Resource Guide for Access & Functional Needs (AFN) of Children & Youth in Disaster Planning

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OKLAHOMA
State Department
of Health

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1.0 Introduction

Children (0-18 years of age) are a highly vulnerable segment of the population in times of disaster. Children in this age category comprise nearly 25 percent of the U.S. population and have important and often complex planning and emergency response needs. Under normal conditions, there are components at the governmental, private and non-profit level which together form the networks on which children depend to support their development and protect them from harm. In addition to these systems, children fall under the supervision of their parents, guardians and/or primary caregivers. Once a disaster occurs, however, most or all of these foundations in a child's life may suddenly collapse.

The childcare centers and schools to which they were enrolled may be damaged, destroyed or used for shelters. Their parents or guardians may be stretched between caring for the needs of their children and addressing the needs of the whole family's recovery. The child victims, who are generally incapable of managing their own needs, can suffer disproportionately and fall behind their peers in development, and education. Additionally, the physical and psychological damage sustained by children can far outweigh the same effects inflicted on fully-grown members of society, often requiring years of physical, psychological, and other therapeutic treatments to address.

1.1 At-Risk Individuals

At-risk individuals are people with access and functional needs that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. Irrespective of specific diagnosis, status, or label, the terms "access and functional needs" are defined as follows:

1.2 Access-based needs

All people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on.

1.3 Function-based needs

Function-based needs refer to restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency.

The 2013 Pandemic and All-Hazards Preparedness Reauthorization Act defines at-risk individuals as children, older adults, pregnant women, and individuals who may need additional response assistance. Examples of these populations may include but are not limited to individuals with disabilities, individuals who live in institutional settings, individuals from diverse cultures,

individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals experiencing homelessness, individuals who have chronic medical disorders, and individuals who have pharmacological dependency.

1.4 Functional Disabilities

The Centers for Disease Control and Prevention reports that 61 million adults in the United States live with a disability.

- 26 percent (one in 4) of adults in the United States have some type of disability. Graphic of the United States.
- The percentage of people living with disabilities is highest in the South.

1.41 Percentage of adults with functional disability types:

- 13.7 percent of people with a disability have a mobility disability with serious difficulty walking or climbing stairs.
- 10.8 percent of people with a disability have a cognition disability with serious difficulty concentrating, remembering or making decisions.
- 6.8 percent of people with a disability have an independent living disability with difficulty doing errands alone.
- 5.9 percent of people with a disability are deaf or have serious difficulty hearing
- 4.6 percent of people with a disability have a vision disability with blindness or serious difficulty seeing even when wearing glasses.
- 3.6 percent of people with a disability have a self-care disability with difficulty dressing or bathing.

Disability is especially common in these groups, older adults, women and minorities.

- 2 in 5 adults age 65 years and older have a disability
- 1 in 4 women have a disability.
- 2 in 5 non-Hispanic American Indians/ Alaska Natives have a disability.

This information can be found at CDC website: https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html#:~:text=61%20million%20adults%20in%20the,Graphic%20of%20the%20United%20States.

1.5 Access and Functional Needs Populations – Defined

Numerous states have embraced the term “access and functional needs (AFN)” to include the following: people with disabilities, senior citizens, the Deaf community, children, non-English speaking populations, and people without transportation. These groups represent a large and complex variety of specific concerns and challenges for emergency responders and planners. Many of these groups have little in common, but given the definition, it is conceivable that “access and functional needs” could cover at least 50% of the nation’s population rendering the term rather meaningless[1], especially in emergency planning. However, the term is used to assist emergency managers and planners with guidelines for emergency planning and education for their state and county populations.

Although, terminology continues to evolve, Oklahoma State Department of Health (OSDH) will use the collective term “access and functional needs” to describe populations that need “functional support assistance” and “access” before, during, and after emergency situations. The term “access and functional needs (AFN)” is more descriptive of the “assistance requirement” by these individuals for independent living and during occurrences of natural, human-caused, or technological disasters.

Emergency Operations Plans (EOPs) to specifically include the AFN populations. This change in focus facilitates a more effective “whole community” approach to emergency planning efforts. This concept is also consistent with language contained in the National Response Framework (NRF). The concept of Communication, Medical Care, Independence, Supervision, and Transportation (C-MIST) is defined as the different functions of whole community planning. The concept of C-MIST has changed over the years. These changes are more encompassing for whole community response and whole community planning. C-MIST contains the following functions:

1.6 C-Mist

C-Mist functions assist in the care of access and functional needs (AFN) populations planning for disaster preparedness, response, and recovery.

1.6.1 Communication

Individuals who speak sign language, who have LEP, or who have limited ability to speak, see, or hear. People with communication needs may have limited ability to hear announcements, see signs, understand messages, or verbalize their concerns.

1.6.2 Maintaining Health

Individuals who require specific medications, supplies, services, DME, electricity for life maintaining equipment, breastfeeding and infant/child care,

or nutrition, etc. Planning to maintain chronic health conditions, minimize preventable medical conditions, and avoid worsening of health status is important in the event of an emergency.

1.6.3 Independence

Individuals who function independently with assistance from mobility devices or assistive technology, vision and communication aids, services animals, etc. Independence is the outcome of ensuring that a person's access and functional needs are addressed as long as they are not separated from their devices, assistive technology, service animals, etc.

1.6.4 Safety & Support

Individuals who become separated from caregivers may need additional personal care assistance; experience higher levels of distress and need support for anxiety, psychological, or behavioral health needs; or require a trauma-informed approach or support for personal safety.

1.6.5 Transportation

Individuals who lack access to personal transportation, are unable to drive due to decreased or impaired mobility that may come with age and/or disability, temporary conditions, injury, or legal restriction. Emergencies can significantly reduce transportation options, inhibiting individuals from accessing services and staying connected.

2.0 Maternal-Child Health

The purpose to include Maternal-Child Health in this document is to be more inclusive in emergency planning, response, and recovery. People who are pregnant are included in the AFN communities. However, many emergency managers or emergency planners develop/ or include emergency plans to fit their unique access and functional needs.

Including Maternal-Child health brings the whole concept of emergency planning full circle. The U.S. Department of Health and Human Services (HHS) Maternal-Child Health (MCH) Emergency Planning tool-kit was developed to improve the capacity of health care, public health, and social services providers to address maternal and child health in emergency preparedness, response, recovery, and mitigation activities. This tool-kit can be found https://www.phe.gov/Preparedness/planning/abc/mch-planning-toolkit/Documents/MCH-Emergency-Plng-Toolkit-508.pdf

Throughout this guidance the Maternal-Child Health (MCH) Emergency Planning toolkit will be referenced for AFN planning.

2.1 Key Concepts

The key concepts defined and referenced throughout this guidance, and included in the appendices is foundational to contextualizing and using the information from HHS-Maternal-Child Health Emergency Planning Toolkit-May 2021. The key concepts to better understanding of Maternal-Child Health (MCH) populations, emergency management, health equity, and public health priorities. The planning tool can be found at the following link: https://www.phe.gov/Preparedness/planning/abc/mch-planning-toolkit/Documents/MCH-Emergency-Plng-Toolkit-508.pdf

2.2 Health Equity

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.[12] Substantial disparities by social determinants are found for a number of health indicators, including infant mortality, life expectancy, health care access and utilization, health insurance, disability, mental health, preventive health services, and unintentional injuries.[1]

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[1] Health Resources and Services Administration Office of Health Equity (HRSA OHE). (2019-2020). *Health Equity Report 2019-2020*. https://www.hrsa.gov/sites/default/files/hrsa/health-equity/HRSA-health-equity-report.pdf

Health equity is included in the guidance due to the access and functional needs of populations that in the United States. Emergencies can cause disruptions to health care, care providers assistance and resources, medical equipment replacement, medicine replacements, and counseling. Emergencies should not "stop" medical care or resources from those that are in lower economic groups or people with access and functional needs.

2.2.1 Preparedness Considerations for Women who are Pregnant, Postpartum, and/or Lactating in Various Emergency Scenarios

Emergency plans should include protocols to address the needs of people who are pregnant, postpartum, and/or lactating during a variety of emergencies including infectious disease outbreaks, localized emergencies, natural and human-caused disasters requiring evacuation, and natural and human-caused disasters not requiring evacuation.

Emergency Scenario	Considerations for Infants and Young Children
Infectious Disease Outbreaks	• Communicate guidance to caregivers on any lasting effects of the outbreak that impact children, such as different strains of the disease, and prevention measures, such as getting vaccines • Communicate risks of known long-term effects of the infectious disease specific to infants and young children. Communication about individual circumstances and risks should occur one-on-one with providers • Talk with caregivers and young children about changes in behavior in response to necessary measures to prevent the spread of disease (e.g., stay-at-home orders) and provide referrals to child mental health services as needed • Return to a normal routine after stay-at-home orders have lifted and continue to provide children with opportunities to express themselves, such as through art or music
Localized Emergencies	• Follow up with caregivers if an appointment was missed during the emergency, and respond appropriately to new needs that have arisen • Maintain contact with local MCH organizations should service outages persist, such as water and

	power, to ensure caregivers receive supplies to support infants and young children
Natural and Human -Caused Disasters Requiring Evacuation	• Consider safety for young children returning to their homes. Children are more affected than adults by environmental contaminants, mold, and chemicals and should return after cleaning has occurred. Carbon monoxide from generators also poses a threat to health and safety • Consider safety for young children going to temporary housing or relocating with familiar caregiving adults (e.g., parents or relatives) such as following child-safe guidelines with medications and household cleaning supplies • Understand insurance policies and points of contact should health care take place out of network • Ensure continuity of services for newborns and young children who temporarily relocate or relocate out of state, including newborn screenings. Communication among health care and social services providers across state lines is important for continuity of care and services • Communicate information to children in a reaffirming way and give them space to ask questions, talk about their experiences, and help them identify emotions
Natural and Human-Caused Disaster Not Requiring Evacuation	• Maintain contact with local, state, and federal MCH organizations should service outages persist, such as water and power, to ensure caregivers receive supplies to support infants and young children is needed • Recognize that even if a child experienced minimal effects of a natural disaster, such as heavy rain from a hurricane or smokey skies from a wildfire, they can still be impacted from the experience or from the experiences of family or friends

2.2.2 Response Considerations for Infants and Young Children

According to the CDC, younger children are often more affected by emergencies than adults due to a variety of reasons. For example, infants and young children:

- Have thinner skin and breathe faster than adults do, making them more likely to take in harmful substances through the skin or airways
- Have a higher chance of being harmed by very hot or cold temperatures
- May be unable to follow directions or make decisions to keep them away from danger during an emergency
- Use energy more quickly than adult bodies, and they need food and water more often
- Are more likely to put their hands in their mouths, and spend more time outdoors and on the ground, making them more likely to encounter dangers in the environment
- May not be able to explain how they are feeling, which can make it harder to identify a medical problem and treat them quickly
- Have more contact with others, and they have less developed immune systems to fight off infections. This means they are more likely to catch an illness that can spread from person to person
- Some children have special health care needs (e.g., physical, intellectual and developmental disabilities, chronic medical conditions). These can increase a child's chance of getting sick or highly distressed during an emergency, especially if the child is separated from a parent or caregiver Health care, public health, and social services providers who care for and support infants and young children should activate emergency plans to protect the health and safety of infants and young children during emergencies.

For example, providers may need to procure and use or provide appropriate equipment and supplies for treating infants and young children, such as child-size masks and needles, transportation equipment (e.g., infant carriers, car seats), and other necessary supplies (e.g., diapers, wipes, bottles, disposable cups).

2.2.3 Mental Health Considerations for Infants and Young Children in Emergencies

It is important for all individuals who will be caring for and supporting infants and young children during an emergency to understand that children may react differently during emergency situations than adults and mental health needs may present differently depending on the child's age and development. Changes in behavior, fussiness, and anger can be signs of stress, anxiety, or depression in infants and young children. Children react, in part, on what they see from the adults around them. When parents and caregivers deal with an emergency calmly and confidently, they can provide the best support for children. Take the time to calm a child during an emergency, when possible, which will help them follow instructions from teachers, caregivers, or first responders. For example, consider employing

psychological first aid, an early intervention that promotes an environment of safety, calm, connectedness, self-efficacy, empowerment, and hope. National Child Traumatic Stress Network (NCTSN) Common reactions to distress for children include:

- Infants to two (2)-year-olds: Infants may cry more and/or want to be held and cuddled more than usual
- Three (3) to Five (5)-year-olds: Preschool and kindergarten children may return to behaviors they have outgrown, such as toileting accidents, bed-wetting, or being frightened about being separated from their parents/caregivers. They may also have tantrums or a hard time sleeping

2.3 Local Emergency Stockpile Supply List

Local Emergency Stockpile Supply List	
Infants (0-12 months)	Young Children (1-5 Years)
• Car Seats • Ready to Feed Formula • Diapers • Wipes • Bottles, nipples, and disposable cups • Clothing • Infant feeding, cleaning supplies (tub, clean water, dish soap, brush) • Safety approved cribs, and fitted sheets to support safe sleeping	• Car seats • Diapers • Wipes • Pull ups • Disposable cups • Child-size equipment such as masks • Child friendly nutritious snacks, water, and milk • Clothing • Sensory kits • Stress relief activities, such as coloring books, colored pencils, toys, and books • Child-size first aid equipment such as backboards, splints, bandages, and wheelchairs.

3.0 General Information

3.1 Diversity in Oklahoma

The state of Oklahoma is multiculturally diverse. We have people from all over the world living and working in our great state. We have people from Southeast Asia, the continent of Africa, South America, Eastern Europe, Asia, Middle East and Canada. Which provides our state the opportunity to plan for and respond to people of different cultural beliefs, languages, customs, different levels of understanding, and knowledge of emergency planning.

In Oklahoma we have 38 Federal Recognized Nations and Tribes. All 38 Nations and Tribes have a unique culture, customs, and languages. Oklahomans respond to and prepare for a variety of natural and human made disasters. Cultural competency is essential for the exchange of emergency plans and practices for each individual Tribe, Nation, and non-Tribal partner.

Partnerships with respect for customs, language, and culture enhances emergency planning for everyone. Each Tribe and Nation develops his or her own emergency preparedness and response plans. Partnerships with county and state health departments provides networking within the state for responses that are greater than their immediate resources. Oklahoma State Department of Health collaborates with the Inter-Tribal Health Board for guidance cultural competency in emergency preparedness activities across the state of Oklahoma

3.2 Unique Needs of Children in Disasters

The American Academy of Pediatrics has established that children have unique physical and emotional needs when a disaster strike. In addition to being placed at an increased risk of physical harm, children respond to illness, injury, and treatment differently than adults do. They also rely on stable routines in their daily lives, and when a disaster occurs, the drastic changes to their known world not only endanger their safety, but also greatly frighten them. To ensure the physical security and emotional stability of children in disasters, communities must modify their emergency planning efforts to include children's unique needs during disasters.

Children have unique needs that must be addressed in emergency preparedness, mitigation, response and recovery operations. Examples of needs specific to children are the following:

- Children require different dosages of medications and different forms of medical and mental health interventions than those used to treat adults.

- Different approach to mental health evaluation and treatment is necessary to accommodate children's specific mental health needs.
- Decontamination of children is more time and resource intensive than decontamination of adults.
- Children's developmental and cognitive levels may impede their ability to escape danger, evacuate, and self-identify. Young children may not be able to communicate enough information to be identified and reunited with parents, guardians, or caregivers.
- Communication formats such as the following: non-verbal, American Sign Language (ASL), usage of communication devices, and foreign languages will be utilized throughout their stay in the shelter.
- Professional language interpreters will be provided by the shelter staffing for functional needs and care of the children in the shelter.
    - ASL interpreters certified by the Oklahoma state Quality Assurance Screening Test (QAST) Levels IV and V will be used in the shelters.
    - QAST certification Level V will be used in all medical examinations both (mental and physical). iii. ASL interpreters will be used for the parent and/or child as requested and needed by either individual.
- Children may experience increased psychological effects as they may have difficulty comprehending disasters within the context of normal every day events. This may leave children unable to cope long after disasters and result in later consequences including depression, lack of focus and poor school performance
- Critically sick or injured children may have specialized transportation needs.
- Children with mobility disabilities may also require specialized transportation care to and from the shelter.
- Children's safety in a disaster and their individual recovery is dependent on the preparedness, response and recovery capabilities and resources of a network of institutions, including schools, childcare providers and other congregate care settings.

4.0 Purpose

This guide was created to help local and state agencies, and for profit and non-profit organizations in their efforts to develop and maintain Children's Disaster Planning. This Resource Guide for Children & Youth is meant to assist in the disaster planning process. There is no single format that can adequately fit every community or facility. Developing this resource guide is meant to assist organizations and communities in their efforts of whole community disaster planning.

4.1 Vulnerability of Children

- Children require special protection, especially nursing babies, infants and under-fives.
- Adolescent girls and women, and pregnant women in particular, bear an additional burden of vulnerability based on gender.
- Socio-economic status and minority group membership increase vulnerability.
- The family remains the chief source of protection for children. Separation of children from their families increases their vulnerability.
- Children that speak other languages or that have low English-speaking levels.

4.2 During and After an Emergency

- The nutritional status of children at shelters must be assessed regularly in line with accepted state and national standards.
- Trained nutritionists should identify and refer children to health center for nutritional support.
- The school-feeding program could be extended to the shelters and affected areas in the communities to assist in feeding the area affected by the disaster.
- Appropriate food must be available in shelters for children.
- Each child should receive at least three, simple, nutritious meals per day.
- Adequate nutritional supplements for children and pregnant women must be provided.

4.3 Critical Components of a Child's World

Because stable routines are critical to the physical and emotional well-being of a child, an Emergency Operations Plan must consider ways to prevent or minimize disruption to a child's routine during and after a disaster. Much of a child's everyday routine is shaped by:

- Childcare providers/ Before and After school programs

- Child social services
- Classmates, friends, and families
- Schools

4.4 Family as Critical Infrastructure for Children

The primary means of accounting for children in disasters is through the family. Family leaders will make the decisions about whether to evacuate in the face of an impending disaster, whether to seek shelter, and how to provide safety, and care for the children.

Families come in all shapes and sizes in today society. An emergency planner should be familiar with the various legal and societal definitions of a family. In today's society, children live in families that are headed by:

- A single parent and/or Two parent(s)
- Foster parent(s)/ Legal Guardians
- Grandparent(s)/ Guardian(s)
- Sibling(s)

Also, some children may be homeless, with or without parental supervision. Whatever the family unit, emergency planners must consider ways to keep families together when planning for disasters. Maintaining family unity will ensure the continuity in a child's life and increase the chances the child is properly cared for.

5.0 Family Reunification

Being separated from loved ones during an emergency is a frightening situation for anyone, but it is especially traumatic and dangerous for children. Planning for ways to preserve family unity is the most important step you can take to provide for the physical safety and emotional stability of children in disasters. Children can become separated from their families in many situations, including:

- During an evacuation.
- At emergency shelters.
- While at school or a childcare facility.
- While on a school trip out of town.
- While at summer camp or after-school activities.
- While being treated at a hospital or medical clinic.
- While visiting friends or relatives away from home.
- While at the store, at the movies, or other location.
- Death of their parent/guardian/foster parent/sibling.

The Emergency Operations Plan for your community or organization should include procedures for identifying children who have been separated from their families and reuniting the families as soon, and as carefully, as possible.

5.1 Reunification Stations

There are five very important stations when setting up an alternate location and reunification plan.

1. Registration gate staff should be the first to greet the parents/guardians/emergency contacts upon arrival.
2. Childcare Area is where staff will care for all the children still in their care. Staff will need to ensure the child's needs are being met and they are being entertained. Note: This can be very traumatic for the children and they will need more to do than sit and wait for parents.
3. Release Gate will be one of the last places the adult and children see. This is where the childcare staff/emergency staff/or designee's will finish filling forms which state they are the "proper individuals" to pick up the child or children from this facility.
4. Command Post is where the commander and support staff of the alternate care site will work during the disaster. The commander may be the director or designee, or it may be the most qualified staff member on hand. The command post is not usually accessible to parents.
5. Private Area not visible to children and parents is necessary for the commander, director, or designee to bring a parent or guardian to tell them if their child or children are missing, injured, or deceased. It offers

privacy and prevents other parents from becoming more agitated during chaotic circumstances.

5.2 Release Procedure

For the safety of staff and children, parents/guardians are restricted to the check-in and release gates. A runner should be assigned to get the child or children when the parent/guardian arrives to the location. The release procedure will be established by the agencies assigned by shelter operations.

 Note: If the child is injured/missing/decreased the process stops. Someone from the command post or designee will contact the family/guardian away from the public and explain the situation to the individuals.

5.3 Preserve Family Unity

The Centers for Disease Control and Prevention (CDC) has developed five critical steps to help shelters, hospitals, and medical clinics prevent separation of children from their families and identify those who have already been separated.

These steps have also been adopted by Save the Children.

5.4 Five Critical Steps to Preserve Family Unity during Emergencies

1. Survey all children to identify children who are not accompanied by an adult who is supervising them.
2. Place an identification bracelet on the child that matches a supervising adult, if available.
3. Report all unaccompanied children to the emergency operations center and the National Center for Missing and Exploited Children (NCMEC).
4. Send a complete list of unaccompanied children to local emergency management officials.
5. Have a physician, preferably a pediatrician; conduct a social and health screening of the child and the supervising adult.

6.0 Human Trafficking

In the United States, the Trafficking Victims Protection Act of 2000 (TVPA), as amended by the Justice for Victims of Trafficking Act of 2015 (JVTA), defines sex trafficking as “recruiting, harboring, transporting, providing, obtaining, patronizing, or soliciting of an individual through the means of force, fraud, or coercion for the purpose of commercial sex”. However, it is not necessary to demonstrate force, fraud, or coercion in sex trafficking cases involving children under the age of 18.

6.0.1 Sex Trafficking

Sex trafficking is a form of modern-day slavery in which individuals perform commercial sex through the use of force, fraud, or coercion. Minors under the age of 18 engaging in commercial sex are considered to be victims of human trafficking, regardless of the use of force, fraud, or coercion.

Sex traffickers frequently target victims and then use violence, threats, lies, false promises, debt bondage, or other forms of control and manipulation to keep victims involved in the sex industry for their own profit.

Sex trafficking exists within diverse and unique sets of venues and businesses including fake massage businesses, escort services, residential brothels, in public on city streets and in truck stops, strip clubs, hostess clubs, hotels and motels, and elsewhere.

6.0.2 Definition of Commercial Sex Act

The term “commercial sex act” is defined as “any sex act on account of which anything of value is given to or received by any person” (*22 U.S.C. 7102*).

Sex trafficking may be distinguished from other forms of commercial sex by applying the Action + Means + Purpose Model. Human trafficking occurs when a trafficker takes any one of the enumerated actions, and then employs the means of force, fraud, or coercion for the purpose of compelling the victim to provide commercial sex acts. At a minimum, one element from each column must be present to establish a potential situation of sex trafficking. The presence of force, fraud, or coercion indicates that the victim has not consented of his or her own free will. In addition, minors under the age of 18 engaging in commercial sex are considered victims of human trafficking regardless of the use of force, fraud, or coercion.

6.0.3 Demand For Sex Trafficking: What You Need To Know

Sex trafficking is a market-driven criminal industry that is based on the principles of supply and demand. Therefore, people who purchase commercial sex increase the demand for commercial sex and likewise provide a profit incentive for traffickers, who seek to maximize profits by exploiting trafficking victims. Therefore, buyers of commercial sex need to

recognize their involvement in driving demand. By not buying sex and not participating in the commercial sex industry, community members can reduce the demand for sex trafficking.

6.0.4 What is slavery?

Slavery: being forced to work without pay, under the threat of violence, and being unable to walk away.

6.0.5 Where do slaves work?

Slaves work in-farm fields, factories, mines, construction sites, logging camps, restaurants, hotels, retail stores, brothels and private homes- anywhere slave owners can feed their greed.

6.0.6 Are you supporting slavery?

Many everyday products are made by slaves, or with slavery-tainted parts or raw materials –such as cars, computers, chocolate, cell phones and clothing.

6.0.7 Who can end slavery?

Everyone can help put an end to slavery: governments, businesses, investors, international organizations, faith communities, schools, consumers, and you.

6.0.8 What words are used for slavery?

Slave holders use many terms to avoid the word “slavery” such as debt bondage, bonded labor, attached labor, forced labor, indentured servitude and human trafficking.

6.0.9 Assessments Questions on Human Trafficking

1. Are you in control of your identification/personal documents? If not, who is?
2. Were you recruited for one job and are doing another?
3. Has someone asked you to engage in sexual activity in exchange for anything?
4. Have you been asked to do something for pay that you did not want to do, or felt uncomfortable with?
5. Are you in control of your own money? Do you have to turn over the money you make?
6. Do you have deb you cannot pay off?
7. Are you paid for your work? Are you paid enough? Do you only earn tips?
8. Can you leave if you want?
9. Has anyone threatened to harm you/your family if you leave your job?

Look for signs of physical, psychological, or sexual abuse that may also indicate human trafficking. There are two terms that need to be clarified in their definition and they are Human Trafficking and Human Smuggling. The differences in these two terms are defined below.

6.0.10 Human Trafficking

Sex trafficking is defined as: sex act is induced by force, fraud, or coercion, or in which the person induced to perform such as has not attained 18 years of age; or

The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

6.0.11 Human Smuggling

Human Smuggling is defined as the importation of people into the United States involving deliberate evasion of immigration laws. This offense includes bringing illegal aliens into the United States as well as the unlawful transportation and harboring of aliens already in the United States.

The terms are not interchangeable terms.

- Smuggling is transportation-based
- Trafficking is exploitation-based

Information provided on the following website: www.dhs.gov/bluecampaign

6.0.12 Blue Campaign

- Serves as the unified voice for DHS's efforts to combat human trafficking.
- Educates the public through awareness resources including public service announcements, posters, brochures, and infographics.
- Partners with state, local, and tribal governments, federal agencies, and nongovernmental and private organizations to provide training and resources on recognizing and reporting suspected human trafficking.
- Use social media to communicate with stakeholders and the general public about DHS efforts, how to recognize and report human trafficking, and how to get involved.

6.0.13 How to Get Involved

As an individual or organization there are many actions you can take to help raise awareness of human trafficking and work to combat this heinous crime. Visit www.dhs.gov/bluecampaign

- Educate yourself by viewing free educational awareness products and videos at www.dhs.gov/bluecampaign

- Learn more about how to recognize and report suspected human trafficking.
- Download and share free resources in your community and online at www.dhs.gov/bluecampaign

6.0.14 Trafficking Indicators

- Is the victim in possession of identification and travel documents; if not, who has control of the documents?
- Was the victim coached on what to say to law enforcement and immigration officials?
- Was the victim recruited for one purpose and forced to engage in some other job?
- Is the victim's salary being garnished to pay off a smuggling fee? (Paying off a smuggling fee alone is not considered trafficking.)
- Was the victim forced to perform sexual acts?
- Does the victim have freedom of movements?
- Has the victim or family been threatened with harm if the victim attempts to escape?
- Has the victim been threatened with deportation or law enforcement action?
- Has the victim been harmed or deprived of food, water, sleep, medical care, or other life necessities?
- Can the victim freely contact friends or family?
- Is the victim a juvenile engaged in commercial sex?
- Is the victim allowed to socialize or attend religious services?

Report Suspicious Activity: 1-866-DHS-2-ICE (1-866-347-2423)
www.dhs.gov/bluecampaign

6.1 Indicators of Human Trafficking

Recognizing human trafficking is the first step in combating the heinous crime. Learning the indicators and reporting tips helps law enforcement identify victims and connect them with the care and services they need. The indicators listed below may help you recognize human trafficking, but any one indicator is not necessarily proof of human trafficking.

6.1.1 Physical

Does the person…

- Show signs of physical and/or sexual abuse, physical restraint, confinement, or torture?
- Appear to be deprived of food, water, sleep, medical care, or other necessities?
- Lack personal possessions?

6.1.2 Social

Does the person…

- Work excessively long and/or unusual hours?
- Show sudden or dramatic changes in behavior?
- Act fearful, anxious, depressed, submissive, tense, or nervous/paranoid?
- Defer too another person to speak for him or her?
- Appear to be coached on what to say?
- Appear disconnected from family, friends, community organizations, or place of worship?
- Not have the ability to freely leave where they live?

6.2 What Disaster Responders Need To Know

As a disaster responder and/or a healthcare provider, the likelihood that you will come in contact with a human trafficking victim is very high! Remember that anyone can be trafficked- men and boys, women and girls.

6.3 Disasters Increase the Risks of Human Trafficking

6.3.1 Beginning of Disasters

- Disruption and chaos make it easy to exploit disaster survivors
- Perpetrators of trafficking may pose as responders offering survivors help with housing, food, or water

6.3.2 During Disasters

- Disaster survivors may engage in survival strategies that make vulnerable to be taken advantage of
- Children may be separated, sometimes permanently, from their parents

6.3.3 After Disasters

- Rebuilding and cleanup create new markets for cheap or free labor
- Disaster survivors may lose their main source of income and look for new types of work, including commercial sex

6.4 Signs of Human Trafficking

6.4.1 Labor Trafficking

- Reports performing work duties in exchange for basic necessities (food, water, housing), rather than money
- Unable to freely choose where they live
- Identification documents are held by employer

6.4.2 Sex Trafficking

- Reports providing sex in exchange for basic necessities (food, water, housing)
- Unexplainable injuries
- Reports being forced to engage in commercial sex
- Aged <18 and involved in commercial sex
- Reports unusually high number of sex partners

6.4.3 Labor Trafficking

- Reports performing work duties in exchange for basic necessities (food, water, housing), rather than money
- Unable to freely choose where they live
- Identification documents are held by employer

6.5 Labor Trafficking Definition

Labor Trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery, (*22 USC § 7102*). The federal government has three different categories of labor trafficking.

1. Involuntary Servitude
2. Debt Bondage
3. Coercion

6.5.1 Involuntary Servitude

A condition of servitude induced by means of any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such condition, that person or another person would suffer serious harm or physical restraint; or the abuse or threatened abuse of the legal process *(22 U.S.C. 7102 (6))*.

6.5.2 Debt Bondage

The status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined *(22 U.S.C. 7102 (5))*.

6.6 Coercion

a) Threats of serious harm to or physical restraint against any person;

b) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or

The abuse or threatened abuse of the legal process (*22 U.S.C. 7102 (3)).*

If you think someone may be a victim of human trafficking, call and/or encourage them to call the National Human Trafficking Hotline: 1 (888) 373-7888 to receive help, resources, and information.

7.0 Shelters in Disasters

7.1 Children Needs in Emergency Disaster Shelters

This section will provide guidance and suggestions to shelter managers and staffs that ensure children have a safe, secure environment during and after a disaster. The information below will include appropriate support suggestions and access to essential resources that can be used in the planning process for children and youth in disasters.

7.2 Standards and Indicators for All Shelters

Under most circumstances a parent, guardian, or caregiver is expected to be the primary resource for their children, age 18 and younger.

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

- Children in the shelters come in all ages and with unique needs. Age appropriate and nutritious food (including baby formula and baby food) and snacks are available, as soon as possible after needs are identified. Diapers are available for infants and children as soon as possible after needs are identified.
    - General guidelines suggest that infants and toddlers need up to 12 diapers a day. (See Appendix A for Guidelines for Establishing and Maintaining a Diapering Station in an Evacuation Center) (See Appendix B- D for Infection Control and Cough Guidelines) Guidelines provided by The Centers for Disease Control and Prevention (CDC).
- Age-appropriate bedding, including folding, portable cribs or playpens are also available.
- Mothers who are breastfeeding should be hydrated and encouraged to breastfeed as the safest form of infant feeding.
    - A safe space for breastfeeding women is provided so they may have privacy and a sense of security and support (this can include a curtained off area or providing blankets/ personal covering for privacy).
    - A private area with electrical outlet for breast pumps and containers for collecting milk should be available.
    - Mothers should have access to certified lactation consultants who have been previously credentialed to provide staff training on breastfeeding and to assist in shelters during emergencies.
- Basins and supplies for bathing infants are provided as soon as possible after needs are identified.
- Food and snack selections that is healthy and safe for infants and children with food allergies.

7.3 Standards and Indicators for Temporary Respite Care for Children

Temporary Respite Care for Children provides temporary relief for children, parents, guardians, or caregivers. It should be a secure, supervised and supportive play experience for children in a Disaster Recovery Center (DRC), assistance center, shelter, or other service delivery site. When placing their child or children in this area parents, guardians, or caregivers are required to stay on-site in the disaster recovery center, assistance center or shelter. A designee to the family may be responsible for their child or children and will also be required to stay on-site.

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

- Temporary respite care for children is provided in a safe, secure environment following a disaster.
- Temporary respite care for children is responsive and equitable. Location, hours of operation and other information about temporary respite care for children is provided and easy for parents, guardians, and caregivers to understand.
- All local, state, and federal laws, regulations, and codes that relate to temporary respite care for children are followed.
- The temporary respite care for children area should be free from significant physical hazards and/or architectural barriers and remains fully accessible to all children.
- The temporary respite care for children area should have enclosures or dividers to protect children and ensure that children are supervised in a secure environment.
- The temporary respite care for children area is placed close to restrooms and a drinking water source; hand washing and or hand sanitizer stations are available in the temporary respite care for children area.
- Procedures are in place to sign children in and out of the temporary respite care for children area and to ensure children are only released to the parent(s), guardian(s), caregiver(s), or designee(s) listed on the registration form.
- All documents---such as attendance records and registration forms (which include identifying information, parent, guardian or caregiver names and contact information), information about allergies and other access and functional needs, injury and/or incident report forms; are provided, maintained, and available to staff at all times.
- Ensure all toys and materials in the temporary respite area are safe and age appropriate.
- Prior to working in the temporary respite care for children area, all shelter staff members should receive training and orientation. In addition, such staff must successfully complete a criminal and sexual offender background check. Spontaneous volunteers are not permitted. When inside the temporary respite area, staff shall visibly display proper credentials above the waist at all times.
- When children are present, at least two adults should be present at all times in the respite area. No child should be left alone with one adult who is not their parent, guardian, or caregiver.
- All staff members must be 18 years or older. Supervision of the temporary respite care for children area is provided by a staff person at least 21 years of age.
- An evacuation plan will be developed with a designated meeting place outside the center. The evacuation plan will be posted and

communicated to parent(s), caregiver(s), and guardian(s) when registering their child.

- The child to staff ratio is appropriate to the space available and to the ages and needs of the children in the temporary respite care at all times.

8.0 Child-Friendly Spaces

Child-Friendly Spaces is Save the Children's signature emergency response program in the United States and around the world, meeting a Common Standard of Mass Care Disaster Response that helps ensure children are safe and protected in shelters and other locations, such as recovery centers where families congregate during disasters.

Child-Friendly Spaces are a critical component in providing support to children and families in temporary locations following a disaster. The program's structured, supervised activities offer comfort to children who are used to daily routines, strengthen children resilience, and help them begin to cope. These Spaces also provide a forum for sharing valuable child safety and recovery information with families when they need it most.

8.1 The Child-Friendly Spaces Program

- Gives children a sense of normalcy and community when their lives are disrupted by disasters.
- Provides children with a safe, designated area where they can play, socialize, and express themselves under the supervision of caring, trained and background-checked adults.
- Helps children interact with peers, build self-esteem, and begin the recovery process by working through their emotions and building upon their natural resilience.
- Enables parents to have time to register for emergency assistance and start to re-establish their lives.

8.2 Child-Friendly Kits

In partnership with the American Red Cross, Save the Children has pre-positioned Child-Friendly Spaces kits in high-risk areas across the United States to support the Child-Friendly Spaces program. Kit materials include age- appropriate, fun activities items such as jump ropes, books, toys, arts and craft supplies, and board games. These kits are located in Oklahoma City and can be requested through the state health department emergency manager.

8.3 Training

Save the Children offers Child-Friendly Spaces training that supports emergency leaders, organizations and communities in meeting the needs of children in disasters. The training includes best practices on site selection, organization and set-up of the space, gives guidance for addressing children's unique needs, and promotes child safety and well-being while in temporary locations. The Child-Friendly Spaces program, also referred to as

temporary respite care for children, helps communities meet the Common Standards of Mass Care in Domestic Emergency Response.

For more information concerning Child-Friendly Kits go to www.savethechildren.org/GetReadyGetSafe.

8.4 List of Agencies that Assist in Children Disaster Responses

- Children's Crisis Centers (statewide)
- Children First (statewide)
- Women, Infants, and Children (WIC) (statewide)
- Oklahoma State Department of Health (OSDH)
- Oklahoma City County Health Department (OCCHD)
- Tulsa Health Department (THD)
- Oklahoma Disability Law Center (ODLC)
- American Red Cross (ARC)
- Oklahoma Developmental and Disability Council (ODDC)
- Oklahoma Children's Hospital
- Oklahoma Department of Human Services/Children Protection Services (OKDHS) (statewide)
- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) (statewide)
- Children Special Recovery Center, Norman OK
- Children Disaster Services
- Save the Children

9.0 Cultural and Linguistic Competency in Disaster Preparedness and Response

The racial and ethnic diversity of the United States population is increasing, necessitating an inclusive and integrated approach to disaster preparedness, response, and recovery activities. This approach ensures that culturally and linguistically diverse populations are not overlooked or misunderstood, and receive appropriate services as needed. The "Whole Community Approach" to emergency planning includes people with disabilities, the Deaf communities, people who are senior in age, children and youth, people that speak English as a second language, and people who have low English literacy in our communities.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), issued by the Department of Health and Human Services, Office of Minority Health (OMH), offer individuals working in the areas of emergency management, public health, and other health-related organizations a framework for developing and implementing culturally and linguistically competent policies, programs, and services. Cultural competency is defined as "the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each.

Developing cultural and linguistic competency allows public health officials and emergency managers to better meet the needs of diverse populations and to improve the quality of services and health outcomes during and after a disaster. To be effective, however, cultural and linguistic competency must be included in all phases of a disaster or public health emergency – preparedness, response, and recovery.

9.1 Language Line Services

This is one area of planning that must take highest priority of networking and community planning. This level of community planning will reduce the barriers that can occur with communication. The Oklahoma State Department of Health has a contract services call Language Line Solutions. This service provides is provided 24 hours a day /7 day a week. Video services (tablet, laptop, or smart phone) are provided by the top 20 languages requested and this does include American Sign Language.

Language Line Solutions provide interpretation services in approximately 240 languages (audio only). Telephone interpretation and document translations are services also provided in the Oklahoma State Department of Health (OSDH) contract. The language interpretation can be used on a laptop, tablet,

or cell phone. The laptop or tablet must have cellular capabilities to utilize these services. The approved OSDH employee must have the agency's account number and "special code" to activate the Language Line Insight Video Interpreting or Audio Services. The Oklahoma State Department of Health/ Office of Communications will be able to guide the OSDH employee in the account and "code" process. The contact is

10.0 Five Elements of Cultural Competency within Disaster Preparedness

- Awareness and Acceptance of Difference: Responders and survivors are often different in their racial, ethnic and/or language characteristics. By improving communication skills as well as becoming self-aware of potential biases and stereotypes, however, public health officials and emergency managers can provide quality care to diverse populations in a culturally competent manner.

Example: Not all cultures react to pain in the same way. While the experience of pain is universal, the way of perceiving, expressing, and controlling pain is one of these learned behaviors, that when manifested, is culture-specific.[2] An example of cultural competency is a public health official's and an emergency manager's self-awareness of expectations associated with how an individual expresses pain or stress.

- Awareness of One's Own Cultural Values: Examining personal prejudices and cultural stereotypes by performing and individual self-assessment can help public health officials and emergency managers become aware of their own cultural values and biases. The Valuing Diversity and Self-Assessment: This questionnaire is a widely used self-assessment that allows individuals to identify their own strengths and weaknesses when working with or treating populations with backgrounds different than their own.

Example, Immigrant and refugee populations may speak a language other than English, have different cultural norms, come from a different socioeconomic background, and have a different style of dress. Recognizing and respecting cultural differences and understanding your own biases and beliefs are critical to effectively serving or assisting culturally diverse populations during or after an emergency.

- Understanding and Managing the Dynamics of Difference: This refers to the various ways cultures express and interpret information. Taking an individual's medical history is a systematic way to collect both medical and cultural information. This information promotes cultural understanding and improves the quality of services provided to the individual.

The RESPOND Tool succinctly defines the key components of taking the medical history of culturally and linguistically diverse populations.

R – Build rapport

E – Explain your purpose

S – Identify services & elaborate

P – Encourage individuals to be proactive

O – Offer assistance for individuals to identify their needs

N – Negotiate what is normal to help identify needs

D – Determine next steps

- Development of Cultural Knowledge: Cultivating a working knowledge of different health and illness related beliefs, customs, and treatments of cultural groups in your local area can better equip public health officials and emergency managers with the information necessary to provide timely and appropriate services.

Example: Research illustrates that racial and ethnic minorities are disproportionately vulnerable to, and impacted by, disasters. Minority communities also recover more slowly after disasters because they are more likely to experience cultural barriers and receive inaccurate or incomplete information as a result of cultural differences or language barriers.

- Ability to Adapt Activities to Fit Different Cultural Contexts: This concept refers to the ability to adapt and as appropriate, to modify, the services offered to fit the cultural context of the patients and communities you are serving.

Example: Increasingly, the role of disaster personnel includes involvement with interpreters during the triadic interview. A triadic interview is a process in which people with limited English proficiency can communicate their needs in the language of their choice and the interpreter relays this information to the disaster personnel. This process fosters mutual understanding and builds trust between the survivor and the responder.

Note: To ensure proper translation is occurring, certify you have a translator that is educated to the level that is conducive to your needs. Having medical personnel that is bilingual is essential to accurate medical translation. The same situation will occur with mental health counseling. Having a bilingual mental health counselor is important for the accurate translation of their questions and guidance for mental health care.

The same situation occurs with American Sign Language (ASL) interpretation. Having proper certification in ASL interpretation will ensure accurate translation is occurring for both medical and mental health care needs in people who are Deaf or Hard-of-Hearing (H-o-H).

11.0 Tips Concerning Children Who Have Access and Functional Needs

All children benefit from concrete information presented at the proper level of understanding and maturity. Helping all children to stop and think about their reactions and behavior, especially with regard to anger and fear, is recommended and often necessary in order for them to make "good choices." For some children with behavioral disorders, training in anger management, coping and conflict resolution skills are important additions to a comprehensive intervention program. The following information addresses specific, additional considerations for children with access and functional needs.

11.1 Autism

Children with autism pose very difficult challenges to caregivers. It is difficult to know how much information a child who is nonverbal, is absorbing from television and conversations. It is important to pay close attention to the cues they may provide regarding their fears and feelings and provide them with ways to communicate. Remember that any change in routine may result in additional emotional or behavioral upset. If the child's environment must be changed (e.g., an evacuation, the absence of a parent), try to maintain as much of the normal routine (e.g., meals, play, bedtime) as possible—even in the new environment. In addition, try to bring concrete elements from the child's more routine environment (e.g., a toy, blanket, doll, and eating utensils) into the new environment to maintain some degree of "sameness" or consistency.

Many children with autism can be helped to comprehend behavior they observe but poorly understand through the use of "social stories." The parent or teacher's explanation of what is happening can be reduced to a social story. A storybook can then be kept by the child to help reinforce the information on a concrete, basic level.

11.2 Verbal Autism

Children who are verbal with autism may state a phrase repeatedly, such as, "we are all going to die." This type of statement will serve to isolate the child socially from his peers and other adults. To help the child avoid such statements, it will be necessary to provide very concrete information about the situation and appropriate ways to react and respond that are within the child's skill level.

The Oklahoma State Department of Health/Emergency Preparedness & Response services has developed a presentation to educate the first responders and community advocates on emergency planning for people

who have Autism or family members that have Autism. This presentation can be found on their website:

The Oklahoma State Department of Health and Emergency Preparedness and Response Services has Sensory Kits for people with Autism or Cognitive or Developmental Disabilities.

For assistance in the area of autism; please contact the Autism Foundation of Oklahoma (AFO)- Emily Scott – Executive Director.
www.AutismFoundationOK.org

12.0 Five Tips For Families to Prepare For Emergency Situations

Children and youth should be prepared for emergencies just like we teach adults to be prepared for emergencies. However, extra steps should be taken to teach children and youth emergency preparedness because of their unique problem-solving patterns. Teaching children and youth how to communicate and what to communicate to first responders is the first step in emergency preparedness. Below you will find five tips on how to achieve this with children and youth on the Autism Spectrum. The following information is adapted from the Autism Society.

Overview

1. Make sure you have a form with up-to-date personal identification information and a photo completed for your child. Keep copies at home, in your car, and with you whenever possible.
2. Practice providing personal information with your child (things like name, address and phone number).
3. Stress water safety- it can mean the difference between life and death. Enroll your child in swimming lessons if he/she does not know how to swim.
4. Make an effort to get to know your neighbors and community members (including police officers and other emergency personnel) and introduce them to your child. Be a resource to help them understand autism.
5. Involve other family members, friends, and neighbors in your emergency planning. Establish a phone tree and action plan that can be engaged if the worst happens.

Note: The above information was provided by Autism Services, Education, Resources and Training (ASERT). The website is https://paautism.org/resource/tips-to-prepare-for-emergency/ for more information on Autism resources.

12.1 Cognitive Limitations

Children with developmental or cognitive disabilities may not understand events or their own reactions to events and images. Teachers and caregivers need to determine the extent to which the child understands and relates to the traumatic event. Some lower functioning children will not be able to understand enough about the event to experience any stress, while some higher functioning children with cognitive disabilities may understand the event but respond to it like a younger child without disabilities.

Overall, children with cognitive limitations may respond to traumatic events based more on their observations of adult and peer emotions rather than the verbal explanations that they may receive. Discussions with them need to be specific, concrete and basic; it may be necessary to use pictures in explaining events and images. These children will need concrete information to help them understand that images of suffering and destruction are in the past, far away (if true) and that they are not going to hurt them. A parent may offer words of reassurance such as, “We are lucky to have the Red Cross in our community to help all the families who were hurt by the flood;” “The boys who brought the guns to school are in jail, they can’t hurt anyone else now.”

12.2 Learning Disabilities

Children/youth with learning disabilities (LD) may or may not need supports that are different from children without disabilities, depending upon their level of emotional maturity and ability to understand the concepts discussed. Many children with (LD) are able to process language and apply abstract concepts without difficulty, while others have specific deficits in these skills. In particular, some children with (LD) interpret very literally; therefore teachers and parents need to choose their words carefully to ensure the child will not misinterpret. For example, even referring to terrorism as “acts of war” may confuse some children who interpret language literally; they may envision foreign soldiers, tanks and fighter planes attacking America.

If your child or student appears to have difficulty following the news reports and class discussions of the traumatic events and their aftermath, reinforce verbal explanations with visual materials; use concrete terms in discussion; check for understanding of key vocabulary. Remember that some children with (LD) have difficulty with time and space concepts, and may be confused by what they see on television-- they may have difficulty understanding what happened when, what is likely to happen next, etc. They may also be uncertain as to where these events took place and might benefit from looking at simple maps.

Some children with (LD) have difficulties with social skills and self-management, and may need additional instruction in anger control, tolerance of individual differences and self-monitoring. Additionally, some of the tips listed for children with cognitive disabilities may be applicable to some students with (LD) who, despite their higher cognitive ability, have similar difficulties with verbal learning, memory, and communication.

12.3 Visual (low vision or blindness), Hearing (low hearing) or Physical Limitations

Children who do not possess developmental or cognitive disabilities but who have visual disabilities, hearing disabilities, or have mobility disabilities will

understand, at their level of development, what is happening and may become frightened by the limitations their disability poses on them. In your explanations, be honest but reassuring. Safety and mobility are major concerns for children challenged by visual, hearing and physical disabilities. As with all children, they need to know that they are going to be safe and that they can find a safe place in an emergency. Review safety plans and measures with them, provide lots of reassurance, and practice with them, if necessary. Explanations should be performed in a very simple and explicit manner. Children with visual disabilities will need to have the area carefully described to them. While the students challenged by physical or hearing disabilities may need visual aids as to what they have to do and where they have to go. Note: The children who are deaf should have a certified sign language interpreter for all questions and concerns around their living area.

12.4 Vision disabilities (low vision or blindness)

The child with visual disabilities (low vision or blindness) cannot pick up on visual cues such as facial expressions. Use verbal cues to reinforce what you are feeling and seeing. Many children have seen video clips of the disaster or traumatic event and are talking about them. The child or children with low vision or blindness may need a verbal description to reinforce what they have heard about the events. Ask questions to clarify their understanding of what has happened. Children with visual disabilities may have extraordinary concerns about their mobility and ability to move to safety during a crisis. Ask questions and provide additional orientation and mobility training if needed.

12.5 Hearing disabilities (low hearing)

Children who have low hearing disability will generally not be able to keep up with the fast talking of adults during traumatic events. Caregivers will need to be aware of the child's frustration when trying to keep up with the conversation, if the child has sufficient hearing to participate. Not being able to understand will result in greater fear reactions. Children who have low hearing may not be familiar with all the new terminology used in describing or explaining the events that are occurring. Be aware of the language you use, be very concrete and check for understanding. Use visual materials in conjunction with any verbal or signed explanations. Certified Sign Language interpreters can and should be requested as needed for clarification of information.

12.6 People who are Deaf

Professionals and Certified Sign Language Interpreters will be provided by the shelter staffing for access and functional needs and care of the children/youth in the shelter.

1. ASL (American Sign Language) interpreters certified by the Oklahoma state Quality Assurance Screening Test (QAST) Levels IV and V should be used in the shelters.
2. QAST certification Level V should be used in all medical examinations both (mental and physical).
3. ASL interpreters should be used for the parent and/or child as requested and needed by either individual.

Total Communication Children's procedures should include providing a certified signer near them. They need to know that someone will be there for them. For oral communicators distance may be an issue as they may experience difficulty with lip reading. Darkness such as blackouts or disaster drills in areas with poor lighting, presents problems for total and oral communicators. In helping them understand that they are safe, that you are going to keep them safe, be sure and show them a flashlight and let them know where they are going to be kept and that they are a part of the safety plan and available for them in case of a black out or a brown out.

13.0 Protecting Children during Disasters

The Emergency Operations Plan for your community or organization must consider the physical and emotional dangers to children during a disaster and include appropriate prevention and mitigation methods.

Save the Children, a charitable organization dedicated to helping children in need, has identified that children in disaster areas require protection from:

13.1 Children's Safety in Disasters

13.1.1 Physical Harm in Disasters

Because of the nature of disasters, children are at an increased risk for physical harm from many dangers:

- Injury from building collapse, motor vehicle crashes, or debris.
- Injury or assault in an evacuation shelter.
- Infection from spilled chemicals or pollutants in standing water.
- Ingestion of spoiled food or polluted water.
- Extended periods without proper nutrition or water.
- Exposure to inclement weather (hot or cold).
- Attack by feral animals.
- Existing or chronic illness aggravated by disruption in medical attention.
- Lack of access to appropriate health care professionals, medicine, and equipment.

13.1.2 Exploitation and Gender Based Violence

During emergency situations, children are especially vulnerable to sexual violence and other means of exploitation, particularly when they are separated from their families or otherwise displaced, such as when evacuated to a large shelter.

13.1.3 Psychosocial Distress

Because the physical needs of disaster victims are generally the focus of relief efforts, there is a danger of overlooking the emotional well-being of children who are subjected to stressful situations during an emergency. Communities must consider ways of reducing psychological and social distress during disasters, while fostering hope and confidence in children.

13.1.4 Family Separation

When an emergency occurs, families are often separated because they cannot safely get to each other's location. In large disasters involving evacuation, families may be separated for extended periods.

13.1.5 Abuses Related to Evacuation

Children placed in temporary homes may be subject to abuse at the hands of those who are supposed to be taking care of them. Children evacuated to shelters may be at risk of violence and emotional trauma due to the nature of the mixed population at the shelter. Besides these kinds of abuse, children may also suffer unintentional neglect of their medical needs because basic health services may not be available.

13.1.6 Denial of Children's Access to Quality Education

Often during emergencies, even when a school building is left intact by the disaster, the building may be used as a temporary shelter, and other issues such as loss of power may prevent the school from operating.

13.2 Oklahoma's Infants and Children's Crisis Centers

13.2.1 Infant Crisis Services

Infant Crisis Services Inc. is a center that provides life-sustaining formula, food and diapers to babies and toddlers, blankets, clothing, and other basic necessities in times of crisis. Based on availability of items, the Infant Crisis Services will provide the baby or toddler with the following items:

- One week's supply of diapers
- Pack of baby food or toddler food, formula, and bottle • Seasonal clothing (6 items of clothing)
- Sleeper, socks, blanket, and other miscellaneous items
- Age-appropriate toy and book

The Infant Crisis Services

4224 N. Lincoln Blvd.

Oklahoma City, OK. 73105

405-528-3663

info@infantcrisis.org

Children's Recovery Center 320 12th Ave. N.E.

Norman, OK. 73071

405-364-9004

14.0 Programs to Assist in Emergency Response

14.1 Children First Program

The Children First program is a community-based voluntary family resource program which offers home visitation to families expecting to deliver and/or parent their first child. The program encourages early and continuous prenatal care, personal development, and the involvement of fathers, grandparents, and other supporting persons in parenting. Public Health Nurses provide home visitation services during pregnancy and the first two years of the child's life. Activities are designed to be responsive to the developmental needs of mothers, children, and families during pregnancy and early parenthood.

Women meeting the following enrollment criteria

- Pregnant woman less than 28 weeks gestation
- Families expecting to deliver and/or parent their first child
- Families with little financial or social support

The information above is from Sooner Care- Child Health Checkup Provider manual.

14.2 OSDH Children First Program

Oklahoma State Department of Health (OSDH), Oklahoma City Health Department (OCCHD), and Tulsa Health Department (THD) provide Children First services in our state. The OSDH provides specially trained public health nurses that perform home visits. The nurses are prepared to answer questions and provide guidance that will promote the health, safety, and optimum development of child during the early stages of development and up to the first two years of the child’s life. Children First services are free to all eligible mothers.

The following services are provided during visits:

- Brief health assessments
- Child growth and development evaluations
- Nutrition education
- Parenting and relationship information
- Links to other services such as childcare, education, and job training

These services are not intended to replace services provided by the mother or child’s primary health care provider. Nurses will work collaboratively with such providers to assure the needs of the family are met.

14.3 Women, Infants, and Children (WIC)

The Women, Infants, and Children (WIC) program provides nutritious foods to supplement the diets of women, infants, and children. WIC foods are specifically chosen to provide the nutrients to women and their children need in their lives.

WIC provide information about healthy eating and promotes active lifestyles. For more information concerning WIC link on the Oklahoma State Department of Health website: Https://www.ok.gov/health and search WIC.

15.0 Mental Health Needs

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is our primary resource for mental health services in our state. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) partners with many local and nonprofit agencies during disaster responses. Contact information is as follows:

Primary: Ashley House

Clinical Behavioral Care, Disaster Coordinator

Oklahoma Department of Mental Health and Substance Abuse Services (OKMHSAS)

Work Cell: 405- 248- 9335

Ashley.House@odmhsas.org

Secondary: Penny Sanders, LADC-MH-C

Program Manager Open Access /APS Team Lead

OK-Dept of Mental Health and Substance Abuse Services

Work Cell:405-445-2983

Penny.Mitchell@odmhsas.org

Children's Crisis Centers assist young people who are in need of crisis intervention and stabilization for trauma, emotional, behavioral, or substance abuse issues. The services are provided in a secure residential setting for up to five days, if needed. Program components include individual, group, and family therapy, along with medication management if deemed medically necessary. Admission Criteria is set by the Oklahoma Health Care Authority and applicable state law (Title 43 A).

Children's Crisis Centers work with no insurance and Medicaid clients, and are in network with some private insurance companies. While the units are located in specific towns, they serve children across the state. The following Infant Crisis Centers are as follows:

The following organizations are the primary resources for mental health needs for children in Oklahoma.

- Red Rock 4404 N Lincoln Blvd. Oklahoma City, OK 73105
  405-425-0333
  www.red-rock.com -- Serving Ages 10 to 17
- Children's Recovery Center 320 12th Ave NE Norman, OK 73071

405-364-9004 ---Serving Ages 13 to 17

- CALM Center 6126 E 32nd Place Tulsa, OK 74135
  918-394-CALM (2256)
  www.crsok.org Serving Ages 10 to 17.

Children's mental health and resilience building are essential aspects of all phases of emergency preparedness including response, recovery, and mitigation. The following recommendations address the mental health needs of children before, during, and after a disaster.

15.1 Recommendations for Mental Health Preparedness in Children

- Incorporate mental health needs of children in the preparedness planning of federal, state, and regional/local government agencies. Avoid separating planning for safety, security, and other health needs from planning for mental health needs. Reviewing and incorporating existing international disaster preparedness guidelines could facilitate the improvement of planning in the United States.
- Recognize factors that place children at risk and act proactively to help improve the mental health infrastructure for those children and their families. This includes the creation of a network or system that improves referral mechanisms and information about available resources.
- Children need to be engaged as active participants during disaster preparedness and throughout the resiliency process. Issues related to age, cognitive development and current skill level need to be taken into account to increase the potential for empowering and educating children. Successfully engaging children throughout the resiliency process will increase their self-efficacy, coping, and overall resiliency to disaster.
- Risk communication needs to be more effectively implemented. Recognize and consider the mental health implications of announcements in the media and responsibly communicate messages to caregivers. This involves taking into account recipients' literacy level, access to resources and the assessment of the trust of public messages.
- Recognize limitations in preparedness that may impact preparedness activities. These limitations can be proactively addressed by requiring training for all medical and mental health professionals who will be working appropriately assess, treat and provide referrals.
- Create a national emergency mental health funding mechanism to preauthorize generic crisis response plans that address the mental health needs of children and families.

- Disaster is not an isolated event and continues to affect people throughout their life. Due to the long-range implications and effects of disaster, it is essential that all disaster plans include vast resources for assessing and treating child mental health issues and concerns throughout the child's lifespan.
- Professionals who care for children need to be trained to understand mental health issues impacting children post-disaster. This includes having a better understanding and practice with differential diagnosis for disorders such as Post Traumatic Stress Disorder (PTSD), Autism Spectrum Disorder (ASD), adjustment, anxiety and mood disorders. Implementing training programs for graduate students can help to broaden the understanding of mental health issues that impact children for these future practitioners.

15.2 Mental Health Needs of Children during Disaster and Terrorist Events

- Provide federal funding for mental health care of children and families after a disaster to include both screening and therapy. Funding must be sufficiently flexible to allow for a response tailored to the needs of local communities that does not exclude those with pre-existing mental health problems.
- Ensure that children with pre-existing mental health conditions are not excluded from eligibility for mental health care after a disaster or crisis. Such children may be especially vulnerable to post-traumatic stress reactions and a range of other mental health problems after the event.
- Set time limits on government funding for mental health intervention based on clinical evaluation. Mental health problems in children may present soon after a disaster or persist over long periods of time. Even children who do not meet full criteria for a mental health diagnosis may have significantly impaired functioning and need intervention.
- Provide public information about the immediate and long-term effects of disasters to help parents, teachers, pediatricians, and other community service providers identify children suffering from long-term effects in mental health.
- Commission mental health professionals in the media to provide information to caregivers on how to help children cope during times of stress (anniversaries of the event, holidays, life changes, threats, etc.).
- Recommend a family-centered approach that includes assessment, early intervention, and treatment with primary caregivers and other family members. Additionally, incorporate nonclinical approaches to treatment that may be effective with some child particular populations.
- Interventions should always be culturally and linguistically appropriate and would ideally engage the parent as a treatment collaborator.

- Support parents' mental health and concrete needs. Research has shown that appropriate parental functioning after a disaster is a protective factor for children's mental health functioning.
- Take into account cultural, socioeconomic, community, history, risk, and vulnerability factors when preparing and implementing interventions in particular communities. It is essential that multicultural issues are reviewed when developing intervention guidelines for different members of the community.
- Children and families heal as communities heal and find ways to cope with new realities. As such, it is important to keep in mind community recovery as essential and positively correlated to individual recovery.

15.3 Helping Children Cope in Emergencies

Regardless of your child's age, he or she may feel upset or have other strong emotions after an emergency. Some children react right away, while others may show signs of difficulty much later. How a child reacts and the common signs of distress can vary according to the child's age, previous experiences, and how the child typically copes with stress.

Children react, in part, on what they see from the adults around them. When parents and caregivers deal with a disaster calmly and confidently, they can provide the best support for their children. Parents can be more reassuring to others around them, especially children, if they are better prepared.

15.4 Factors that Influence the Emotional Impact on Children in Emergencies

The amount of damage caused from a disaster can be overwhelming. The destruction of homes and separation from school, family, and friends can create a great amount of stress and anxiety for children.

The emotional impact of an emergency on a child depends on a child's characteristics and experiences, the social and economic circumstances of the family and community, and the availability of local resources. Not all children respond in the same ways. Some might have more severe, longer-lasting reactions. The following specific factors may affect a child's emotional response:

- Direct involvement with the emergency
- Previous traumatic or stressful event
- Belief that the child or a loved one may die
- Loss of a family member, close friend, or pet
- Separation from caregivers
- Physical injury
- How parents and caregivers respond
- Family resources

- Relationships and communication among family members
- Repeated exposure to mass media coverage of the emergency and aftermath
- Ongoing stress due to the change in familiar routines and living conditions
- Cultural differences
- Community resilience

15.4.1 Severe Emotional Disturbance/Behavior Disorder

Children who have serious emotional and behavioral problems are at high risk for severe stress reactions following a crisis. Typically, these children can have limited coping skills to handle “normal” daily stress; they are likely to be overwhelmed by unexpected and traumatic events such as a terrorist attack or the loss of family member. Those who suffer from depression and anxiety disorders are likely to exhibit exaggerated symptoms-- greater withdrawal, heightened agitation, increased feelings of worthlessness and despair, increase in nervous behaviors such as thumb sucking, nail biting, pacing, etc. Children with a history of suicidal thinking or behavior are especially prone to increased feelings of hopelessness and need to come to the attention of school personnel following any serious event likely to trigger these feelings. Additional information on preventing suicide in troubled children and youth may be found on the National Association of School Psychologists (NASP) website (Https://www.nasponline.org/).

Those children who experience conduct problems, noncompliance and aggression are also likely to exhibit more extreme versions of problem behaviors. The children may demonstrate higher levels of disruptive and oppositional behaviors more frequent or more severe acts of aggression, etc. These children thrive on the consistent, predictable routines that are difficult to maintain in an emergency or crisis situation.

15.4.2 Therapy or Emotional Support Animals

Therapy dogs are typically pets that have been obedience trained, tested, and registered by Therapy Dog organization. Under The American with Disabilities Act (ADA), "comfort," "therapy," or "emotional support animals" do not meet the definition of a service animal. With or without a legal definition it is generally known that for patients or children who are anxious, apprehensive, or depressed Therapy Dogs have a calming effect. By rhythmically touching and patting them it has the same reassuring, comforting effect as a child hugging a special toy or nuzzling a favorite blanket.

The results are immediate as the dogs simultaneously raise spirits and lower blood pressure. They encourage interaction while making no demands of

their own. Their indiscriminate acceptance of people and unconditional love are, indeed, just what the doctor ordered.

A legal definition of a therapy dog does not exist at this current time.

16.0 Disaster Recovery for Children

16.1 Birth (ages 0- 2 years)

When children are pre-verbal and experience a trauma, they do not have the words to describe the event or their feelings. However, they can retain memories of particular sights, sounds, or smells. Infants may react to trauma by being irritable, crying more than usual, or wanting to be held and cuddled. The biggest influence on children of this age is how their parents cope. As children get older, their play may involve acting out elements of the traumatic event that occurred several years in the past and was seemingly forgotten.

16.2 Preschool (ages 3 through 6 years)

Children often feel helpless and powerless in the face of an overwhelming event. Because of their age and small size, they lack the ability to protect themselves or others. As a result, they feel intense fear and insecurity about being separated from caregivers. Preschoolers cannot grasp the concept of permanent loss. They can see consequences as being reversible or permanent. In the weeks following a traumatic event, preschoolers' play activities may reenact the incident or the disaster over and over again.

16.3 School (ages 7 through 10 years)

The school-age child has the ability to understand the permanence of loss. Some children become intensely preoccupied with the details of a traumatic event and want to talk about it continually. This preoccupation can interfere with the child's concentration at school and academic performance may decline. At school, children may hear inaccurate information from peers. They may display a wide range of reactions — sadness, generalized fear, or specific fears of the disaster happening again, guilt over action, or inaction during the disaster, anger that the event was not prevented, or fantasies of playing rescuer.

16.4 Pre-adolescence to adolescence (ages 11 through 18 years)

As children grow older, they develop a more sophisticated understanding of the disaster event. Their responses are more similar to adults. Teenagers may become involved in dangerous, risk-taking behaviors, such as reckless driving, or alcohol or drug use. Others can become fearful of leaving home and avoid previous levels of activities. Much of adolescence is focused on moving out into the world. After a trauma, the view of the world can seem more dangerous and unsafe. A teenager may feel overwhelmed by intense emotions and yet feel unable to discuss them with others.

16.5 Helping Children Cope with Disasters

Disasters can leave children feeling frightened, confused, and insecure. Whether a child has personally experienced trauma, has merely seen the event on television or has heard it discussed by adults, it is important for parents and teachers to be informed and ready to help if reactions to stress begin to occur.

Children may respond to disaster by demonstrating fears, sadness or behavioral problems. Younger children may return to earlier behavior patterns, such as bedwetting, sleep problems and separation anxiety. Older children may also display anger, aggression, school problems or withdrawal. Some children who have only indirect contact with the disaster but witness it on television may develop distress.

16.6 Recognize Risk Factors

For many children, reactions to disasters are brief and represent normal reactions to "abnormal events." A smaller number of children can be at risk for more enduring psychological distress as a function of three major risk factors:

- Direct exposure to the disaster, such as being evacuated, observing injuries or death of others, or experiencing injury along with fearing one’s life is in danger.

16.7 Loss/grief

This relates to the death or serious injury of family or friends

- On-going stress from the secondary effects of disaster, such as temporarily living elsewhere, loss of friends and social networks, loss of personal property, parental unemployment, and costs incurred during recovery to return the family to pre-disaster life and living conditions.

17.0 Vulnerabilities in Children

In most cases, depending on the risk factors above, distressing responses are temporary. In the absence of severe threat to life, injury, loss of loved ones, or secondary problems such as loss of home, moves, etc., symptoms usually diminish over time. For those that were directly exposed to the disaster, reminders of the disaster such as high winds, smoke, cloudy skies, sirens, or other reminders of the disaster may cause upsetting feelings to return. Having a prior history of some type of traumatic event or severe stress may contribute to these feelings.

Children are coping with disaster or emergencies are often tied to the way parents cope. They can detect adults' fears and sadness. Parents and adults can make disasters less traumatic for children by taking steps to manage their own feelings and plans for coping. Parents are almost always the best source of support for children in disasters. One way to establish a sense of control and to build confidence in children before a disaster is to engage and involve them in preparing a family disaster plan. After a disaster, children can contribute to a family recovery plan.

17.1 Meeting the Children's Emotional Needs

Children's reactions are influenced by the behavior, thoughts, and feelings of adults. Adults should encourage children and adolescents to share their thoughts and feelings about the incident. Clarify misunderstandings about risk and danger by listening to children's concerns and answering questions. Maintain a sense of calm by validating children's concerns and perceptions and with discussion of concrete plans for safety.

Listen to what the child is saying. If a young child is asking questions about the event, answer them simply without the elaboration needed for an older child, or adult. Some children are comforted by knowing more or less information than others; decide what level of information your particular child needs. If a child has difficulty expressing feelings, allow the child to draw a picture or tell a story of what happened. Try to understand what is causing anxieties and fears. Be aware that following a disaster, children are most afraid that:

- The event will happen again.
- Someone close to them will be killed or injured.
- They will be left alone or separated from the family.

17.2 Reassuring Children after a Disaster

17.2.1 Suggestions to help reassure children after the disaster:

- Personal contact is reassuring. Hug and touch your children.

- Calmly provide factual information about the recent disaster and current plans for ensuring their safety along with recovery plans.
- Encourage your children to talk about their feelings.
- Spend extra time with your children such as at bedtime.
- Re-establish your daily routine for work, school, play, meals, and rest.
- Involve your children by giving them specific chores to help them feel they are helping to restore family and community life.
- Praise and recognize responsible behavior.
- Understand that your children will have a range of reactions to disasters.
- Encourage your children to help update your family disaster plan.

If you have tried to create a reassuring environment by following the steps above, but your child continues to exhibit stress, if the reactions worsen over time, or if they cause interference with daily behavior at school, at home, or with other relationships, it may be appropriate to talk to a professional. You can get professional help from the child's primary care physician, a mental health provider specializing in children's needs, or a member of the clergy.

17.2.3 Check List for Helping Your Young Child's Health

Young children, toddlers, and preschoolers- even babies – know when bad things happen, and they remember what they have been through. After a scary event, we often see changes in their behavior. They may cry more, become more clingy and not want us to leave, have temper tantrums, hit others, have problems sleeping, become afraid of things that did not bother them before, lose skills… Changes like these are a sign that they need help. Here are some ways you can help them.

Safety- Focus on safety first- Your young child feels safe when you

- Hold them or let them stay close to you.
- Tell them you will take care of them when things are scary or difficult. With children who are learning to talk, use simple words, like saying "Mother, Daddy, or Grandmother is here."
- Keep them away from frightening television (TV) images and scary conversations.
- Do familiar things, like sings a song you both like or telling a story.
- Let them know what will happen next (to the degree that you know).
- Have a predictable routine, at least for bedtime: a story, a prayer, cuddle time.
- Leave them with familiar people when you have to be away.
- Tell them where you are going and when you will come back.

17.3 Allow Expression of Feelings

- Young children often “behave badly” when they are worried or scared. Children can “act out” as a way of asking for help. Remember! Difficult feelings= Difficult behavior.
- Help your child name how she feels: “scared,” “happy,” “angry,” “sad”. Tell them it’s ok to feel that way.
- Help your child express anger in ways that won’t hurt, using words, play, or drawings.
- Talk about the things that are going well to help you and your child feel good.

17.4 Follow Your Child’s Lead

- Different children need different things. Some children need to run around, others need to be held.
- Listen to your child and watch their behavior to figure out what they need.

17.5 Enable your child to tell the story of what happened during and after the disaster

- Having a story helps your child make sense of what happened and cope better with it.
- Children use play to tell their story. For example, they may throw blocks to show what the disaster was like. They may separate toy animals to show how they were separated from you.
- Join your child in showing and telling not only what happened, step by step, but also how you both felt.
- As you tell the story, follow your child’s lead. When the story is difficult, your young child may need breaks: running around, being held, playing something else. This is ok. They will come back to the story when they are ready.
- It can be hard to watch your children’s play or listen to their stories. Get support if it is too hard for you to listen without becoming upset.

17.6 Ties—Reconnect with supportive people, community, culture, and rituals

- Simple things like a familiar bedtime story, a song, and family traditions remind you and your child of your way of life and offer hope.
- If you belong to a group, like a church, try to find ways of reconnecting with them.
- You can help your child best when you take care of yourself. Get support from others when you need it.

17.7 Your Child Needs You! This is the most important fact to remember

- Reassure your child that you will be together.
- It is common for children to be clingy and worried about being away from you.
- If you need to leave your child, let her know for how long and when you are coming back. If possible, leave something that belongs to you, or a picture that you child can have.
- Just being with your child, even when you can't fix things, helps your child.

17.8 When Children Need More Help

Programs may also be interested in knowing when they should suggest to parents their children may need more support than the program or parents can provide. Children may need the help of a mental health professional if:

- There is not sign of any decrease in the child's emotional or physical reactions to the disaster. Usually, children will return to their normal behavior in the days and weeks following a traumatic event. If, after a month, the intensity of the child's reactions has not lessened, the help of a counselor or psychologist may be needed.
- There is an increase in the severity of the child's symptoms. If the child's symptoms become more intense, this should alert providers the child is experiencing depression, post-traumatic stress disorder, or other mental health issues. Worsening symptoms area a signal the help of a mental health professional is needed.
- The child's symptoms are distressing to the family. After a disaster, relationships among a family can become increasingly complex. If a child's continued reaction to a traumatic event results in extreme concern or disruption within a family, mental health services for the child and/or the whole family may be warranted.
- The child's reactions interfere with the child's normal activities, such as attending childcare, preschool, or school. Parents can sometimes help children make these adjustments by staying with them in the childcare program or school for a period. This should only be done for a specific period of time and should not continue so long it creates dependency. If children are not able to engage in the routines in which they normally participated after a few weeks, the help of a counselor or psychologist may be needed.

Parents and providers may be interested in how they can teach children to be resilient and how they can help them adapt well in the face of adversity, trauma, tragedy, threats, and significant sources of stress resulting from

disasters and other events. Some tips on how to help children develop resiliency from the American Psychological Association found on their website.

18.0 Equity

The term “equity” means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

The term “equitable” treatment is also referenced for children and adults in disaster preparedness and response. Everyone should be treated with respect during disaster planning. Disaster planning is “inclusive” not exclusive in the delivery of resources, medical treatment, planning and/or responses before, during, or after a disaster.

19.0 Legal Information for Children and Youth Disaster Planning

19.1 Civil Rights - Federal Laws

A summary of the rights of the child under Article 5 of the UN Convention on the Rights of the Child is as follows: Article 5 clearly states that children have the right to a family and that families have the right to care for their children. These rights are just as applicable in emergency situations as in any other situation. Actions to support and reunite separated children may require a long-term commitment, involving not just the initial phase of an emergency or the first few months but possibly a number of years.

Currently, three Federal statutes already require states to take disabled children into account in disaster planning, including (1) The American with Disabilities Act, (2) The Individuals with Disabilities Education Act, and (3) The Rehabilitation Act.

Above and beyond Federal law, Federal Emergency Management Agency (FEMA) has also pointed out that the broader population of access and functional needs children include infants and toddlers, who are immobile, trapped in cribs and playpens and who, in emergency situations, must rely on caregivers for evacuation and relocation.

The Americans with Disabilities Act of 1990, (Pub. L. 101-336, enacted July 26, 1990), codified as 42 U.S.C. § 12101 et seq. In Re: Childcare, Title II (Public); Title III (Center and Home-based). See Also:

- “U.S. Department of Justice Civil Rights Division; Disability Rights Section- Commonly Asked Questions about Childcare Centers and The Americans with Disabilities Act.
- The Individuals with Disabilities Education Act of 1990, (Pub. L. 101-476 enacted October 30, 1990), codified as 20 U.S.C. 1400 et seq.
- The Rehabilitation Act of 1973, (Pub. L. 93-112, enacted September 26, 1973), codified as 29 U.S.C. § 701.

20.0 Federal and Local Disaster Agencies

20.1 FEMA

The Federal Emergency Management Agency's (FEMA) National Emergency Family Registry and Locator System (NEFRLS) facilitate family reunification when individuals are separated during a disaster.

The system provides a secure Web-based environment where survivors and their loved ones can communicate their location as well as provide a personalized message. FEMA also has a call center to assist people who do not have Internet access.

To support the reunification of children under 21 years of age with their parent(s)/legal guardian, FEMA works in collaboration with the National Center for Missing and Exploited Children (NCMEC). Individuals reporting or searching for a child missing as a result of a disaster should call the NCMEC National Emergency Child Locator Center at 1-866-908-9572. NCMEC is staffed 24-hours a day.

20.2 American Red Cross

The American Red Cross (ARC) maintains Safe and Well, a Web-based system that helps reunify friends and family displaced by a disaster. To speak with someone at the ARC concerning a missing friend or relative, please contact the local ARC chapter where you live or are staying (visit Https://www.redcross.org To find a local chapter).

21.0 Service Animals in the Shelter

Children in a shelter will need to maintain their routines as much as possible. Many times, children will have a need for a “service animal” to maintain their daily routine. The federal government has strict guidelines for service animals and comfort animals in disaster responses and daily routines.

21.1 Definition of Service Animals

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person’s disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under The Americans with Disabilities Act (ADA).

This definition does not affect or limit the broader definition of “assistance animal” under the Fair Housing Act or the broader definition of “service animal” under the Air Carrier Access Act. Some State and local laws also define service animal more broadly than the ADA. Information about such laws can be obtained from the State Attorney General’s office.

21.2 Where Service Animals Are Allowed

Under the ADA, State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital it would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms, Intensive Care Unit (ICU’s), or burn units where the animal’s presence may compromise a sterile environment.

21.3 Service Animals Must Be Under Control

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal’s work or the individual’s disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

21.4 Other Specific Rules Related to Service Animals

The following information states other specific rules, inquiries, charges, and exclusions that pertain to service animals:

- When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask two questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform. Staff cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.
- Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, for example, in a school classroom or at a homeless shelter, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the facility.
- A person with a disability cannot be asked to remove his service animal from the premises unless: (1) the dog is out of control and the handler does not take effective action to control it or (2) the dog is not housebroken. When there is a legitimate reason to ask that a service animal be removed, staff must offer the person with the disability the opportunity to obtain goods or services without the animal's presence.
- Establishments that sell or prepare food must allow service animals in public areas even if state or local health codes prohibit animals on the premises.
- People with disabilities who use service animals cannot be isolated from other patrons, treated less favorably than other patrons, or charged fees that are not charged to other patrons without animals. In addition, if a business requires a deposit or fee to be paid by patrons with pets, it must waive the charge for service animals.
- If a business such as a hotel normally charges guests for damage that they cause, a customer with a disability may also be charged for damage caused by himself or his service animal.
- Staff workers are not required to provide care or food for a service animal.

21.5 Types of Service Animals

The list below contains the various types of service dogs or miniature horses that assist the access and functional needs populations. The service dog/miniature horse can be trained for all types of services for their owners. The list below should not be considered complete.

- Diabetes Alert Dog
- Guide Dog/ Miniature Horse
- Hearing Alert Dog
- Migraine Alert Dog
- Mobility Aid Dog/ Miniature Horse
- Narcolepsy Alert Dog/ Narcolepsy Response Dog
- Psychiatric Service Dog
- PTSD Service Dog
- Seizure Alert Dog/ Miniature Horse/ Seizure Response Dog/Miniature Horse

22.0 Differences between a Service Dog and a Therapy Dog

The differences between service dogs and therapy dogs are very noticeable from the perspectives of services provided and legal perspectives. The terms, ‘service dog” and ‘therapy dog’ are not meant to be used as equivalents and should not be used to mean the same thing; they are not the same type. According to Federal Law, a service animal is not a pet. The Americans with Disabilities Act (ADA) states that a service animal is any animal that has been individually trained to provide assistance or perform tasks for the benefit of a person with a physical or mental disability which substantially limits one or more of the person’s major life functions.

22.1 A Therapy Dog

A therapy dog is one that is trained to provide comfort and affection to people in long-term care, hospitals, retirement homes, schools, mental health institutions, and other stressful situations such as disasters. Therapy dogs provide people with animal contact; these persons may or may not have a form of disability. Therapy dogs work in animal-assisted activities and animal-assisted therapy. The dog is commonly owned by the person handling it, who considers the dog to be a personal pet.

22.2 Therapy or Emotional Support Animals

Therapy dogs are typically pets that have been obedience trained, tested, and registered by Therapy Dog organization. Under the ADA, "comfort," "therapy," or "emotional support animals" do not meet the definition of a service animal. With or without a legal definition it is generally known that for patients or children who are anxious, apprehensive, or depressed Therapy Dogs have a calming effect. By rhythmically touching and patting them it has the same reassuring, comforting effect as a child hugging a special toy or nuzzling a favorite blanket.

The results are immediate as the dogs simultaneously raise spirits and lower blood pressure. They encourage interaction while making no demands of their own. Their indiscriminate acceptance of people and unconditional love are, indeed, just what the doctor ordered.

A legal definition of a therapy dog does not exist at this current time. Under the U.S. Federal Laws, Emotional Support Animals (Therapy Dogs) cannot go into no-pets allowed places, but they are allowed to live in “no-pet” housing and in the cabins of airplanes when accompanied by a note from their handler’s doctor.

22.3 Miniature Horses

In addition to the provisions about service dogs, the Department's revised ADA regulations have a new, separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities. (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds). Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

23.0 Oklahoma Laws

23.1 Oklahoma Law on Child Abuse

Oklahoma statutes define child abuse as harm or threatened harm to a child's health or welfare by a person responsible for the child. This includes non-accidental physical or mental injury, sexual abuse or neglect (10 O.S. Section 7102). Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services (OKDHS). Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

- Physical abuse is non-accidental physical injury to a child
- Mental injury is an injury to a child's psychological growth and development. It is caused by a chronic pattern of behaviors, such as belittling, humiliating and ridiculing a child.
- Sexual abuse, in general terms, includes any sexual activity between an adult and a child for the purpose of sexually stimulating the adult, the child or others. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or is in a position of power or control over the child.
- Neglect is the failure of the parent or caretaker to provide a child with basic needs such as food, clothing, shelter, medical care, protection and supervision.
- Threatened harm means a substantial risk of harm to the child. It may include acts or expressions of intent to inflict actual harm presently or in the future.

23.2 Who Must Report

Every person, private citizen or professional, who has reason to believe that a child has been abused, is mandated by law to promptly report suspected abuse. Failure of do so is a misdemeanor. A person making a report in good faith is immune from civil or criminal liability. The name of the reporter is kept confidential.

23.3 When to Report

A report should be make when there is reasonable cause to believe that a child has been abused or neglected or is in danger of being abused. A report of suspected abuse is a request for an investigation. Investigation of child abuse reports is the responsibility of Child Welfare workers and, when a crime may have been committed, law enforcement officials.

If other incidents of abuse occur after the initial report has been made, another report should be made.

23.4 How Is Abuse Reported

A report may be made to any county office of the Oklahoma Department of Human Services or to the 24-hour statewide Child Abuse Hotline, 1-800-522-3511.

24.0 Childcare Information and Resources

24.1 Childcare Centers

Many families use childcare centers, daycare centers, before, and after school programs in their daily routines. The childcare centers, daycare, before, and after school programs, and agencies must develop all hazard disaster plans. These plans ensure the safety of the children before, during, and after a disaster. Childcare workers must understand the policies of their agencies plans and demonstrate the procedures of the disaster plans.

Under the circumstances that a disaster occurs while children are present in the childcare, daycare, or before and after school program; the care providers must take the initial steps to keep their clients safe. The next step would be to contact the children's parents or guardian(s), so their families are aware of their situation and know their children are safe. Reunification of parents/guardians with their children is one of the key factors in emergency planning.

Appendix A

Federal Laws that Assist AFN Population's Emergency Planning

Public Law 111 - 274 - Plain Writing Act of 2010

Public Law 111-274. Date Approved- October 13, 2010

Full Title - An act to enhance citizen access to Government information and services by establishing that Government documents issued to the public must be written clearly, and for other purposes.

Bill Number - H.R. 946. Report Number- H Rept. 111-432

Statutes at Large Citations- 124 Stat. 2861, 2862 and 2863

https://www.govinfo.gov/app/details/PLAW-111publ274

Effective Communications

The ADA requires that title II entities (State and local governments).

Title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities.
https://www.ada.gov/effective-comm.htm

The Americans with Disabilities Act (ADA)

Under Title II of the ADA, emergency programs, services, activities, and facilities must be accessible to people with disabilities and generally may not use eligibility criteria that screen out or tend to screen out people with disabilities.

https://www.ada.gov/pcatoolkit/chap7emergencymgmt.htm

Service Animals

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, contain updated requirements, including the 2010 Standards for Accessible Design (2010 Standards).
https://www.ada.gov/service_animals_2010.htm

Miniature Horse (Service Animal)

In 2010 the ADA was revised to include miniature. In 2010 the ADA was revised to include miniature horses. (Miniature horses generally range in

height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds.

https://www.ada.gov/service_animals_2010.htm

504 Rehabilitation Act

Section 504 of the Rehabilitation act of 1973, as amended, (29 U.S.C. 794 - PDF) prohibits discrimination against otherwise qualified individuals on the basis of disability:

Programs and activities that receive financial assistance from HHS; 45 C.F.R. Part 84 and

Programs or activities conducted by HHS. 45 C.F.R. Part 85

https://www.hhs.gov/civil-rights/for-individuals/disability/laws-guidance/index.html#:~:text=Section%20504%20of%20the%20Rehabilitation,assistance%20from%20HHS%3B%2045%20C.F.R.&text=Programs%20or%20activities%20conducted%20by%20HHS.

Stafford Act

Robert T. Stafford Disaster Relief and Emergency Assistance Act, PL 100-707, signed into law November 23, 1988; amended the Disaster Relief Act of 1974, PL 93-288. This Act constitutes the statutory authority for most Federal disaster response activities especially as they pertain to FEMA and FEMA programs. https://www.fema.gov/disaster/stafford-act

Appendix B

Federal Supported Programs and Resources Available at the State Level

Program	Information	Learn More Links
Head Start and Early Head Start	Early Head Start serves women who are pregnant and families with children under age 3, and Head Start programs serve children between 3 and 5 years old. Head Start programs promote the school readiness of infants, toddlers, and preschool-aged children from low-income families. Services are provided in a variety of settings including centers, family child care, and a child's own home. Head Start programs also engage parents or other key family members in positive relationships, with a focus on family well-being. Head Start programs are available at no cost to children ages birth to 5 from low-income families, and programs may provide transportation to the centers. Families and children experiencing homelessness and children in the foster care system are also eligible.	• Office of Head Start • Head Start and Early Head Start Overview
Healthy Start	Healthy Start is a federal program operating 101 Healthy Start projects in 34 states, Washington, DC, and Puerto Rico to strengthen the foundations at the community, state, and national levels to help women, infants, and families reach their fullest potential.	• Healthy Start Website
Family-to-Family Health Information	F2F Health Information Centers are nonprofit organizations, funded by the HRSA, that provide information, education, technical assistance, and peer support to families of children and youth with special	• Information on F2F • Find your State/Territory's F2F

Centers (F2F)	health care needs and the providers who serve them.	
Health Care Coalitions (HCCs)	HCCs, funded by ASPR's Hospital Preparedness Program (HPP), are networks of individual public and private organizations in a defined geographic area that partner to prepare health care systems to respond to emergencies, ultimately increasing local and regional resilience.	• Find an HCC near you
Health Centers	Health Centers, funded by HRSA, is one of the largest systems of primary and preventive care in the country that provides care to millions of patients regardless of ability to pay.	• Health Centers Website
Maternal, Infant, and Early Childhood Home Visiting Program	The Maternal, Infant, and Early Childhood Home Visiting Program gives women who are pregnant and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.	• Home Visiting Website • State Fact Sheets

Program	Information	Learn More
Perinatal Quality Collaborative (PQC)	PQCs are state or multistate networks of teams working to improve the quality of care for mothers and babies.	• PQC Website • State-Based PQCs

Temporary Assistance for Needy Families (TANF)	The TANF program provides states and territories with flexibility in operating programs designed to help low-income families with children achieve economic self-sufficiency. States use TANF to fund monthly cash assistance payments to low-income families with children, as well as a wide range of services.	·TANF Website

Appendix C

Reunification - Federal and Local Disaster Agencies

FEMA

The Federal Emergency Management Agency's (FEMA) National Emergency Family Registry and Locator System (NEFRLS) facilitate family reunification when individuals are separated during a disaster.

The system provides a secure Web-based environment where survivors and their loved ones can communicate their location as well as provide a personalized message. FEMA also has a call center to assist people who do not have Internet access.

To support the reunification of children under 21 years of age with their parent(s)/legal guardian, FEMA works in collaboration with the National Center for Missing and Exploited Children (NCMEC). Individuals reporting or searching for a child missing as a result of a disaster should call the NCMEC National Emergency Child Locator Center at 1-866-908-9572. NCMEC is staffed 24-hours a day.

American Red Cross

The American Red Cross (ARC) maintains Safe and Well, a Web-based system that helps reunify friends and family displaced by a disaster. To speak with someone at the ARC concerning a missing friend or relative, please contact the local ARC chapter where you live or are staying (visit Https://www.redcross.org to find a local chapter).

Appendix D

Planning Checklist for Diapering Stations in Shelters

Building and Placing a Diapering Station

- Is diapering station as far from water stations, food prep and dining areas as possible?
- Is the diaper changing surface made of non-porous material?
- Is there a rail or similar barrier that surrounds the diaper changing surface to help protect children from falls?
- Is one station available for every 8 diapered children?
- Is the diapering station within arm's reach of sink? Sink should not be used for food preparation, dishwashing, or dispensing water to drink.

Stocking the Station

- Is sink stocked with liquid soap? If diapering station cannot be placed within reach of an existing sink and a temporary handwashing station cannot be set up, provide hand sanitizer containing 60% alcohol. Place sanitizer within reach of caregiver, but out of reach of children (ideally in a fixed wall dispenser).
- Are paper towels or air dryers available for drying hands?
- Is a lidded, plastic-lined trash receptacle (preferably with a foot-operated opening mechanism) available in the diapering area?
- Are clean paper towels, butcher paper, or other disposable materials available for lining the changing table?
- If shelter will provide diapers and wipes, are these placed within reach of caregivers but away from diapering surface?
- Is appropriate disinfectant solution* in reach of caregivers, but out of children's reach?

*EPA-registered disinfectant appropriate for the diapering surface or freshly prepared bleach solution.

Education

- Are signs posted to instruct caregivers to wash their hands and child's hands with soap and water immediately after the diaper change?
- Are signs posted to use the diapering station sink for handwashing but not for drinking, cooking, or washing dishes or clothing?
- If diapering station is not near sink or temporary handwashing station, are signs posted at diapering station to direct caregivers to nearest sink?
- Are instructions posted about how to use the disinfectant solution? Consider labeling spray bottle with instructions in large type, or including these instructions on posters about diapering procedures.

For more information go to the following website: https://www.cdc.gov/healthywater/emergency/planning-checklist-for-diapering-stations-in-shelters/

Print-and-Go Fact Sheet

Planning Checklist for Diapering Stations in Shelters pdf icon[PDF – 1 page] (English)

Planning Checklist for Diapering Stations in Shelters pdf icon[PDF – 1 page] (Español)

Appendix E

Infection Control Guidance for Community Evacuation Centers Following Disasters

These recommendations provide basic infection control guidance to prevent exposure to or transmission of infectious diseases in temporary community evacuation centers.

Community evacuation centers include medium and large-scale, organized, temporary accommodations for person displaced from their homes (e.g., following natural disasters such as hurricanes, floods, and earthquakes). Evacuation facilities may be residential (e.g., dormitories or campsites) or non-residential (e.g., sports stadiums and churches), with varying degrees of sanitary infrastructure. Individuals in evacuation centers are required to share living spaces and sanitary facilities and may be exposed to crowded conditions. Evacuees may have health problems including traumatic injuries, infectious diseases, and chronic illnesses such as renal failure.

General Infection Prevention for Residential Evacuation Centers

Use of appropriate infection prevention measures by all staff and evacuees can reduce the spread of infectious diseases.

- Staff and residents should wash their hands with soap and water frequently.
- Children should be assisted in washing their hands with soap and water frequently.
- Alcohol hand gels are an effective addition to hand washing, and a reasonable temporary substitute when soap and clean water are not readily available.
- Alcohol hand gel should be positioned throughout the evacuation center, especially at the beginning of food service lines and outside of toilet facilities.
- Encourage good personal hygiene practices including the following:
    - Cover your cough with tissues, disposing tissues in the trash, or with your hands. Wash your hands or use alcohol hand gel after coughing. If possible, tissues should be provided in evacuation center living areas.
    - Follow good hygienic practices during food preparation.
    - Do not share eating utensils or drinking containers.
    - Do not share personal care items such as combs, razors, toothbrushes, or towels with any one else.

- Facilities should be adequate to allow residents to bathe at least twice weekly.
- Laundry facilities should be available to allow appropriate laundering of clothes and bed linens.

Hand Hygiene

After an emergency, it can be difficult to find running water. However, it is still important to wash your hands to avoid illness. It is best to wash your hands with soap and water but, when water isn't available, you can use alcohol hand gels made for cleaning hands. Below are some tips for washing your hands with soap and water and with alcohol hand gel.

When should you wash your hands or use an alcohol hand gel?

1. Before eating food.
2. After handling uncooked foods, particularly raw meat, poultry, or fish.[1]
3. After going to the bathroom.
4. After changing a diaper or cleaning up a child who has gone to the bathroom.
5. Before and after tending to someone who is sick.
6. Before and after treating a cut or wound.
7. After blowing your nose, coughing, or sneezing.
8. After handling an animal or animal waste.
9. After handling garbage.

Cleaning the Living Area

Keeping surfaces and items clean helps to reduce the spread of infections to residents and staff.

- Clean surfaces with a household detergent when visibly dirty and on a regular schedule:
    - Kitchens and bathrooms should be cleaned daily and as necessary.
    - Living areas should be cleaned at least weekly and more often if necessary.
    - Bed frames, mattresses and pillows should be cleaned/laundered between occupants.
    - Other furniture should be cleaned weekly and as needed.
    - Spills should be cleaned up immediately
- Sanitize (i.e., reduce microbial contamination to safer levels) high-risk surfaces using a household disinfectant (e.g., a product with a label stating that it is a sanitizer) or a mixture of 1 teaspoon of household

bleach in 1 quart of clean water (mixed fresh daily). High-risk surfaces include:
    - Food preparation surfaces.
    - Surfaces used for diaper changing.
    - Surfaces soiled with body fluid (e.g., vomitus, blood, feces)

Laundry

- Garments heavily soiled with stool should be handled carefully, wearing gloves, and placed in a plastic bag for disposal. If stool can easily be removed using toilet paper, the garment may be laundered as described below.
- Wash clothing in a washing machine using normal temperature settings and laundry detergent.
- Household bleach can be used at normal concentrations.
- Dry clothes completely in a dryer.
- There is no need to disinfect the tubs of washers or tumblers of dryers if cycles are run until they are completed.
- Make sure donated clothing is washed before distribution.

Garbage

- Waste disposal should comply with local requirements including disposal of regulated medical waste such as syringes and needles.
- Facilities should provide for proper disposal of syringes and needles used for medications. Containers designed for sharp waste disposal should be placed where sharp items are used. A heavy plastic laundry detergent bottle with a lid may be used if official sharps containers are not available.
- Use trash receptacles lined with plastic bags that can be securely tied shut.
- Trash bags should not be overfilled.
- Place trash in an area separated from the living spaces, preferably in trash bins.
- Have waste pick-ups scheduled frequently—daily, if possible.
- Separate medical waste from household waste for pickup; follow local guidelines for pickup of medical waste.

Special Consideration for Non-Residential Evacuation Centers

Non-residential evacuation centers such as stadiums and churches have limited capacity for providing sanitary and food preparation facilities. Bathing

and laundry resources are also likely to be limited. In general, it is preferable for non-residential facilities to be used only for very short-term evacuation. Food-service and laundry should be provided from external sources rather than attempting to set up poorly controlled on-site alternatives or allowing residents to attempt these activities individually.

Because of the potentially high ratio of residents to toilets, non-residential facilities have a particular need for frequent and supervised cleaning and maintenance of sanitary facilities. Designated evacuation center personnel should staff each restroom, controlling the number of individuals using the facility at one time, ensuring that surfaces are wiped down with disinfectant at least hourly, and that basic supplies such as hand soap, paper towels, and toilet paper are maintained.

The ability to clean surfaces in non-residential settings may be limited by the size or other physical characteristics of the facility. This increases the importance of hand hygiene. However, such facilities are also likely to have limited availability of hand washing sinks. Thus, additional attention should be paid to positioning alcohol hand gel dispensers in convenient locations throughout the living areas and at the beginning of food service lines, and ensuring that all arriving residents are instructed on their use and availability.

Open sleeping areas should be set up to prevent crowding, ideally with at least 3 feet separating each cot from the next.

Management of Persons with Infectious Diseases in Evacuation Centers

Arrival of evacuees who may have open wounds, symptomatic infections, and unrecognized or incubating infectious diseases, combined with potential for crowding and limited sanitary infrastructure, increases the risk of infections spreading among residents and between residents and staff. In particular, respiratory infections, diarrheal diseases and skin infections or infestations are prone to spread under these conditions. Before entering an evacuation center, all residents should be screened for the following conditions:

- Fever
- Cough
- Skin rash or sores
- Open wounds
- Vomiting
- Diarrhea

Persons with any of the above conditions should be admitted to the evacuation center only after appropriate medical evaluation and care. Residents of the center should be instructed to report any of the above conditions to the center staff. If a potentially infectious condition is identified

in a person already residing at the evacuation center, the ill individual(s) should be separated from other residents or transferred to a special needs evacuation center (see below). A separate area or room should be identified in advance to be used to house potentially infectious residents awaiting evaluation or transfer. If several residents with similar symptoms are identified, they may be housed together in one area. However, cots should still be separated by at least 3 feet. A dedicated restroom should be identified if possible and reserved for use of the ill individuals only. More than one separate area may be needed if more than one illness is identified in the population, e.g., an area for people with diarrhea, and another area for people with a cough and fever. Such separate areas will need to have extra staff members dedicated to monitoring people housed there and ensuring that the area is kept clean and appropriately supplied.

Staff members with any of the above symptoms should not work in the evacuation center, but should seek medical evaluation for assessment and clearance prior to returning to work. Staff members working with residents who have symptoms of illness should use Standard Precautions (defined below) for any interactions that require potential contact with body fluids, and should place particular emphasis on hand hygiene.

Each evacuation center should have a clear plan for transferring individuals with potentially communicable diseases from the evacuation center to an appropriate healthcare facility. This includes plans for having ill individuals with respiratory symptoms wear a paper mask while awaiting evaluation or transfer. A waiting area should be designated that is separate from the main center living areas, but which can be closely monitored by center staff. A system for identifying and notifying the receiving facility must be in place.

Special-Needs Evacuation Centers (Access and Functional Needs Centers)

Special-needs (Access and Functional Needs) evacuation centers are places that can provide safe refuge to those individuals who require supervision by a healthcare professional. They include:

- People with minor health or medical conditions that require professional observation, assessment, and maintenance beyond the capabilities of the general evacuation center staff or facility.
- People with infectious diseases whose care requires protective equipment or isolation that are not available at the general evacuation center.
- People who require assistance with activities of daily living or more skilled nursing care but do not require hospitalization.
- People who need medications or monitoring by health professionals.

Standard Precautions[2] should be used whenever working with ill individuals, to protect residents and staff from exposure to recognized and unrecognized sources of infection.

Transmission-Based Precautions, including personal protective equipment (e.g., gloves, masks, and gowns) and isolation of ill individuals in separate rooms or areas, are based on the type(s) of symptoms an ill individual has. These precautions should be used when appropriate in the special-needs evacuation center. If possible, special-needs evacuation center staff should have access to healthcare personnel who are trained in infection control.

Footnotes

1. Food handlers should wash hands with soap and water before beginning work, and before returning to work from any toilet visit or break. Alcohol hand gel should not be substituted in food handlers.
2. Standard Precautions (summary): During the care of any ill individual, personnel should:
    - Wear gloves if hand contact with blood, body fluids, respiratory secretions or potentially contaminated surfaces is expected.
    - Wear a disposable gown if clothes might become soiled with a patient's blood, body fluids or respiratory secretions.
    - Change gloves and gowns after each patient encounter and wash hands or use alcohol hand gel immediately after removing gloves.
    - Wash hands or use alcohol hand gel before and after touching a patient, after touching the patient's environment, or after touching the patient's respiratory secretions, whether or not gloves are worn.
    - When hands are visibly dirty or contaminated with respiratory secretions, wash hands with soap (either plain or antimicrobial) and water.

For more information go to:

https://www.cdc.gov/disasters/commshelters.html

Appendix F

Infection Control- Coughing and Sneezing

Covering coughs and sneezes and keeping hands clean can help prevent the spread of serious respiratory illnesses like influenza, respiratory syncytial virus (RSV), whooping cough, and COVID-19. Germs can be easily spread by:

- Coughing, sneezing, or talking
- Touching your face with unwashed hands after touching contaminated surfaces or objects
- Touching surfaces or objects that may be frequently touched by other people

To help stop the spread of germs:

- Cover your mouth and nose with a tissue when you cough or sneeze
- Throw used tissues in the trash
- If you don't have a tissue, cough or sneeze into your elbow, not your hands

Remember to immediately wash your hands after blowing your nose, coughing or sneezing.

Washing your hands is one of the most effective ways to prevent yourself and your loved ones from getting sick, especially at key times when you are likely to get and spread germs.

Covering coughs and sneezes and washing hands are especially important for infection control measures in healthcare settings, such as emergency departments, doctor's offices, and clinics.

- Wash your hands with soap and water for at least 20 seconds
- If soap and water are not readily available, use an alcohol-based hand sanitizer that contains at least 60% alcohol to clean hands

To help prevent the spread of respiratory disease, you can also avoid close contact with people who are sick. If you are ill, you should try to distance yourself from others so you do not spread your germs. Distancing includes staying home from work or school when possible.

https://www.cdc.gov/healthywater/hygiene/etiquette/coughing_sneezing.html

Appendix G

Radiation Safety and Your Health

A nuclear power plant accident, a nuclear explosion, or a dirty bomb are examples of radiation emergencies. If something like this happens, you may be asked to get inside a building and take shelter for a period of time instead of leaving. The walls of your home can block much of the harmful radiation. Because radioactive materials become weaker over time. Staying inside for at least 24 hours can protect you and your family until it is safe to leave the area.

Getting inside of a building and staying there is called “shelter in place”.

There are three simple steps to be taken during a radiation emergency.

Step One: Get Inside

In a radiation emergency you may be asked to get inside a building and take shelter for a period of time.

- This action is called “sheltering in place”.
- Get to the middle of the building or a basement, away from doors and windows.
- Being pets inside.

Step Two: Stay Inside

Staying inside will reduce your exposure to radiation

- Close and lock windows and doors
- Take a shower or wipe exposed parts of your body with a damp cloth
- Drink bottled water and eat food in sealed containers.

If you are indoors during the radiation emergency:

1. Stay inside. Close and lock all windows and doors. Go to the basement or the middle of the building. Radioactive material settles on the outside of the buildings; so the best thing to do is stay as far away from the walls and the roof of the building as you can.
2. If possible, turn off fans, air conditioners, and forced-air heating units that bring air from the outside. Close fireplace dampers.

If you are in a car, bus, or other vehicle during a radiation emergency:

A. Get inside a building right away. Cars do not provide good protection from radioactive material. If you can get to a brick or concrete multistory building or basement within a few minutes, go there. But being inside any building is safer than being outside. Once inside, go to the basement or the middle of the building.

Radioactive material settles on the outside of buildings, so the best thing to do is stay as far away from the walls and roof of the building as you can.

B. Carefully remove your outer layer of clothing before entering the building, if you can. Radioactive material settles on your clothing and your body, like dust or mud. Once inside, wash the parts of your body that were uncovered when you were outside. Then put on clean clothing, if you can. This will help limit your radiation exposure and keep radioactive material from spreading.

C. If you have loved ones in schools, daycares, hospitals, nursing homes, or other places during a radiation emergency:

- Stay where you are! Going outside to get loved ones could expose you and them to dangerous levels of radiation.
- Children and adults in schools, daycares, hospitals, nursing homes, or other places will be instructed to stay inside until emergency responders know that it is safe to evacuate.
- Schools, daycares, hospitals, nursing homes, and other places have emergency plans in place to keep people safe at the facility. D. If you have pets:
- Bring pets inside with you, if you can. Bring indoors any supplies from outside that your pets might need for at least 24 hours.

Step Three: Stay Tuned

Emergency officials are trained to respond to disaster situations and will provide specific actions to help keep people safe.

- Use radios, televisions, computers, mobile devices, and other tools to get the latest information.
- Emergency officials will provide information on where to go to get screened for contamination.

For more information go to:

https://www.cdc.gov/nceh/radiation/emergencies/index.htm#:~:text=In%20a%20radiation%20emergency%3A,you%20and%20your%20family%20safe.

Appendix H

Oklahoma Childcare Requirement for Emergency Planning

The state of Oklahoma establishes guidelines for emergency planning for childcare facilities. These requirements must be met to receive childcare license for facility operations. The Oklahoma Child Care Facilities Licensing Act link is: https://oklahoma.gov/okdhs/services/child-care-services/child-care-licensing/licensing-requirements.html .

Oklahoma Child Care Emergency Preparedness and Response Plan

The information contained in this Appendix is to provide guidance and procedures for the Department of Human Services Child Care Services (CCS) to respond to a disaster that significantly affects a community's child care infrastructure. The plan outlines the roles and responsibilities of CCS and partner organizations in providing support to child care providers and families affected by a disaster.

This plan was created using the following assumptions:

1) Child care is an integral and essential part of a community's economic viability and should be restored as soon as possible following an emergency event.
2) Child care providers have their site-specific emergency and disaster plans as required by Child Care Licensing Requirements which outlines the mandates to practice drills, review and adjust as needed based on children, families, staff, and facility needs and to keep families informed of current and any revised procedures.
3) Child Care providers should have enough food, water and supplies to take care of children for up to three days without intervention in an extreme situation.
4) This document is consistent with other local, state and federal disaster planning documents related to caring for the needs of young children.
5) Families may need temporary assistance with respite care for their children while they work in the recovery phase following an emergency/disaster.
6) Emergency responders may need care for their own children in order to meet the needs of the community.
7) Emergency responses will vary depending on the needs of a community, the particular emergency or disaster, the geographic area involved, extent of the damage and auxiliary services available.
8) Child care providers update their emergency plan as needed and communicate their plan to all families, staff and to their licensing

specialist; especially important for any new family and new staff or at any time there have been changes to the plan.

9) Supplies are prepared for the unexpected emergency, special attention should be followed relating to any food allergies and/or medication needs of children or adults.
10) Some emergencies happen without warning so important paperwork and supplies are kept in a convenient location and be ready to "grab and go" at a moment's notice. All contact information is accessible and up-to-date for families of children and staff.

The key emergency response functions relating to child care are:

- Support the safety and well-being of children in child care through continued licensing efforts.
- Ensure the continuation of Child Care Services division services. A Continuity of Operations Plan (COOP) reviewed annually outlines the administrative plan if CCS staff or facilities are involved in an emergency/disaster in any part of the state.
- Provide technical assistance as requested by providers, licensing personnel and make recommendations for temporary or emergency child care.
- Continue child care subsidy payments to providers.
- Continue eligibility determinations and subsidy authorizations for parents and address any new needs for subsidy due to the impact of the emergency, such as a loss of employment.
- Disseminate information to providers and families regarding disaster assistance and response including recovery, reunification and rebuilding with the Oklahoma Emergency Operation Center and other agencies that offer support following an emergency.

Planning For Continuation of Services to Child Care Families

Oklahoma Department of Human Services has in place a Continuity of Operations Plan (COOP) which incorporates Child Care Services. This plan designates responsibility for essential staffing needs relative to the agency's primary mission to improve the quality of life of vulnerable Oklahomans by increasing people's ability to lead safer, healthier, more independent and productive lives. The office of Emergency Management Services coordinates state wide responses and provides updates during and immediately following an event.

A) Continuity of Service

The priority is to protect the health and safety of children in care while minimizing the impact to providers and families. Any time a situation exists in the state where child care might be affected due to structural damage of a facility, loss of utilities or any other condition that would limit the ability to

care for children in healthy, safe environments, licensing specialists across the state monitor the impact and report findings to CCS. Individual responses are made dependent on the situation.

B) Coordination with other State/Territory Agencies and Key Partners

Child Care Services and Department of Human Services staff collaborates with members of Children in Emergencies Committee. The committee meets quarterly and is convened by the Oklahoma Department of Emergency Management. Representatives on the committee are from local, state, regional agencies. The Oklahoma State Department of Health Resource Guide for Access and Functional Needs of Children and Youth in Disaster Planning is used to monitor emergency response to meet the needs of vulnerable populations, such as children.

Emergency Preparedness Regulatory Requirements for Child Care Providers

Licensing Requirements for Child Care Programs and Family Child Care Homes detail situations that emergency plans should include procedures for

(A) serious injuries

(B) serious illnesses

(C) poison exposure

(D) outbreaks of communicable diseases, including pandemic influenza;

(E) weather conditions, including tornados, floods, blizzards, and ice storms;

(F) fires, including wildfires;

(G) man-made disasters, including chemical and industrial accidents

(H) human threats, including individuals with threatening behaviors, bomb threats, and terrorist attacks;

(I) lost or abducted children

(J) utility disruption

(K) other natural or man-made disasters that could create structural damage to the facility or pose health hazards.

Specific details are found in Licensing Requirements. Emergency plans must be written and individualized to the program and hours of operation; reviewed annually with staff and families; and drills are conducted at various times throughout the hours of operation, so that each child and staff member, including volunteers, participates at least one time every three months.

Fire drills are conducted at least monthly by evacuating and meeting at pre-determined locations; tornado drills are conducted at least monthly by sheltering in pre-determined on-site locations; lock down and relocation procedures reviews: at least once every 12 months; and the director updates, as necessary, and reviews emergency plans and procedures: at least once every 12 months; upon enrollment of children with disabilities or chronic medical conditions; after a drill when procedure issues are identified; and after an emergency.

Emergency plans should include:

Procedures for addressing each child's needs, with additional considerations for:

- 2-year-olds and younger; and
- Children and staff with disabilities or chronic medical conditions.
- Each family, staff member, and volunteer is informed of procedures for every type of emergency response.
- Ways to account for the location of each staff and child during an emergency include:
    - Sheltering in place (an appropriate response at times when safety is sought within an occupied building, such as a tornado watch.
    - Lock down procedures (should be initiated when there is a credible threat to safety of children and staff. A response might include staying in classrooms, lock all outside and inside doors, and remain out of sight.);
    - Evacuation procedures (to exit the building to a pre-determined location on the property such as a typical fire drill. Could also consist of leaving the area to travel to a predetermined location and includes a transportation plan. Reasons for this kind of evacuation could include a gas leak, weather-related disaster, or specific, serious damage to a facility).
    - Informing families of the pre-determined transportation plan and evacuation location and alternate location;
    - A method for reuniting parents or other approved adults with the children in each type of emergency involving lock-down, shelter-in-place, or evacuation.
- Procedures for notifying emergency authorities and parents including a method and backup method. Texting may be the best form of communication in times of emergencies. Procedures should ensure all personnel including volunteers receive training and are familiar with emergency plans and procedures for different types of emergency responses. Training includes personnel roles and responsibilities in an

emergency; location of posted emergency routes and alternate routes; location of first aid and emergency supply kits; and location and use of fire extinguishers.

- First responders may be available to share specific emergency procedures for a specific facility, if inquiry is done prior to an emergency situation.
- Accessible, operable phones must be available in emergency sites including off-site if an evacuation is conducted. There should also be a phone in each vehicle when children are transported.
- Posted emergency information must include program information and emergency numbers; first aid kit, emergency supply kit, and fire extinguisher locations; and evacuation routes.
- Emergency first aid and supply kits are required to have mandated supplies listed in Licensing Requirements; records of all children and personnel currently in attendance with up-to-date emergency contact information; and children and staff's prescribed medications.
- Emergency equipment should include smoke and carbon monoxide alarms that are operable and tested at least monthly; central detection and alarm system for smoke and carbon monoxide, inspected and tagged at least every 12 months by a state licensed authority; fire extinguishers and automatic sprinkler systems that are fully functional; and inspected and tagged at least every 12 months by a state licensed authority.

Post Disaster Support

Child Care Licensing Specialists in the affected areas assess the needs of child care providers to continue child care that meets health and safety requirements. Programs that are closed due to structural or utility disruption are noted and families are provided alternate program referral information by Child Care Resource and Referral. Licensing staff will contact the CCS state office to report on the numbers of programs impacted, to what degree, and specific needs of the community are taken into consideration.

If there is a need for additional child care in disaster declared areas, Child Care Services staff will work with the Oklahoma Department of Emergency Management, Red Cross, FEMA, Oklahoma Child Care Resource and Referral, etc. to determine where care can be made available at other locations. Child Care Providers may be asked if they can care for additional children who have been impacted by the emergency.

Reunification of families with their children should be included in programs' emergency plans. Reunification is defined as 'the process of assisting displaced disaster survivors, including children, in voluntarily reestablishing contact with family and friends after a period of separation'. Swift and safe reunification should include procedures to identify and verify who has

permission to assume responsibility for a child. Collaboration with Emergency Management, community officials, and other disaster relief organizations is part of a reunification plan.

Post-disaster supports may be available for families and providers. In each disaster response, CCS will assist emergency management and other responders with getting information disseminated related to child care and keeping children safe. Oklahoma has used resources available through county and state health and mental health departments to assist with physical and emotional health supports.

Child Care Licensing Specialists have access to materials and resources that can used to assist providers with emergency preparedness and response.

IV. Restoring or Rebuilding Child Care Facilities and Infrastructure after a Disaster

Oklahoma Child Care Services has a system in place to identify the needs of communities following a disaster or emergency and to ensure that the safety and needs of young children and their families are met. Collaborative meetings are held by phone or in person with national, state and local emergency management teams to include child care in the immediate and post-emergency restoration of services.

Multiple Oklahoma organizations and agencies related to children and emergencies meet regularly to discuss coordination of efforts. A few links to provide additional assistance are:

Disaster Distress Helpline https://www.samhsa.gov/find-help/disaster-distress-helpline

FEMA resources are available at the following links:

Public Assistance guide, 2016: https://www.fema.gov/media-library/assets/documents/111781

Post-Disaster Child Care Needs and Resources:

https://www.acf.hhs.gov/archive/ohsepr/response-recovery/post-disaster-child-care-needs-and-resources

The National Child Traumatic Stress Network http://nctsn.org

Appendix I

AFN Planning for Community Resources Template

Throughout this document community outreach and resources was explained in various formats. Information provided on school programs, community programs, and non-profit organizations in the state of Oklahoma. Information also provided on state and federal guidelines that offer assistance during emergencies. Each component carriers an impact in “whole community planning”.

Knowing your community resources, community partners, federal and state partners is a major part of all hazard’s emergency planning. Knowing your local community statistics in areas of: gender, age, language, social-economic levels, and disabilities; ensures your local community plans will be effective in preparedness, response, and recovery from disasters.

The template below can be used to simplify the location of resources for your local community plans. Each community in our state is comprised of different resources, abilities, disabilities, and of course different access and functional needs during disasters. The template just simplifies the location and identification of these resources before a disaster occurs in your community. Which in turns allows you more time as a planner to prepare and respond to the disaster in your local community. Each table has at least three lines to increase the possibility of communications and response. I hope this helps you in your whole community, local emergency management.

Access and Functional Needs
Whole Community Planning Template

Name of the County_____

Name of the Local Emergency Response Coordinator_____

Name of the Emergency Manager _____

Emergency Manager telephone number _____

Emergency Manager email address _____

Date: _____ Review Date: _____

Durable Medical Equipment (DME) Resources

Name of Agency/ Contact Person	Address of Agency	Telephone # Agency	Email address

List of DME that can used during emergencies:

_____

_____

Home Health Agencies

Name of Agency/ Contact Person	Address of Agency	Telephone # Agency	Email address

Other information needed for this resource

_____

_____

Local Hospitals

Name of Agency/ Contact Person	Address of Agency	Telephone #	Email address

Other information for this resource

_____

_____

Out Patient Medical Clinics (AM/PM) Clinics

Name of Agency/ Contact Person	Address of Agency	Telephone # Agency	Email address

Other information for this resource

_____

_____

Pharmacies

Name of Agency/ Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for this resource

_____

_____

Nursing Schools

Name of Agency / Contact Person	Address of School	Telephone # Agency	Email Address

Other information for this resource

_____

_____

Veterinary Hospitals/ Schools

Name of School / Contact Person	Address of School	Telephone # Agency	Email Address

Other information for this resource

_____

_____

ARC/Food Pantry/ Non-Profit Organizations

Name of Agency /Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for these resources

Local Disability Organizations – For People Who Are Blind or Have Low Vision

Name of Agency/ Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for this resource

Local Disability Organization for People who are on the Autism Spectrum

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for these resource

Local Organizations for People who are Hard-of-Hearing or who are Deaf

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for these resource

_____

_____

Local Disability Organization for People with Mobility Disabilities

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for these resources

_____

_____

Local Organization for People Senior in Age

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for these resources

_____

_____

Local Organizations that Speak Spanish

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information for those resources

Local Homeless Organizations

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information from these resources

Local Organizations that Speak Other Languages - Outreach

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information from these resources

Community Youth Organizations (example- YMCA, Boys and Girls Club)

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information from these resources

Local Faith Based Organizations (FBO's)

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information from these resources

Local Community Based Organizations (CBO's)

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information from these resources

Local Utilities for Community (water, electric, gas)

Name of Agency / Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information from these resources

_____

_____

Local Mental Health Organizations

Name of Agency/ Contact Person	Address of Agency	Telephone # Agency	Email Address

Other information from these resources

_____

_____

_____

Appendix: J

Accessible Communications for Shelters, Multi-Agency Resource Centers (MARC's), and Disaster Recovery Center's (DRC's)

The number one complaint in every disaster is communications. The primary gap in disasters start with communications. Having accessible communications before, during, and after a disaster is very important for community safety, response, and recovery. Below is a checklist that will assist agencies, non-profits, faith-based organizations, or individual's in "accessible communications for shelters, multi-agency resource centers (MARC's) and disaster recovery centers (DRC's). Simply having documents on the computer does not make them accessible for everyone in your community. Many people do not own computers or have the computer skills to access your website. People have to have "money" for internet services. Internet services might not be accessible due to the Wi-Fi capabilities in the community. People might need to have adaptive devices to see your web page if it is not accessible for their abilities on the computer. Last but not least is your website using "plain language or easy reading" material for their document to use during and after the disaster? These factors are what makes the producing reading materials challenging, but rewarding for "whole community" preparedness and response. The checklist below is a simple process to cause you to think about what is needed in shelters, MARC's and DRC's for accessible communications.

Please understand this list below can be added to at any time. This list is considered a "living document"; that can be expanded as we learn more on access and functional needs population's planning and needs for disaster responses in our state. The bullets below will also have the reason why the formatting is important for emergency planning and responses during disasters. The number one rule is as follows: If you have the information in English; you should have it in Spanish, American Sign Language (ASL), and any other language used for emergency messaging.

The information below is also important for education in inclusive, equitable, and diverse emergency planning and responses for local, regional, or state emergency response agencies.

- Large Print documents (16-18-20, and 22 size font, Arial, Bold) Flyers
    - This format is useful for people with visual disabilities.
    - This format is useful for people who are older in age.
        - When creating your large print document just make the font size larger.

        - Use Black or Dark Blue for your font color for high contrast (non-glossy paper, white paper) on your computer flyers or printed documents for your community.
        - Don't forget to put ASL services on your fliers for people who are Deaf or Hard-of-Hearing. You can use the graphic for ASL or put ASL Services available.
- Audio Format information messages
    - This format is useful for people who have visual disabilities
    - This format is useful for people who are hard-of-hearing
    - This format is useful for people who have cognitive disabilities
    - This format is useful for people who are older in age
    - This format is useful for people with low literacy
- American Sign Language (ASL) messages
    - This format is useful for people who use ASL for communication (people who are Deaf or people who are Hard-of- Hearing)
    - If possible, use Certified ASL interpreters (for accurate language interpretation services)
    - If this is not possible, think about the safety of your clients and the importance of "accurate" information transference.
    - Medical information should only be interpreted by a certified ASL interpreter.
    - Legal information should only be interpreted by a certified ASL interpreter.
    - Video Remote Interpreting (VRI) services will allow the interpretation to occur your "smart device" or computer on an "as needed" bases. Use your smart phone, tablet, or computer for these services. (e.g., facetime, goggle Duo, etc.) These services will reduce the people in your facility and can be used on the "as needed" bases.
- Information in Spanish (audio and written format)
    - This format is useful for people who use Spanish as their primary language
    - This format is useful for people who have low literacy in the English language and use Spanish for important decision-making decisions.
    - Ensure you have "accurate" Spanish interpretation.
    - Ensure you have television or radio stations that focus on these specific populations.
        - The basic rule is as followings: If you have the information in English on the television; they ensure you have the same in other languages.

- Foreign Language Documents and Messages (audio and written format)
    - This format is useful for people with low literacy in English and need their primary language for important decision-making decisions.
    - Ensure you have “accurate” foreign language interpretation.
    - Ensure you have television or radio stations that focus on these specific populations.
        - The basic rule is as followings: If you have the information in English on the television; they ensure you have the same in other languages. (if possible)
- Easy Reading Documents (Graphics)
    - This format is useful for people who cognitive disabilities.
    - This format is useful for people who are on the Autism Spectrum.
    - This format is useful for people who are older in age.
    - This format is useful for people with low literacy.
        - For people did not attend college or trade school.
        - For people that did not attend high school.
        - For people who have cognitive disabilities. (e.g., stroke, traumatic brain injury,
    - Understand that culturally competent “graphics” should be “inclusive” for the communities.
- Plain Language Documents (computer, audio, and written)
    - Create your documents in “plain language”.
    - Use terms that are easily understood by everyone. Instead of stating involuntarily undomiciled; use without permeant house or housing.
    - Instead of stating submission of applications; use the following- how do I apply?
    - Do not make the form complicated.
    - Do not use acronyms.
    - This format is useful for people who cognitive disabilities.
    - This format is useful for people who are older in age.
    - This format is useful for people with low literacy.
        - For people did not attend college or trade school.
        - For people that did not attend high school.
        - For people who have cognitive disabilities. (e.g., stroke or traumatic brain injury)

Acronyms

ADA- Americans with Disabilities Act
ASERT- Autism Services, Education, Resources and Training
ASL- American Sign Language
ARC- American Red Cross
ASD- Autism Spectrum Disorder
BPA – Bisphenol A
CCS- Child Care Services
CDC- Centers for Disease Control and Prevention
C-FAST- Children's- Functional Assessment Support Team
CLAS- Culturally and Linguistically Appropriate Services
DHS- Department of Human Services
DRC- Disaster Recovery Center
ED-Emergency Department
ENPC- Emergency Nursing Pediatric Course
EOP - Emergency Operations Plan
FEMA- Federal Emergency Management Agency's
Flu- Influenza
HICS- Health/Hospital Incident Command System
Hr. - Hour
ICS- Incident Command System
J-I-T-T- Just- In-Time-Training
LD- Learning Disabilities
MCC- Hospital/Medical Command Center
MCH- Maternal Child Health
MD- Medical Doctor
NACCRRA- National Association of Childcare Resource & Referral Agencies
NASP- National Association of School Psychologist
NCMEC- National Center for Missing and Exploited Children
NCTSN- The National Child Traumatic Stress Network

NEFRLS- National Emergency Family Registry and Locator System

NOAA- National Oceanic and Atmospheric Administration

NP- Nurse Practitioner

OCCHD- Oklahoma City County Health Department

ODMHSAS- Oklahoma Department of Mental Health and Substance Abuse Services

OK- Oklahoma

OKDHS- Oklahoma Department of Human Services

OMH- Office of Minority Health

OSDH- Oklahoma State Department of Health

O.S. - Oklahoma Statutes

PA- Physician Assistant

PALS- Pediatric Advanced Life Support

PIO- Public Information Officer

PNP- Pediatric Nurse Practitioner

PTSD- Post Traumatic Stress Disorder

PVA- Polyvinyl Alcohol

QAST- Quality Assurance Screening Test

RN- Register Nurse

RSV- Respiratory Syncytial Virus

SARS- Severe Acute Respiratory Syndrome

THD- Tulsa Health Department

TV- Television

UN- United Nations

WIC- Women's, Infants, and Children

References

1. Americans With Disabilities Act- United States Department of Justice Civil Rights Division Https://www.ADA.gov-
2. ADA- Checklist for Emergency Shelters https://www.cdc.gov/healthywater/emergency/planning-checklist-for-diapering-stations-in-shelters/
3. ADA Checklist for Emergency Shelters https://www.ada.gov/pcatoolkit/chap7shelterchk.pdf
4. American Red Cross Https://www.ARC.org-
5. Agency for Healthcare Research and Quality Https://www.archive.ahrg.gov/prep/nccdreport/nccdrptapf.htm
6. ASERT- 5 Tips for Families to Prepare for Emergency Situations https://paautism.org/resource/tips-to-prepare-for-emergency/
7. Centers for Disease Control and Prevention Https://www.cdc.org-
8. Infection Control Guidance for Community Evacuation Centers Following Disasters https://www.cdc.gov/disasters/commshelters.html
9. Planning Checklist for Diapering Stations in Shelters https://www.cdc.gov/healthywater/emergency/planning-checklist-for-diapering-stations-in-shelters/
10. Infection Control for Coughing and Sneezing https://www.cdc.gov/healthywater/hygiene/etiquette/coughing_sneezing.html
11. Radiation Safety https://www.cdc.gov/healthywater/hygiene/etiquette/coughing_sneezing.html

HHS SAMHSA Disaster Distress Helpline

Anyone can call or text the Disaster Distress Helpline at 1-800-985-5990 to get immediate help and support for any distress that you or someone you care about may be feeling related to any disaster. The Helpline is free, confidential, and available 24/7/365, and answered by trained counselors.

Center for the Study of Traumatic Stress: Restoring Safety and Coping with Stress

12. https://www.cstsonline.org/assets/media/documents/CSTS_FS_restoring_sense_of_safety_aftermath_shooting.pdf
13. https://www.cstsonline.org/assets/media/documents/CSTS_FS_Coping_with_Stress_Following_Mass_Shooting.pdf

Child Care Aware: Helping Children Cope with Traumatic Events

14. https://www.childcareaware.org/our-issues/crisis-and-disaster-resources/tools-publications-and-resources/helping-children-understand-and-cope-with-disasters/

Head Start Early Childhood Learning and Knowledge Center: Supporting Recovery After Trauma

15. https://eclkc.ohs.acf.hhs.gov/mental-health/article/supporting-recovery-after-trauma

Save the Children: 10 Tips for Helping Children Cope with Disaster

16. https://www.savethechildren.org/us/charity-stories/help-children-cope-with-disaster

American Psychological Association: Managing Your Distress

17. https://www.apa.org/topics/gun-violence-crime/mass-shooting

State Resources

1. Infants Crisis Services, Inc. Https://www.crsok.org
2. National Association of School Psychologists Https://www.nasponline.org
3. U.S. Department of Homeland Security Https://www.dhs.gov
4. Federal Emergency Management Agency Https://www.fema.gov
5. Children First Https://www.occhd.org/childrenfirst
6. Oklahoma State Department of Health Children First:
7. https://oklahoma.gov/health/family-health/family-support-and-prevention-service/children-first-program.html
8. Oklahoma Department of Rehabilitation Services Https://www.okrehab.org/info/interpeters.htm
9. Oklahoma Department of Mental Health and Substance Abuse Services Https://www.red-rock.com-
10. Save the Children Https://www.Savethechildren.org
11. HHS Maternal- Child Health Emergency Planning Toolkit

https://www.phe.gov/Preparedness/planning/abc/mch-planning-toolkit/Documents/MCH-Emergency-Plng-Toolkit-508.pdf

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