of medications following the Hurricane Katrina disaster. Id.


The inevitability of regionalization [of care] has serious implications for disaster management. This related not only to the increased geographic distance that must be traversed to manage care needs but also to the associated need for interstate coordination between health care providers and state governmental agencies to accomplish such regional
who were able to access clinical care after Hurricane Katrina, many pediatricians had difficulty treating conditions the medical history of which they had no knowledge.\footnote{See Abramson, supra note 34, at 1–2. In a study of 665 randomly selected households in FEMA-subsidized housing units, 34 percent of the children had at least one diagnosed chronic health condition. Id. A number of parents reported that they had a child who was either hospitalized or required repeated visits to the emergency room for acute asthmatic episodes because they could not get their child’s asthmatic medications. The reasons cited included the loss of medical records, lack of insurance coverage accepted at local pharmacies, inability to get to pharmacies, and medical providers who would not prescribe the medications because they were unfamiliar with the child’s past medical history. Id.}

Hurricane Katrina also brought about an increased demand for mental and physical health care for children in communities impacted by the disaster.\footnote{See Rath et al., supra note 43, at 409. In a study conducted of 531 individuals aged 0 to 24 years, 47.1 percent visited a clinic or an emergency department after Hurricane Katrina for a new health problem, while 41.1 percent missed regularly scheduled appointments with a physician due to the hurricane. Id.}

For instance, a pediatric mental health study conducted of elementary school students in Orleans Parish by Louisiana State University following Hurricane Katrina showed a significantly higher prevalence of mental health conditions in the children surveyed.\footnote{Joy D. Osofsky et al., Katrina’s Children: Social Policy Considerations for Children in Disasters, 21 SOC. POL’Y REP. 1, 6 (2007), available at http://www.srcd.org/documents/publications/spr/21-1_katrina_children.pdf. The Trauma Team of mental health professionals from Louisiana State University Health Science Center, reported from their work with children post-Katrina that “almost one half of the 4th to 12th grade students and over one quarter of younger children met . . . criteria for mental health services, based on the number and severity of their behavioral symptoms.” Id. at 1. Osofsky’s study was conducted on a study population of 2,192 children in the 4th–12th grades in Orleans Parish. Id. at 6. Assessments of these children were conducted using the National Child Traumatic Stress Network Screening Instrument. Id. at 6.}

Pediatric health care providers also reported increased prevalence of disaster-related illness in their patients.\footnote{O. W. “Skip” Brown, Hurricane Katrina Experiences: Receiving Patients in Longview, Texas, 350 Miles From Ground Zero, 117 PEDIATRICS S439, S440 (2006). “We began to see more children with exacerbations of their asthma, lower respiratory infections, methicillin-resistant \textit{Staphylococcus aureus} infections, otitis and pharyngitis, immersion wounds, rashes, and a very aggressive gastroenteritis.” Id.; See Rath et al., supra note 43, at 406. “Disaster survivors with pre-existing chronic conditions may be particularly vuln-}
to pediatric specialty services became even more difficult to obtain. For these children, reliance on specialized health care needs meant that availability of health information to properly treat their conditions was critical to effective treatment. 49

In after-action reports of pediatric providers involved in disaster response, an expansion of their role beyond that of clinical provider was suggested. 50 In light of their importance as stakeholders for children in foster care, they are perhaps best positioned to provide education to foster families about many emergency preparedness issues. 51 For example, in response to identified needs for availability of medical information, the American Academy of Pediatrics (AAP) has created tools for parent preparedness such as the AAP’s Emergency Information Form for Children with Special Needs that includes the name of the pediatric patient, contact information and signature for consent, physicians’ contact information, past pertinent medical history, medical management data, immunizations, and common symptoms with specific care-management suggestions. 52 Use of this form as a standardized tool to facilitate availability of pediatric patient history could serve to improve care, particularly to children in foster care.

In addition to information sharing, collaboration in emergencies is also a critical component to linking foster children to proper health services. In a study of the health problems experienced by Louisiana’s displaced children and families, research identified breakdowns in systems for: “1) access to care, 2) availability of ongoing primary, mental health and dental care, 3) assurance of continuity of care, and 4) ability of the schools to reach out and engage students and their families.” 53 Improving the channels for obtaining medical information and strengthening stakeholder partnership has been shown by the Hurricane Katrina disaster to be urgently needed for the provision of adequate mental and physical health care to children in foster care.

49. AM. ACAD. OF PEDIATRICS, CHILDREN, TERRORISM & DISASTERS TOOLKIT, THE YOUNGEST VICTIMS: DISASTER PREPAREDNESS TO MEET CHILDREN’S NEEDS 1 (2002), available at http://www.aap.org/terrorism/topics/PhysiciansSheet.pdf. Children have unique treatment needs including different dosages of medications, different sized medical equipment, and special considerations for decontamination efforts. Id.


51. Id. at S459. “Pediatricians and other providers need to educate families on many aspects of disaster planning. . . . Pediatricians can help by advising families directly or providing information with respect to available resources, online or otherwise.” Id.


53. ON THE EDGE, supra note 34, at 5.
III. Social Services for Children in Foster Care

Once children are placed in foster care, the child welfare system stands as their legal guardians. Caseworkers in the child welfare system follow children from their initial entry into protective custody and placement in foster care, through the court’s foster care review process, to the child’s ultimate return to parental custody, adoption, or aging out of the system. During this time, the child welfare agency maintains records on the child in foster care. Child welfare agencies are therefore best positioned to provide information to other child welfare agencies in areas from which a child has been evacuated.

After Hurricane Katrina, the ability of child welfare agencies to share information on children in foster care for the purposes of finding children, obtaining their personal data, or tracking their case progression was made difficult to impossible. Social services were faced with the overwhelming task of tracking displaced families while communication systems were down and files were lost. Meanwhile, they still had new cases to investigate, arising from the aftermath of the hurricane.


55. Mary O’Brien et al., Nat’l Child Welfare Res. Ctr. for Org. Improvement, Coping with Disasters and Strengthening Systems: A Framework for Child Welfare Agencies 31 (2007). In assessing and responding to client needs, a welfare agency should consider “[c]oordinat[ing] with other systems that have child and family location information.” Id. An agency should “[p]rovide information, support, and services for these families, and coordinate services with other agencies” during a disaster. Id. An agency should also coordinate with courts and “[w]ork towards integrated information systems, so the agency and courts share appropriate case level information.” Id. at 18.

56. Daniel D. Broughton et al., Reuniting Fractured Families After a Disaster: The Role of the National Center for Missing & Exploited Children, 117 PEDIATRICS S442, S442–43 (2006). The National Center for Missing & Exploited Children found that oftentimes “children were separated from parents, caretakers, or other loved ones as they moved from their homes, to the Louisiana Superdome, to the Reliant Astrodome, and elsewhere. Records were sparse or nonexistent. Because communication systems were compromised, the nation suddenly was faced with an acute disaster-related missing children crisis.” Id.

57. See Lessons Learned for Protecting Children, supra note 2, at 3. “Social workers recreated case files from memory and other documentation because close to 300 current case files had been destroyed and even more were inaccessible.” Id.
and community mental health issues. Social worker caseloads for investigations of abuse were already high before the hurricane, and the follow-up necessary after Katrina created an increased workload at the same time that many social workers were themselves displaced. Just when children in foster care needed help from caseworkers the most, these caseworkers needed greater infrastructural capabilities and help from the other stakeholders.

Many of the problems with information sharing for children in foster care are ongoing. Disasters exacerbate these problems on a larger scale. Displacement of children in foster care after a disaster such as Hurricane Katrina makes the scope of the problem much worse and calls for greater levels of collaboration because of the number of children involved and the diversity of agencies across county and state lines. Planning efforts raise concerns about investment of child welfare agency resources already overtaxed by heavy caseloads and funding issues. Efforts that not only address emergency preparedness issues but that also are useful on an ongoing basis ensure an efficiency of resources, even if a disaster never strikes a particular area. In a Government Accountability Office (GAO) report on the

58. See id. at 4. “In addition, heightened levels of stress can increase the likelihood of abuse or neglect, which can increase the need for child protective services and foster parents. In some cases, foster parents were unable to cope with the effects of the storm and returned children to the child welfare agency.” Id.

59. See id. at 3. “Prior to the hurricanes, approximately 1,885 families were under investigation for abuse and neglect, and 364 were receiving family services in the affected areas.” Id. An additional hurdle to finding displaced foster children was that “about 640 of the state’s social workers were also initially displaced from the heavily affected communities.” Id.


State challenges in serving the children and families in the child welfare system are long-standing and continuing. Resolving these problems has been difficult, however, in part due to the child welfare system’s heavy reliance on various non-dedicated funding streams at the federal and state levels that require an interagency approach to establish appropriate priority and funding for child welfare families across different programs and populations. ... [C]aseworkers sometimes were unaware of the full array of federal resources ... available in their locale or had not coordinated with other agencies to use them.

61. Id. at 23. In a survey of disaster planning for child welfare system systems across the United States, “21 states in all reported having a disaster plan in place, ... but few states had included strategies for placing children from other states.” Id.


Fortunately, many of the steps agencies might take to prepare for disasters can also strengthen systems critical to ongoing agency management.
child welfare system’s response to disaster, recommendations for executive action include coordinating services and sharing information with other states.63

IV. Personal Safety for Children in Foster Care

In recognition of emergency preparedness for children in foster care, some states’ child welfare systems have provided guidance to foster families and foster care stakeholders on personal safety issues and emergency-action steps. For example, Florida State Social Services maintains a toll-free number with a procedure for foster parent call-in if a disaster strikes.64 All foster parents also are required to have a disaster plan in place that is shared with the social worker.65 California uses a standardized form called the Emergency Plan for Foster Family Homes.66 It includes information on emergency contacts, local resource numbers, home evacuation, utility shut-off, and the location of any emergency equipment.67 In Missouri, each foster parent must have (1) a list of local facilities where they could find temporary lodging in a disaster; (2) an emergency communication plan with written protocol on using the emergency toll-free number, including who will contact the birth parents and how, how often foster parents will check in, and documentation; (3) an evacuation plan with a designated meeting place for the family; and (4) a disaster kit including “special needs” items.68 The Alaska Center for Resource Families has designed a guidebook

For example, an agency may need to enhance automated information systems to enable staff to access case information from any location during a disaster—but more accessible automated systems could also improve the agency’s success in managing cases on a day-to-day basis.

Id.

63. See Federal Action Needed, supra note 11, at 3. In a GAO report on the child welfare system’s response to disaster, recommendations for executive action include “preserving child welfare records, identifying children who may be dispersed, identifying new child welfare cases and providing services, coordinating services and sharing information with other states, and placing children from other states.” Id.

64. Hurricane and Disaster Foster Care Communication Procedures, Foster Fam. Update (P’ship for Strong Families, Gainsville, Fla.), Aug. 2005, at 1. Partnership for Strong Families (PSF) has created a toll-free phone number for foster parents to call both before and after a disaster to report their status. Id. If foster parents do not call the number after a disaster, a PSF representative will contact the parents to verify the status of the parents and child(ren). Id.

65. Id. at 1. Foster parents are asked to share their personal disaster plans with a PSF representative before a disaster. Id.


67. Id.

and training course to introduce foster parents to state regulations on fire safety, first aid, and emergency preparedness.69 The guidebook includes relevant sections of the Alaska statutes,70 along with safety tips and emergency preparedness guidance.

Although personal safety is an ongoing concern for children in foster care, it becomes particularly important during emergencies. Among the total 2,300 foster children displaced from Louisiana by Hurricane Katrina, as many as 158 went missing in the chaos that followed.71 Limited availability of emergency contact information and the lack of copies of evacuation plans from foster families made efforts by social workers difficult.72 Tracking foster families and maintaining contact with social services proved problematic.73 Louisiana set up a telephone hotline for foster parents for tracking purposes, but the line was only staffed from 7 a.m. to 7 p.m.74 Meanwhile, as Louisiana set up databases to track the whereabouts of children, so did FEMA, the Red Cross,75 NCMEC,76 and the Federal Bureau of Investigation,77 leading in some instances to redundant efforts.


71. See URGENT NEED, supra note 40, at 1. National Public Radio reported more than 2,300 foster children were displaced in Louisiana due to the hurricane. Id. One month later, 158 children remained unaccounted for. Id.

72. See LESSONS LEARNED FOR PROTECTING CHILDREN, supra note 2, at 3. After the hurricane, Louisiana officials faced difficulties contacting foster parents both because of sparse emergency contact information and limited accessibility to displaced case records. Id.

73. See id. at 4. Problems were seen in tracking foster families who evacuated. Id. Recommendations include use of updated "emergency contact information and automated case file systems [to] help locate and serve foster children more quickly." Id.

74. See Orr, supra note 17, at 2. "National CASA [Court Appointed Special Advocates] is working with the [sic] Louisiana to send volunteers to shelters throughout the country to locate children and foster families." Id. The state established an 800 number operating from 7 a.m. to 7 p.m. and, as of September 9, 2005, was in the process of establishing a database to track children in Texas, Tennessee, and Georgia. Id.

75. See LESSONS LEARNED FOR PROTECTING CHILDREN, supra note 2, at 2. "Standing agreements for data sharing among organizations tracking missing persons and the American Red Cross and the Federal Emergency Management Agency (FEMA) can help locate missing persons more quickly." Id.

76. See Broughton, supra note 56, at S443. "[NCMEC] went into the shelters, took photographs of the children, and worked with state and local law enforcement, social service personnel, the state missing children’s clearinghouses, and every other possible resource." Id.

77. See id. "When there was enough information on the missing child, it was entered into the Federal Bureau of Investigation’s (FBI’s) National Crime Information Center miss-
The GAO Report on Federal Action Needed to Protect Children Displaced by Disasters suggests that foster families and stakeholders familiar with an available toll-free number would be more likely to access it in an emergency situation. The National Child Welfare Resource Center for Organizational Improvement advocates for preparation for child welfare before a disaster that includes creating a plan, preparing to manage, and enhancing critical infrastructure. The GAO also recommends that emergency planning for foster families be included in licensure. For disaster preparedness, needs include “establish[ing] liaisons with other States to coordinate services and share information [and] build[ing] collaborations with other relevant State agencies and programs.” For nonsocial service agencies working directly with child safety, such as the National Center for Missing and Exploited Children (NCMEC), interagency collaboration also has been identified as a key component for locating and identifying missing children in foster care.

Safety information from various agency perspectives should be integrated into a resource list with guidance on how stakeholders can prepare for a similar disaster situation in the future. This information could include: the Louisiana Department

78. GAO Report; See also O’Brien, United States Gov’t Accountability Office, Federal Action Needed to Ensure States Have Plans to Safeguard Children in the Child Welfare System Displaced by Disasters. No. GAO-06-944 (2006); See also O’Brien et al., supra note 55 at 30.

79. See id.

80. See id. at 27. The National Child Welfare Resource Center for Organization Improvement suggests child welfare agencies provide foster families with emergency preparedness training, including information on creating effective disaster plans, as a requirement of foster care licensure. Id. Such emergency preparedness information may include preparing and updating disaster plans, contacting child welfare agencies, packing essential documents (identification, citizenship, medical information, court, educational records) for the child in the event of an evacuation, and creating a disaster supply kit. Id.

81. See id. at 29.

82. Nat’l Ctr. for Missing & Exploited Child., Recovery and Reunification of Missing Children: A Team Approach 1, 3 (Kathryn M. Turman, 1995). Developing a multi-agency reunification team may present special challenges due to limited availability of training and educational materials focusing on missing children and their families. Agencies may be unclear about the needs of these children as well as how to respond to them. Effective communication and cooperation with law enforcement on missing child cases does not exist in many communities.

83. See Lessons Learned for Protecting Children, supra note 2, at 4. “Future state disaster plans should include evacuation information and instructions for foster parents and social workers. Louisiana is in the process of conducting foster parent emergency preparedness courses.” Id.
of Social Services, who dealt firsthand with the needs of children in foster care and their families during Hurricane Katrina; the AAP,\textsuperscript{84} whose physician-members became intimately familiar with children’s healthcare needs in Hurricane Katrina; and the National Center for Missing and Exploited Children,\textsuperscript{85} who worked directly in tracking missing children.

\section*{V. Information Sharing and Interagency Collaboration Initiatives to Address Education, Health, Social Services, and Safety Issues}

Even on a day-to-day basis, there is confusion over who is authorized to share information on children in foster care.\textsuperscript{86} Navigating the law in this area complicates processes that may involve many stakeholders, leading to delays in services and disconnection among various care providers.\textsuperscript{87} Although federal laws that govern information sharing concerning children such as FERPA\textsuperscript{88} (for education records)

\begin{itemize}
\item \textsuperscript{84} \textit{See} Johnston & Redlener, supra note 50, at S459.
  Many authors reported a lack of any medical information, much less credible medical or mediation history, on patients for whom they were caring. Although there are efforts to fill this gap with an electronic medical chart, there is a need for patients to be better educated and to have some record with them. Children with special health care needs are a readily identifiable target group that should have emergency information. \textit{Id.}

\item \textsuperscript{85} \textit{See} Broughton, supra note 56, at S445. The National Center for Missing & Exploited Children advises families to have emergency plans for where to go and how to reconnect with each other in case a disaster of any kind occurs. \textit{Id}. Parents are also encouraged to always keep current photographs of their children with them and to provide their children with an ID that includes descriptive information and, if possible, a photograph. \textit{Id.}

\item \textsuperscript{86} \textit{See} Cooney, supra note 24, at 72. “One of the greatest obstacles to children in foster care receiving appropriate services involves confusion over who is legally entitled to consent for evaluations and services.” \textit{Id.}

\item \textsuperscript{87} Lynda E. Frost et al., Hogg Found. for Mental Health, Information Sharing & Confidentiality 2, http://www.hogg.utexas.edu/programs_InfoShare.html (last visited Aug. 21, 2007).

\item \textsuperscript{88} Family Educational Rights and Privacy Act [FERPA], 20 U.S.C.A. § 1232g (2002) (binding obligation for all schools receiving federal funds to protect privacy of student education records).
\end{itemize}
and HIPAA\textsuperscript{89} (for medical records) apply to all states, each state has different legal requirements with which stakeholders must be familiar to legally share foster children’s school files with various service providers.\textsuperscript{90}

In recognition of the need for information sharing, initiatives such as the Justice Management Institute’s National Curriculum for Caseflow Management in Juvenile Dependency Cases Involving Foster Care, have made efforts to address ongoing collaboration issues in foster care cases by bringing stakeholders together to participate in training and discuss how to make information sharing more efficient.\textsuperscript{91}

For the handling of juvenile cases, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the Department of Justice funded juvenile information-sharing training sessions conducted across the country. The joint training sessions included review and discussion of confidentiality practices, privacy protections, and federal and state confidentiality laws relevant to stakeholders in juvenile justice.\textsuperscript{92} One of the goals of the training sessions was to generate strategies for improved information sharing practices for these stakeholders to deal more effectively with the multitude of juvenile records.\textsuperscript{93}


\textsuperscript{90} See FERPA, supra note 88 (giving states the authority to determine who may make educational decisions on behalf of a child, so long as states do so in a manner consistent with federal statutes); see also Office of Juv. Just. & Delinquency Prevention, State Statutes on Juvenile Interagency Information & Record Sharing, available at http://dept.fvtc.edu/ojjdp/states.htm (last visited Sept. 5, 2007) (listing each state’s juvenile agency records provisions).

\textsuperscript{91} Nancy Salyers et al., Justice Mgmt. Inst., A National Curriculum for Caseflow Management in Juvenile Dependency Cases Involving Foster Care 5, 41 (2005). Groups analyze and evaluate their existing caseflow management systems and create diagrams on key events and activities associated with processing. Id. at 5. Participants are asked to relate the specific items of data that influence critical decision points in case analysis, and “any current statutory, policy, procedural, or practice limitation on the ability to share the data with other members of the team on an ongoing basis.” Id. at 41.

\textsuperscript{92} Office of Juv. Just. and Delinquency Prevention, Dep’t of Just., Guidelines for Juvenile Information Sharing 2 (2006) [hereinafter GUIDELINES FOR JUV. INFO. SHARING]. “One-hundred-seven (107) teams of youth service agencies from state and local jurisdictions across the country participated in JIS [Juvenile Information Sharing] trainings, including: judges and court administrators, law enforcement, probation and parole officers, defense attorneys, prosecutors, school administrators, technology staff, child welfare administrators and case workers, government officials, state juvenile justice system specialists . . . juvenile corrections administrators and staff, pro-social service providers, family advocates, substance abuse treatment counselors.” Id.

\textsuperscript{93} Id. at 3. Examples of juvenile information-sharing records include child welfare records, substance abuse treatment records, runaway and homeless youth records,
The Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the Virginia Department of Criminal Justice Services and the University of Virginia’s Institute for Law, Psychiatry, and Public Policy funded one such project. The project began with a study of local service providers and their information-sharing practices and investigated the impact of agency culture and policies on juvenile information-sharing practices. Dr. Lynda Frost subsequently developed a Juvenile Records and Information Sharing manual—a user-friendly reference guide to federal and Virginia state law, practice, and procedure related to juvenile records and information sharing. It includes sections on education records, juvenile justice records, law enforcement records, juvenile court records, social service records, medical records, mental health treatment records, substance abuse treatment records, and appendices on the Code of Virginia and Federal Statutes and Regulations. Beginning in 2001, Dr. Frost hosted a number of trainings for juvenile justice stakeholders across the state based on this manual. In the trainings, participants used the manual to work through practical scenarios and identify the parameters of appropriate information sharing. The training concluded with a discussion of local best practices and formulation of an action plan.

In Washington, funding from Casey Family Programs was used to support an information-sharing project specifically for children in foster care. The project, entitled *Helping Foster Children Achieve Educational Stability and Success, A Field Guide for Information Sharing*, included information on federal laws (FERPA) mental health records, public records acts, juvenile court and juvenile probation records, child protection records, prosecution records, law enforcement records, public education records, Medicaid records, interstate compact records, federal youth offender records, self-sufficiency program records, and medical and behavioral health records.

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94. See Guidelines for Juv. Info. Sharing, supra note 92, at 1. The Department of Justice Office of Juvenile Justice and Delinquency Prevention initiatives funded training exercises that brought interagency stakeholders together to facilitate more efficient access to data and information, to build collaborations, and to develop and agree on confidentiality practices. Id.


96. See Frost, supra note 10, at 1 (acknowledging research contributions and examples research funded by OJJDP’s Information Sharing Advisory Committee).

97. Id.


and HIPAA\textsuperscript{100} and Washington state laws.\textsuperscript{101} The field guide also included an overview of information-sharing laws, a “player’s guide,” a decision making tree, an outline of laws on information sharing with outlines specific to parents, CASAs and GALs, social workers, school staff and educators, relative and licensed caregivers, and resources.\textsuperscript{102} Sections of the guide were formatted in flow charts and included a quick-reference grid for givers and receivers of information.\textsuperscript{103}


Although some initiatives have undertaken to facilitate interagency collaboration and information-sharing initiatives, there are still many unaddressed needs that delay service delivery to children in foster care. During disaster situations, these service delivery problems are exacerbated on a larger scale, leading to further disruption and disconnection for displaced foster children. Investigation by the GAO has identified information sharing and emergency coordination as major priorities for the child welfare system to better prepare for disaster situations.\textsuperscript{104} Training and working together ahead of time to anticipate challenges that stakeholders will face in responding to the needs of children in foster care during a disaster will lead to a more coordinated response.\textsuperscript{105} Questions such as who will collect information,
how it will be collected and stored, and how it will be shared, can be answered ahead of time. This will serve to avoid unnecessary delays and get stakeholder groups immediately in place to work in the most effective capacity. Understanding the roles of various stakeholders, and those who may become involved as stakeholders, in a disaster situation will make clear who has a legitimate interest in foster children and the legality of sharing records and information concerning a particular child.

To best achieve information-sharing goals in a disaster, initiatives used on an ongoing basis can be looked to as models on which to build. Adding to information-sharing manuals or field guides geared toward improving the navigation of federal and state information-sharing laws, with information on how laws change in an emergency situation and a delineation of the various roles of agencies involved with children in foster care (like in the Player’s Guide within the Washington State Information Sharing Field Guide) and disaster response is important for coordination and communication in a disaster.

what foster families should do in emergencies, who should be contacted if a Department of Social Services office is closed, hotlines used by staff and clients, extra support dealing with the stresses of disaster (i.e., referrals to the National Foster Parent Association, Louisiana Foster Parent Association’s Advocacy Support Team, and Office of Child Services Placement Support Services), Medicaid card use, Red Cross resources available for clothing, and the extension of Placement and Special Board Authorizations to ensure foster children’s board payments are made. Id. at 4–10.


107. See Lessons Learned for Protecting Children, supra note 2, at 2. Officials from NCMEC told us that both the American Red Cross and FEMA had information on the location of children in their databases, but it was difficult to obtain this information because of privacy concerns. NCMEC signed memorandums of understanding with both organizations, but the negotiations and review process to complete these memorandums slowed efforts to locate the children. The U.S. Postal Service made data available to NCMEC to help find missing children. Id.

108. See Nat’l Ctr. for State Courts, supra note 106, at 10–11. A disaster may bring new stakeholders into the child protection system. Id. “When disaster strikes an area, volunteers from many fields come to the disaster area to lend their skills and expertise to the relief effort.” Id. at 11.

109. See Frost, supra note 87, at 2. “Most confidentiality laws include exceptions for agencies and other entities that have a ‘legitimate interest’ in obtaining information contained in confidential records.” Id.

110. See School as Safety Net, supra note 22, at 16. “Schools and relief agencies agree that inadequate communication between the agencies and the schools is a significant barrier to getting displaced students into school and keeping them there.” Id.
Additionally, stakeholder involvement in preplanning for information-sharing needs in a disaster will lead to clear procedures on, and formats for, how information will be collected and disseminated. For instance, after-action reports of workers involved with children in foster care displaced by disasters suggest that authorization to share information could be given at the time a foster family enters a disaster shelter in order to make medical and education records more easily accessible. Such model orders have been drafted by some state child welfare systems similar to those drafted by CASA for Washington State Social Services.

Other agencies involved in disaster response, such as health centers in the gulf states, the AAP, and the NCMEC, have also made recommendations that could

111. **Stephanie Delaney**, *Protecting Children from Sexual Exploitation & Sexual Violence in Disaster & Emergency Situations, A Guide for Local & Community Based Organisations* 67 (ECPAT Int’l 2006), available at [http://www.ecpat.net/eng/pdf/Protecting_Children_from_CSEC_in_Disaster.pdf](http://www.ecpat.net/eng/pdf/Protecting_Children_from_CSEC_in_Disaster.pdf). In responding to unaccompanied and separated children, [all] agencies should use a common format for data collection to ensure ease of information sharing, but measures should be in place to ensure confidentiality is maintained. Retaining some key information (such as particular identification signs such as scars or a preferred toy) within the organisation and using it as a means of verification with claiming parents/relatives provides a useful counter check.


112. *See School as Safety Net*, supra note 22, at 19. “[M]any shelters have incorporated a release of information into their standard intake documentation to allow shelter staff to share with local liaisons the names and ages of school-aged children and youth staying in the shelter or receiving other assistance.” *Id.* Consequently, these shelters can share information with schools without violating the Family Educational Rights and Privacy Act. *Id.*


114. *See Rath et al.*, supra note 43, at 414–15. Preparedness measures (such as evacuation medication packs, immunization registries that are readily transferable to other locations, and paperless medical records) may have helped to limit negative health outcomes at the time of simultaneous displacement of chronically ill patients, their families, and their regular health care providers. Clearly defined disaster preparedness plans for children and adolescents with chronic conditions may be able to reduce disruptions of care during disaster. *Id.*

115. *See Nat’l Ctr. for Missing & Exploited Child.*, supra note 82, at 4–5. Recommendations for a team approach to reunification include “improv[ing] communication
be included into an emergency collaboration segment of a manual designed to address the needs of children in foster care during disasters. Inclusion of these suggestions as lessons learned from stakeholders involved in Hurricane Katrina might ensure that considerations are made for all aspects of service provision to children in foster care, from education and health care to social services and personal safety matters.

Assistant Secretary for the Office of Community Services for the Louisiana Department of Social Services Marketa Garner Gatreau, in discussing changes that have come about after Hurricane Katrina, highlighted an obstacle that is shared by many agencies across the country when she stated, “No child welfare system ever has enough money to do what it needs to do.” Disaster planning efforts that facilitate emergency preparedness while at the same time support ongoing operations are an investment of money and time that will have immediate results. Funding opportunities for such disaster planning efforts may become more widely available as child welfare disaster planning becomes a mandatory part of state emergency-preparedness efforts.

As of 2005, there are over a half-million children in the foster care system in the United States. The status of children in foster care as a vulnerable population make it all the more important that they be connected to educational, health, and social services, and that their personal safety needs are taken into account in disaster situations. With the ever-growing risk of future natural and man-made...
disasters and public health emergencies, the importance of coordination and emergency planning becomes more significant. The consequence of failing to plan for information sharing and collaboration will prove especially harmful for children in foster care. A manual that clarifies how information will be shared and disseminates agency resource information will address many of the problems that were faced by foster child-evacuees as a result of Hurricane Katrina. Training on a manual of this sort that brings together foster care stakeholders will connect people and elucidate issues relevant to emergency planning to ensure other children in foster care are better protected in the future.

Id.; Goldman et al., Off. on Child Abuse & Neglect, U.S. Dept. of Health & Hum. Services, A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice 32–33 (2003), available at http://www.childwelfare.gov/can/factors. Although children are not responsible for the abuse inflicted upon them, certain child characteristics have been found to increase the risk or potential for maltreatment. Id. Common child risk factors for child abuse and neglect include: physical/cognitive/emotional disability, chronic or serious illnesses, child aggression, behavior problems, attention deficits. Id.

120. See Federal Action Needed, supra note 11, at 30. “Without disaster plans, these states may be unprepared to provide continuity of services for children and families who have been dispersed to or from other counties in the state or across state lines.” Id.